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Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Wednesday 29 September 2010

Session 3

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CONTENTS

HEALTH AND SPORT COMMITTEE

27th Meeting 2010, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
Rhoda Grant (Highlands and Islands) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
*Mr Frank McAveety (Glasgow Shettleston) (Lab)
Nanette Milne (North East Scotland) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

THE FOLLOWING GAVE EVIDENCE:

Jim Elder-Woodward (Inclusion Scotland)
Theresa Fyffe (Royal College of Nursing Scotland)
John Gallacher (Unison)
Shelley Gray (Long Term Conditions Alliance Scotland)
Katie Hay (Law Society of Scotland)
Delia Henry (Royal National Institute for Deaf People Scotland)
Dr Bill Mathewson (Royal College of General Practitioners Scotland)
Hilary Patrick (Law Society of Scotland)
Carolyn Roberts (Scottish Association for Mental Health)
Dr Allen Thurston (University of York and Royal National Institute of Blind People Scotland)
Mhairi Thurston (Royal National Institute of Blind People Scotland)
Dr Sally Winning (British Medical Association Scotland)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 29 September 2010

[The Convener *opened the meeting at 09:32*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 27th meeting in 2010 of the Health and Sport Committee. I remind everyone to switch off their mobile phones and other electronic equipment. Apologies have been received from Rhoda Grant, and Frank McAveety will substitute for her later in the meeting.

Agenda item 1 is a decision on whether to take item 5, on our forthcoming work programme, in private. Do we agree?

Members *indicated agreement.*

Patient Rights (Scotland) Bill: Stage 1

09:32

The Convener: Item 2 is our second oral evidence session on the bill. We will hear from three panels of witnesses, the first of which is from the Law Society of Scotland. I welcome Hilary Patrick, the vice-convener of the mental health and disability sub-committee, and Katie Hay, who is a law reform officer. I thank the witnesses for their written submission.

Mary Scanlon (Highlands and Islands) (Con): I will concentrate on mental health. I am not quite sure whether the Law Society is in favour of the bill, given that it has expressed various reservations. There is a paragraph on mental health in the Law Society's submission, but the best submission on mental health is from the Scottish Association for Mental Health. It says that mental health is

"excluded from the treatment time guarantee"

and that mental health treatment can be delivered on an out-patient or day-patient basis, in out-patient clinics, general practitioner surgeries, day centres, and in people's homes by community psychiatric nurses and cognitive behaviour therapists.

There seems to be a flavour of some patients having more rights than others under the bill, and it appears that patients who have mental health issues will receive no benefit at all from the bill. Would the witnesses like to voice their concerns about how the bill will not apply to mental health?

Hilary Patrick (Law Society of Scotland): Obviously, the bill's general principles about treatment being patient focused would apply to patients with mental health issues, but the treatment time guarantee does not appear to apply at all to such patients. I think that the Government is now saying that the treatment time guarantee could apply for child and adolescent services, but I do not really understand why. Some treatments might be available to adults on a planned basis, such as treatment for a long-standing eating disorder or an obsessive compulsive disorder.

I got very excited when I read the bill, because I thought that it might help to deal with the shortage of psychological services that has been an issue over the years. However, the treatment time guarantee cannot help with that. Looking at the situation legalistically, if a provider cannot provide the service within 12 weeks, they will just not agree the service. To be perfectly honest, because of the nature of the treatment time guarantee, if I was a health board lawyer and I knew that the health board would have problems in delivering a service or treatment, I would just try not to agree the treatment. I would say to the patient that, although they might need a hip replacement or some treatment for a mental health issue, we will not agree the treatment and propose that they get it in 12 weeks. The treatment time guarantee kicks in only when there is an agreement between the clinician and the patient.

Have I made that clear? That is just a little technical problem with the way in which the treatment time is guaranteed. Any lawyer would immediately be able to find a loophole or way around it by delaying the period in which treatment is agreed.

The Convener: If someone is going to be told that although they need treatment they are not going to get it, so that the health board can comply with the legislation, that sounds like a bit more than a technical problem.

Hilary Patrick: Why would the health board not do that? That is what I would advise.

The Convener: I am not disagreeing; I am just saying that it is more than a technical problem.

Hilary Patrick: If I were a health board legal officer, I would say, “Please don’t agree the treatment until you know that it can be delivered within the 12 weeks.” I would advise the board to make noises that the treatment would be a good thing and to say that it will get back to the patient. Unless I am missing something, that seems to me to be an easy way of avoiding the impact of the legislation.

Mary Scanlon: The committee did an inquiry into child and adolescent mental health and wellbeing. The treatment time guarantee is to be introduced for children under the age of 16 but, as far as I am aware—there are other experts here—there is no treatment time guarantee and no waiting time target for patients who have mental health issues.

Hilary Patrick: Yes. I suppose that the question is why that group of patients is being discriminated against.

Mary Scanlon: The point is that the Patient Rights (Scotland) Bill brings no more rights to mental health patients. From what you have said, and from what the convener has picked up, am I right in saying that because a mental health patient could get antidepressants or cognitive behavioural therapy by telephone from NHS 24, inappropriate treatments could be given so that targets can be met?

Hilary Patrick: Cognitive behavioural therapy is a good example. Everyone might agree that I need it and that it could help with my depression, but there is no urgency about it. Why could a planned intervention like that not fall within the treatment time guarantee? Is it because it is not being given to an in-patient, and if not, why not? Why is that not discriminatory? Why are adults with mental health issues not being given those rights? It appears to be slightly discriminatory.

Mary Scanlon: I was coming to that point. If the Patient Rights (Scotland) Bill is for all patients, but it excludes mental health patients, is it discriminating against that patient group in law?

Hilary Patrick: I think that I would have to come back to you on the question whether the Government was discriminating. I would have to look again at the Equality Act 2010, but the provision clearly appears to be discriminatory under the normal meaning of the word.

Mary Scanlon: Most patients will have rights but certain patient groups—such as those with fertility problems, for which there are no waiting time targets, and those with mental health issues—will be excluded. Is it fair to say that, according to the bill, some patients will have rights and others will have none?

Hilary Patrick: Yes.

Mary Scanlon: Concerns have been raised about the requirement for mental health patients to have a dual diagnosis for drug and alcohol treatment. Given the health improvement, efficiency, access and treatment—or HEAT—target for drug addiction services, how can they achieve the HEAT target treatment time guarantee while being excluded from the mental health one? Do you understand what I am saying? Those patients need two types of treatment, but only one comes under the guarantee.

Hilary Patrick: I wonder whether it would be fair to suggest that part of the problem is putting such a guarantee in legislation and therefore fixing it in stone. It could be argued that it would be more sensible for the NHS and the Government to deal with treatment time guarantees, waiting time targets, HEAT targets and so on as priorities change.

Mary Scanlon: Reading the British Medical Association submission last night, I noted its comment that waiting time targets distort clinical priorities. Is it fair to say that to make the bill non-discriminatory and to ensure that patients have equal rights every treatment would require to be underpinned by a treatment time guarantee?

Hilary Patrick: I do not know whether I would go quite as far as that, but I think that it is invidious not to include mental health patients in the treatment time guarantee. That said, I question the value of that particular guarantee anyway.

The Convener: That was very clear.

Ross Finnie (West of Scotland) (LD): I want to pursue the introductory comments in your submission about the bill's general principles and, in particular, enforceability. The committee is dealing with two quite separate issues. You think that the bill would be improved if its provisions were enforceable. I can understand that approach—having a lawyer at every bedside is bound to be good for the Law Society—but surely it is not the most logical way of addressing the problem.

However, the committee faces a fundamental difficulty here. This is not really a matter for the Law Society, but I have no doubt that patients' rights would be improved enormously if the work that the Government has done in marshalling them cohesively and coherently were to be issued as a clear direction from the minister, in terms of section 1 of the National Health Services (Scotland) Act 1978, of what she and patients should expect and of what patients should get from the service.

I do not think that the bill really makes sense. For a start, I am not at all clear why these particular rights should be enshrined in a bill, particularly not one that includes section 18, which renders the whole thing a complete nonsense as law. Do you really think that the bill's provisions would be improved if they were made enforceable or, given that more than 90 per cent of those who responded to the consultation said that they did not want to have recourse to the law, would it have made more sense for the Government to produce a document setting out patients' rights instead of putting them in a bill?

09:45

Hilary Patrick: First, Katie Hay will make a few brief comments about where our committee is coming from on this matter.

Katie Hay (Law Society of Scotland): I would like to set our appearance this morning in some sort of context. As you know, the Law Society is a statutory body with the dual function of promoting the profession's interests as well as promoting the interests of the public in relation to the profession. Our role with regard to law reform is very much part of the latter function. Our law reform department has a number of committees—Hilary Patrick, for example, is vice-convener of our mental health and disability sub-committee—and those who sit on them give their time voluntarily with the sole purpose of suggesting how law can be improved to clients' benefit.

Hilary Patrick: The point is that, on this occasion, we are not trying to drum up business for the legal profession.

The Convener: I think that Mr Finnie was making a light comment. You must not feel wounded by it.

Ross Finnie: Maybe you should also have a sub-committee for understanding humour. That might be more appropriate.

I accept that you are not here to promote lawyers or ensure that they get more business, so let us not attempt humour or have any more silly comments and just get down to business and deal with the facts. The nub of the matter is this: if you are interested in promoting good law, do you think that it is good law to have a purported bill that gives people rights but does not set out any way of enforcing them?

Hilary Patrick: I think—

Ross Finnie: Yes or no would do.

Hilary Patrick: Under the bill, someone can still go to court and get what is known as a declarator, or statement from the court, that a health board is breaching the legislation and therefore acting illegally. That will be a charter for lawyers. If a health board—

Ross Finnie: Is that good law?

Hilary Patrick: I do not think that it is particularly good law. We could have expanded our response to make it clear that either you have something that is enforceable and meaningful or you do not have this legislation at all. To be honest, I feel that if the provisions in the bill are not meaningful—I have suggested as much in relation to the treatment time guarantee—and given that the rest of the bill is made up of principles that are hedged with woolly phrases such as "have regard to", "aim to" and so on, I find it difficult to see how they could be enforced.

Before the meeting, I made a list of about 17 rights that patients already have under law, under statute, under common law or under national health service practice. Some of them are actually much tougher than the rights that are set out in the bill, including—

The Convener: Before you list them all, I wonder whether it might be useful if you just give us a number of examples and then provide us with the list in writing.

Hilary Patrick: I will do so.

There are, for example, rights to confidentiality; rights to access to records and to advocacy; human rights, which the bill does not mention; and common-law rights about information. All those rights are tougher than what is set out in the bill. The bill, for example, says that health boards should "have regard to" confidentiality. Actually, under the Data Protection Act 1998 and their own codes of conduct, they have to respect confidentiality.

The bill will not weaken the general law, but what will it add to it other than information about changing the complaints system? Law is not needed to do that; the NHS has its own complaints system. The question for the committee is: what is the benefit of enshrining such a system in legislation? I remain to be convinced that the bill will add anything.

Ross Finnie: Why try to encapsulate all that in a bill and create a law that, apart from providing recourse to judicial review, which you might have in other circumstances anyway, could circumscribe your course of action by including section 18? Most people who were consulted on the matter said that they did not want a right to law, which begs the question why one is trying to introduce a law. However, that is a matter for the Cabinet Secretary for Health and Wellbeing.

From a legal point of view, if instead of producing this bill the Government had sought to draw together all the existing rights—indeed, it might have thought of additional rights or of different ways of expressing them—and published them in a single document, with no particular legal status save only that the cabinet secretary might issue a general direction for how health boards and other health bodies were to act in respect of the general principles of section 1 of the 1978 act, would that have diminished patients' current rights and accesses?

Hilary Patrick: Guidance or even a direction could have been issued to the NHS—power exists to give directions to the NHS. I was going to say that the one change under the Patient Rights (Scotland) Bill would be that someone could still go to court to get a declaration that the health board had behaved illegally. However, if ministers issued guidance to the NHS, one could still go to court and judicial review to say that the health board had not acted in accordance with the guidance.

No; I do not think that enshrining those rights in primary legislation increases patient rights, other than in relation to the treatment time guarantee, which I do not see as a powerful tool anyway.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We have an ombudsman system and this Parliament has established a number of ombudsmen to try to improve people's rights. The Labour-Liberal coalition Government and the SNP Government have endeavoured to improve patient rights in general, and I think that they have improved in the past decade. Would it be better to have a patients charter, as the English have? I do not know whether you have looked at the charter, but it makes a clear declaration of something like 35 rights that are referenced to the legal underpinnings of those rights.

Would it have helped to have a simple measure that, for example, required the health boards to respond to any report of the ombudsman by laying something before Parliament to indicate that they had complied with the decisions of the ombudsman? Such decisions are only a recommendation; as I understand it, the ombudsman currently has no powers to direct a health board and I am not saying that they should. If a report was laid before Parliament, at least that would provide an opportunity for debate if the board refused to—

Hilary Patrick: I might have this wrong, but I thought that if health boards did not comply with the ombudsman's report, he or she could lay a report before the Parliament. Although it is always said that the ombudsman does not have powers, I thought that it was quite a sanction that he or she could lay such a report before Parliament.

Dr Simpson: The ombudsman makes reference to those issues in its annual report, but I have not been aware of any—

The Convener: Instead of having a general discussion, we will clarify that matter before the end of the meeting.

Dr Simpson: My question stands regarding the patients charter. If the National Institute for Health and Clinical Excellence issues guidance to a health board on a question of medication with a particular drug, under the English charter the patient is entitled to that drug and the health board must supply it, if that is clinically appropriate. There are no such rights in Scotland, and there will be no such rights in the bill.

Hilary Patrick: If the patient in such a situation in Scotland came to me, I might well challenge the health board. Judicial review would be available if our equivalent of NICE had recommended the treatment and the health board had disregarded the recommendation. There could be legal challenges, although I do not know whether legal challenges would be the way to go. Personally, I prefer to address complaints through ombudspeople rather than using litigation in the health service.

Dr Simpson: To return to Ross Finnie's point, the Government could issue a direction that if a medication is approved by the Scottish Medicines Consortium, it should have to be delivered, if it is clinically appropriate.

Section 18 states:

> "Nothing in this Act prejudices—
>
> (a) the exercise of clinical judgement".

However, if the doctor's clinical judgment is that the patient should have the medication and the health board disagrees with the medicine being prescribed, that would interfere with clinical judgement, so the law seems to be a complete nonsense. Am I misunderstanding the situation?

Hilary Patrick: No, I do not think that you are.

Dr Simpson: My main question is about people with disability and, in particular, sensory problems. We have heard today about a further report on the provision of proper information whereby people who are blind are able to use the health service effectively.

The Royal National Institute of Blind People Scotland's submission states:

> "One quarter of our respondents have to rely on a friend or relative to make telephone appointments ... While 46% of respondents made appointments over the phone themselves, one-third said they had difficulties communicating with staff"

and so on. The Royal National Institute for Deaf People Scotland's research identified a list of concerns.

Do you have any comments on people who are not only blind but deaf and have other sensory deprivations, such as the 5,000 people in Scotland who are deafblind? Does the bill confer upon them any fresh rights? Does it ensure that the progress that has undoubtedly been made is followed through to a point that gives them a legal right to receive the information that they need, in the form in which they need it?

Hilary Patrick: I do not see what new rights the bill gives to those people. Are you talking mainly about communication issues?

Dr Simpson: Yes.

Hilary Patrick: One of the principles in the bill is about the provision of information and support and encouraging the person to participate, but patients have far wider rights under the Equality Act 2010 in respect of reasonable adjustments and non-discrimination. As I said previously, under that act it is not just about requiring people to "have regard to" those principles, because health boards have to make reasonable adjustments and must not discriminate. One of my concerns is that the bill's principles almost undermine the much tougher law that already exists.

Dr Simpson: That answers one of my main concerns about the bill. My other concern—

The Convener: I appreciate what you have said about existing rights and I am not disputing that. However, section 16(e) refers to

> "publicising the patient advice and support service in such a manner as is likely to bring it to the attention of patients".

Would that not be of assistance in respect of the blind and the partially sighted?

Hilary Patrick: Yes, it would, but masses has been done under the Disability Discrimination Act 1995 and more will be done under the Equality Act 2010. I do not have any particular problem with the bill's provisions on the issue. All I am saying is that, if one asks, "Does it add anything?" the answer is no, because this is already happening and people already have a public equality duty to ensure that people with disabilities are not discriminated against.

10:00

The Convener: Playing devil's advocate, however, I point out that it is not working at the moment. The people whom Richard Simpson has spoken about do not know their rights and do not get prescriptions in the appropriate manner—mind you, I cannot read a prescription either. They are not getting the medical advice or being told about stuff—they are already in the position of not being communicated with. Would that provision not help to get the information provided in a way that they can understand it?

Hilary Patrick: Part of my problem as a lawyer is the fact that people do not know the law.

The Convener: We are talking about helping them to know the law.

Katie Hay: The provision would not hinder that, necessarily. However, the fact that the wording is that a patient rights officer "may undertake" does not strengthen the position.

Dr Simpson: The word "may" is the problem. One thing that I have learned in seven years as an MSP is that these small words have a significant effect.

I want to return to the question of exclusions. We are being asked to consider a bill that entrenches discriminatory rights in law. That is one of our main concerns. The list of exclusions is: assisted conception; obstetrics; complementary and alternative medicine; organ transplant; direct access to services such as X-rays; diagnostic tests; out-patient treatments; certain national specialist services; specialist services that are delivered in England and used by Scottish patients—which I really do not understand; and alcohol and drug misuse services.

I will focus on the last of those exclusions. I draw attention to my being a member of the Royal College of Psychiatrists and having been a specialist in addictions. With the excellent HEAT targets that are being proposed, which we are all signing up to, we are already going to discriminate further between drug services and alcohol services. At the moment, even with the additional money that the Government is investing—for which I give it considerable credit; it has done a very good job in putting in the extra £40 million—there are still long waiting times for specialist alcohol treatments, which will be specifically excluded from the treatment time guarantee as I understand it.

Hilary Patrick: I am sorry to repeat what I said. My concern is that the treatment time guarantee will not help to challenge waiting times because it is an individual relationship between the clinician and the patient. There is no obligation on a clinician to agree a treatment within a certain time limit. If the treatment is not available, it will not be offered and accepted in that sort of contract and the time will run.

I am afraid that I cannot get very excited about the treatment time guarantee. I presume that it is mainly a case of the doctor saying to me, “You need a hip replacement, Hilary,” me saying, “Yes,” and the time running from that point. The doctor will do that only if he or she knows that I can have the operation within 12 weeks. Therefore, as I said, I do not see the treatment time guarantee as being a tool for tackling waiting lists. For me, one of the issues is psychological services, and those will not be included. I suggest that it is not a particularly effective tool.

Dr Simpson: That is very helpful. Thank you.

Helen Eadie (Dunfermline East) (Lab): Let us return to the point about the Scottish Public Services Ombudsman. I believe that all the reports are published on the website. I am interested in the fact that you think that that is a sanction. Some parliamentarians read the reports but others do not; therefore, how do you think that it would be a sanction?

Hilary Patrick: I do not think that it is a sanction; I just think that it is an effective remedy.

Helen Eadie: Why do you think that?

Hilary Patrick: Using the ombudsman is free and does not require much work by the patient, whereas going to lawyers costs a great deal of money. Also, the ombudsman is familiar with and has an understanding of NHS practice. Often, complaints are not about breaches of legal rights but about poor practice, rudeness and delays. As you know, the test that the ombudsman uses relates to maladministration—bad management. That is more common than some dramatic breach of legal rights.

Helen Eadie: You used the word “sanction” when replying to an earlier question. Given that the general thrust of our discussions has been that there are no enforceable rights under the bill, was your use of that word misplaced?

Hilary Patrick: My understanding is that the ombudsman makes a recommendation to the health board to pay compensation to someone or to apologise. Generally, most health boards or others criticised by the ombudsman comply with his or her recommendations. I understand that, if they do not, the ombudsman can lay a report—not the general report—before the Parliament. I thought that it would be a sanction for Lothian NHS Board, for example, if a report were laid before Parliament describing the awful thing that had happened, setting out the ombudsman’s recommendations and indicating that the board was refusing to act. That is not a legal sanction, but the Parliament would ask questions and the board would have to—

The Convener: Forgive me, but I want to move on, as we have exhausted the issue. We will get a note on whether an ombudsman’s report can be laid before Parliament. I imagine that the press, too, will pick up reports and use them.

Helen Eadie: My other question is about evidence that the committee has received. Some people believe that, if the rights for which the bill provides are enshrined in law, patients will come to believe that they are their only rights. What is your view on that issue?

Hilary Patrick: I believe strongly that that is the case. I was making the point that people have much stronger rights. People will take the view that the rights for which the bill provides are their only rights because, under section 15(4), the patient advice and support service, with its new duties, will be able to give patients advice only on their rights under the bill, rather than on all their rights. That is a clear weakness; the service should be able to give advice on patients’ other rights. It is a great concern that patients will get the message that they have no other rights.

Mary Scanlon: I have a brief supplementary on the back of Richard Simpson’s question. The convener pointed to section 16(e), on publicising the patient advice and support service. However, section 1(2) states that health care is to

> “be patient focused: that is to say, anything done in relation to the patient must take into account the patient’s needs”.

If the bill is passed, what additional rights will a patient have on the basis of that provision?

Hilary Patrick: I was going to say, “You tell me.”

The Convener: That has answered the question.

We have exhausted the issue of enforceability. If the committee is content, I will move on to the next panel. I thank our witnesses.

10:08

Meeting suspended.

10:10

On resuming—

The Convener: The committee has a heavy agenda this morning, so I am racing on to the second panel of witnesses, who represent health care professionals. They sat through the previous evidence session, which was useful for us and for them. The witnesses are Dr Sally Winning, who is deputy chair of the British Medical Association Scotland; Theresa Fyffe, who is director of the Royal College of Nursing Scotland; and Dr Bill Mathewson of the Royal College of General Practitioners Scotland. Thank you for your written evidence. We move straight to questions.

Ross Finnie: Good morning. You may or may not have heard the evidence that was given in the previous session. In your written evidence, all of you express grave reservations about whether legislation is the right way to articulate and lay out patient rights. I put it to a previous witness from the Law Society of Scotland that, although it is clearly desirable that we have a body of text that sets out patients' rights, that might be better expressed by publishing those rights and the cabinet secretary issuing them to all relevant health bodies as a direction under the National Health Service (Scotland) Act 1978, given that the bill gives people only a limited right of judicial review and section 18 effectively nullifies all other remedies. Do you share the view that expressing rights in that way would be preferable to creating a piece of legislation that appears not to be enforceable? In my opinion, it is doubtful whether we would want it to be enforceable.

Theresa Fyffe (Royal College of Nursing Scotland): We agree absolutely that there is a need to do something about the principles of rights for patients. We are not against that. The Government is seeking, through the bill, to address a problem. There is a need for better co-ordination and to make it much clearer to patients and others that patients have rights and that, perhaps, they have not been enabled to exercise those rights. However, it is clear to us that the bill will not deliver that. As the previous evidence showed, some rights are included and some are not. That would be confusing for the public, who are already confused about the fact that they have rights but do not necessarily know how to enact them. We should do something about that. There is a need to enshrine patient rights, but we do not believe that legislation is the way forward.

Dr Sally Winning (British Medical Association Scotland): The BMA agrees with that. If we as clinicians and politicians have failed to communicate patient rights effectively, we need to address that and we should do so within the doctor-patient relationship. We could do it by publishing a charter, so that patients feel more empowered to address patient rights issues within the context of an on-going episode of care.

Dr Bill Mathewson (Royal College of General Practitioners Scotland): I agree with my colleagues. Many of the patient rights that are mentioned in the bill are included in codes of practice, especially those that are issued by the General Medical Council, which provides good clinical practice guidance.

The Convener: You say that there is a problem but that the bill may not be the solution. I do not understand why the problem has not been addressed for a long time.

10:15

Dr Mathewson: Patient rights are recognised in everyday practice by general practitioners.

The Convener: They are not, however, recognised by patients and that is the issue. I am not a stupid lady, but I do not know what all my rights are.

Theresa Fyffe: We have an NHS booklet and we have other means by which people can find out about their rights, but it is not clear that patients or the public know how to use them, so it is not clear that those rights are being enabled. It is about communication.

I agree entirely with my colleague that patients' rights may be clear to particular professionals, but that sometimes professionals do not spell things out. From the perspective of my profession, I know that professionals might not make the situation as clear as they could do. Something is not working for patients, and that is a concern. I believe that we need to look at what is there and ask why it is not working. We must work with patients to find out what is not working for them. Something is not right and I am concerned that patients think that they have rights but do not know how to have them met.

Dr Winning: The waiting list initiative is perhaps an example of how a patient's perception of what their rights are has become distorted. Patients now tend to look at quantitative measures of rights, such as that they must be seen within X amount of time, but there are layers and layers of rights beneath that, including rights to do with how they are treated. Patients have made complaints on, for example, being treated with dignity or being dealt with in such a way that they understand the language that is used. Looking at more easily measurable things such as treatment time guarantees and waiting list initiatives can sometimes give patients the wrong impression about what their rights are. We need to shift away from numbers to quality of care. The excellent quality strategy that is currently being implemented will tackle many of those issues.

Mary Scanlon: I am still struggling to understand how the bill will increase patients' rights. The BMA says on page 3 of its submission:

> "we are unclear what this legislation adds."

I am getting to the stage of wondering just how bad the bill might be for patients' rights. Jim Martin, the Scottish Public Services Ombudsman, said that he thought that it would make things worse.

In its submission, the RCN says:

> "the Bill would unbalance relationships and work against the development of a mutual NHS"

and

> "could serve to increase inequalities in health care".

It appears that the bill will not only not add value, but will make things significantly worse. I ask Theresa Fyffe to explain those two points. To say that the bill "could ... increase inequalities" is a serious claim to make.

Theresa Fyffe: As far as relationships are concerned, we have worked extremely hard on the concept of mutuality that the Government brought in, and we fully understand the importance of having a partnership that involves patients, staff and all those who seek to provide a service. We are looking for a role between patient and professional that is complementary, not one that increases tension.

The bill suggests that patients have rights, but it does not strengthen patient responsibilities. As someone who has been a clinician, I know that that makes it difficult for clinicians, when they know that a particular course of action is the best judgment in terms of treatment or intervention, to say that that is the best judgment. I am talking about situations in which there is risk. I am unhappy to see the absence of mutuality between patients and professionals.

There is a lot of evidence from America that I could send to the committee about the change in the relationship between doctor and patient. We looked at that extensively, because a lot of work has been done there to try to redress that imbalance, and to get back to the respectful relationship between doctor and patient that Dr Winning mentioned. I would support that from any other health care professional.

My second point about inequality was addressed in the previous debate. On setting certain things out in and excluding certain things from bills, our experience of any form of process that goes to the NHS is that people will, quite understandably, tackle what they need to do. There is a lot to be done. When a person is considering a process, they will say, "This is what I need to do to meet that." That is why we have said that we are not against targets but are concerned when targets skew people towards meeting them and it is forgotten that a loss of dignity, for example, can be a consequence. That is why we have called for dignity proofing of policy. It is a concern that, when one is dealing with a very big board that must address everything that it meets, inequality could become an issue for groups that are not included. The question is, how does what has been included stand the test of time?

Mary Scanlon: That takes us to issues such as mental health.

Theresa Fyffe: Mental health is a major concern. Again, I agree with my colleague Dr Winning. It can be said that things are easy when there are quantitative measures. However, I have spent a lot of time working with patient groups, and have said to them, "You want to have your target, but what about the experience? Did you feel that you got what you needed? Did the experience match what you wanted and leave you feeling that you had left the care experience in the best way?" That is important. Outcomes are about what happens afterwards, not the treatment.

Dr Winning: I will illustrate that with fairly extreme examples. If I were an orthopaedic surgeon who wanted to replace an elderly lady's hip and I absolutely had to meet a target, she might have to go on to someone else's theatre list. That happens in order to achieve waiting list targets. Surgeons have unknown patients to operate on appearing on their lists. I would want to have a good relationship with my patient, and perhaps I would wait a little bit longer so that she could reduce her body mass index to make the operation safer and I could ensure that she fully understood the procedure, or perhaps I would bring forward the operation or delay it a little until her daughter could arrive from England to be with her during the recuperation phase. A target-driven culture might be to the detriment of good-quality patient care.

Mary Scanlon: That is helpful. Thank you.

Dr Simpson: I am finding it difficult to hear Dr Winning, as there is a big buzz from the sound system. I wonder whether there is a problem with her microphone.

Dr Winning: Shall I try another seat?

Dr Simpson: Would that be possible? I have a slight hearing problem, and am finding it difficult to hear you.

All our witnesses are from organisations that have United Kingdom counterparts, and I am interested in what they have done to compare the bill with the English NHS constitution. That constitution is not, of course, enshrined in a particular act, but it underpins many common law, statutory and other rights in England.

Earlier, I used the example of a clinician recognising that a medicine had been approved by the Scottish Medicines Consortium and recommending it for a particular patient's use. As I understand it, under the bill, the clinician will have no rights in that regard if the health board determined that that medicine should not be used. That is just one example.

It seems to me that, if we are going to pass a bill in Scotland, the committee should be convinced that it will take us ahead of what is happening in England, as we were with the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003. Those acts enshrined new rights in their principles that protected patients and took us ahead of the rest of the UK. Will you comment on the additional rights in the bill? What will it do for Scots patients that will be at least equal to, and preferably better than, what happens in England? If the answer is nothing, just say that.

Theresa Fyffe: I think that the answer to that question is nothing.

Dr Mathewson: I agree.

Dr Winning: So do I.

The Convener: There we are. Those were short answers to a long question. That is not bad.

Michael Matheson (Falkirk West) (SNP): It is clear from your submissions that all the professional bodies that you represent are in favour of patients' rights, that patients already have certain rights, and that you have codes of practice and so on that help to inform professionals in their practice about patients' rights. Theresa Fyffe commented that she believes that patients' rights should be enshrined, but not necessarily in legislation. I am not clear how they could be enshrined by any other means. Given that you are in favour of patients' rights, what do you believe we should be doing, other than in legislation, to ensure that patients can exercise their rights more effectively?

Theresa Fyffe: There are a number of solutions. I believe that we should look at the constitution that has been developed in England. There are elements within it that would perhaps need consideration for Scotland, although I would rather not go into that today because I have not brought it with me. However, as a process, it has brought rights together in one place and made them much more accessible. That is what I meant by enshrining patients' rights. The NHS constitution has made the rights clear to people.

We have also called on the Government to dignity proof its policy. That is about dignity, equality and respect. The Government should look at its policies and ask how they enact dignity. As my colleague Sally Winning does, I believe that the equality strategy will go a long way towards supporting that process.

You will probably be aware from my written evidence that I went to Norway to find out and understand what has been done there. What concerned me was that those who seemed to know the most about patients' rights were the more articulate and able people. I am concerned that, if we do not do something, the very people whom we want to understand their rights and express them will be those who are least able to do so. I am not just talking about mental health in that regard; I am talking about enabling a range of people to access their rights.

I believe that there is work to be done. The next step should be to consider what we can do to ensure that we enable people in the way that I described. We have not done that thinking yet—at the moment, we are just responding to the bill—but I want my organisation to commit to considering what could work and what could make things better.

Michael Matheson: Do any of the other professional bodies want to comment?

The Convener: Please indicate to the chair if you want to comment. I call Dr Mathewson.

Dr Mathewson: The Royal College of General Practitioners Scotland would agree with Theresa Fyffe. We welcome clarification and amplification of patients' rights, but not codification—or whatever the appropriate word is—in legislation. There is a need to make patients more aware of their rights. There is also an enormous burden on general medical practitioners to act appropriately—to indulge in mutuality with the patient, to exchange information, to respect the patient, to encourage them to take up services, and to explain things. All of that is already part and parcel of everyday general practice, as it should be. It is expected and, as I have said before, it is in the strong guidance that is given by the General Medical Council. All those rights and privileges are inherent in the codes of practice that already exist, but we welcome the statement of them, the strong support for and amplification of them, and some method of ensuring that patients become more aware of those rights.

Michael Matheson: And the BMA?

Dr Winning: I agree with everything that my colleagues have said. If we are looking for what the solutions might be, I think that the independent advice and support service is exactly that. It is independent and it is holistic as it covers all sorts of issues such as welfare. If patients' rights were laid out clearly, there are facilities and places where patients can go to get that information in an easily understandable and digestible format.

The Convener: Do you have another question, Michael?

Michael Matheson: Yes. I have a couple of points, if you do not mind.

My difficulty in the debate about rights is what lies behind the word "rights". It is all very well to say that patients have rights, but if the health service in some way fails to meet my rights, what form of recourse do I have to enforce those rights?

10:30

My problem with the bill is the lack of enforceability when it comes to rights. When someone talks about me as an individual having a right, I expect some sort of backbone to that right to enable me to pursue it in the way that I think is appropriate, which, if necessary, should include legal recourse, for example under the European convention on human rights. I have heard a lot of talk about a greater focus on informing people about what their rights might be, but I feel that there is no spine behind the word "right" when it is applied to certain circumstances. Do you oppose in principle the idea of having any form of legally enforceable rights in relation to provision within the NHS, over and above the rights that can be pursued through legal recourse at the moment?

Dr Mathewson: There are two aspects to that. One is that legally enforceable rights would inevitably alter in some way the atmosphere or the doctor-patient relationship in the consultation, despite people's best intentions, because there would be awareness that the consultation was on a legal footing.

Secondly, I understand that rights imply legal recourse or sanctions. There are perhaps three levels at which the patient can clarify whether the rights that they are due are being exercised. The first level is simply to have a discussion—to make a complaint or a statement of concern that their rights are not being respected within the primary care team. The patient should be able to do that. If they do not feel that they can do it on their own, they can do it with local help.

The second level is a complaints procedure that will entertain any complaint that is made against general practitioners, which is the proper way to seek redress, explanation and remedy, although not financial remedy.

At the third level, if the patient feels that in any breach of their rights they have suffered some loss or damage, there is recourse to the civil law to seek redress formally. There are levels of redress or explanation. The best way forward, at least initially, is to look for explanations and apologies at the point at which the care is being delivered, or not being delivered.

The Convener: Have we exhausted that issue?

Michael Matheson: I am keen to hear whether the Royal College of General Practitioners Scotland is opposed in principle to the idea of enshrining rights in law.

Dr Mathewson: RCGP Scotland is opposed in principle to that.

Theresa Fyffe: The RCN Scotland is also opposed in principle to that. As an organisation we are working very hard around the no-fault compensation scheme; I think that recommendations are coming out in late October. It is becoming clear that there is work to be done around the complaints system to redress the balance. That is why we have been committed to that work. For us, the consequences, which Mr Finnie addressed earlier, of having legal redress would not be in the best interests of patients or others.

Dr Winning: The BMA supports the principle of patient rights, but we defer to the views of our legal colleagues, who do not think that the bill will add anything to the rights that already exist.

The Convener: The bill will not add or take away; it is neutral.

Dr Winning: Yes.

Helen Eadie: I get a sense from this morning's discussions and from other discussions that we have had in the committee that everyone wants change that will enhance patients' rights. The question is, how do we do that? We politicians can give you chapter and verse about cases of injustice about which we get enraged on behalf of our constituents. Some of those cases result in death. How can you ever bring back a loved one for someone who has been bereaved in that way?

When you believe passionately, as some of us do, that there needs to be change, one of the first things that you do is to sit around a table and identify who your key allies and other stakeholders are, and who shares your objectives. A lot of thinking is being done in various organisations, but has anyone ever pulled together everyone for a discussion about how we can make things better for patients?

Theresa Fyffe: That is the challenge that we now face. The Government has opened up a good debate about why patients rights are as they are and how patients feel.

We recently ran a workshop around the co-production concept that is coming out of the Health Foundation. I am not keen on the title of the concept, but we are interested in how it might enable new ways of partnership working between patients and professionals. We are only in the preliminary stages of that work, but I believe that such an initiative might help in relation to what we are discussing.

As I said earlier, if the bill does not go through, we should be considering what we need to do. As an organisation, we would be committed to that.

Helen Eadie: In a sense, we are all saying with hindsight that that should be the way forward. However, has it ever been done before? Did the Government call you to meetings to get your views and those of patients and everyone else in the medical profession before it went to the drawing board to prepare its consultation document? Was there an attempt to get a consensus on the appropriate way forward before the Government came to the Parliament? If that had happened, we could have had a more rounded debate.

Theresa Fyffe: That has been happening around various areas of work, such as the work that has been done on no-fault compensation. We have been at the table in relation to some issues and have been very committed to that work. We have had extensive discussions with the Government on the dignity work and our views have been listened to and well received. That is the way it has been happening, rather than—

Helen Eadie: So, it has been a fragmented and piecemeal approach, rather than there being a round-table discussion with all the parties involved.

Theresa Fyffe: Perhaps.

Ian McKee (Lothians) (SNP): I have three questions. First, I gather from everyone's submissions that you are all concerned about the possible distortions that could arise from the 12-week waiting time guarantee—for example, there is a worry that ensuring that someone gets an operation within 12 weeks might mean that the operation of someone who needs it more urgently is delayed. Is that correct?

The Convener: I think that that point was made by previous witnesses, but members of this panel might want to comment.

Dr Winning: I agree. That is correct.

Ian McKee: Section 8(3)(a) deals with the arrangements that apply when a health board has exceeded the 12-week treatment time. It says that the health board

> "must not give priority to the start of any treatment where such prioritisation would, in the Health Board's opinion, be detrimental to another patient with a greater clinical need for treatment".

Would it be better to include that phrase earlier in the bill—perhaps replacing "Health Board" with "treating clinician"—so that it appeared in the section that deals with the meeting of the 12-week guarantee rather than its breach?

Dr Mathewson: Yes, I think that that would be better. The statement should be given prominent consideration in the bill because, without it, individual clinicians, who might be reviewing patients and changing the clinical position to make appropriate actions, would have no latitude. We in the college have discussed the issue; no doubt you will have spoken to secondary care colleagues, who might also have a view on the matter.

Ian McKee: I share Theresa Fyffe's enthusiasm for a concept of mutuality in the health service, but how would that work in practice? What if the bill were to contain responsibilities for patients? Having worked in primary care, I am very well aware that some of the people in greatest need are those who, at first sight, do not seem to meet their responsibilities. Instead of mutuality being some nice, happy concept, I wonder whether introducing such responsibilities would in practice simply increase health inequalities by coming down heavily on the very people whose health needs might be greatest, even if they were not so good at co-operating with the health service.

Theresa Fyffe: That is the conundrum. Once you begin to talk about balancing rights and responsibilities, you get into that very dilemma. As set out in the schedule, the 12th principle is:

> "Patients are encouraged to treat any person involved in the delivery of health care with dignity and respect."

In our written submission, we say that we found the choice of words to be interesting. I would have thought that, if the aim was mutuality, the phrase would have been "are expected" rather than "are encouraged". However, this is where I struggle with what the bill is trying to do. I cannot tell you what the other solutions might be, because that is the issue that we need to examine and it will be a very tough challenge to get rights and responsibilities right at the same time.

Dr Mathewson: I agree. As we all know, there has been enormous movement in the area of rights and responsibilities over the past 10 or 20 years, and the very fact that we are debating it this morning represents another step forward. Those who are less likely to be able to speak for themselves are likely to be more disadvantaged in the mutual aspects of the doctor-patient relationship.

As I say, things are moving on. There will be no big bang; the process will be gradual—though getting faster, I hope—with the doctor-patient relationship improving and rights and responsibilities being recognised and acted on. However, this is a continuation of an enormous change that has been taking place slowly but surely over the past 10 to 15 years.

Ian McKee: You agree, though, that setting out in a bill the requirement for people to keep their appointments and so on might have an effect contrary to improving the country's health.

Dr Mathewson: Yes. Setting out minutiae such as that—well, perhaps not "minutiae"; it is an important element—could be counterproductive.

Ian McKee: My third—and last—question, convener—

The Convener: I have been counting. It seems more than three, but I am sure you are right.

Ian McKee: It is three.

We know that many more procedures are being carried out totally in primary care and that general practitioners and people who work in primary care can do many more things than they used to be able to. In a previous evidence session, we were told that primary care has a responsibility under the health board for such procedures. If a GP agreed with a patient about removing a cyst or something like that, would the health board have to monitor that? How would it work?

Dr Mathewson: As it works at the moment. There would be an exchange of information between the patient and doctor; an understanding would be reached of the problem and the options for dealing with it; and information would be disclosed about possible outcomes and follow-up. As you say, that is an increasing part of primary care and the extended primary care team's activities; indeed, it has become an even greater part, with long-term conditions being looked after by other primary care colleagues.

I do not know whether the health board plays a particular monitoring role in that respect. There are procedures in place for people to make complaints and express dissatisfaction. Professional monitoring, however, is another matter, and there are routes for complaining about professional standards that would not necessarily involve the health board playing Big Brother. It already has an insight into practice through the quality outcomes framework procedures, which is more of an accounting mechanism than a quality one.

10:45

Ian McKee: But the bill places a duty on health boards to monitor each treatment time guarantee and to make the necessary arrangements for the procedure to happen somewhere else if it is not going to happen within 12 weeks. Surely, if that is a health board responsibility, it will involve more bureaucracy than simply leaving the matter to the GP. What if someone says, "I've been waiting 15 weeks," and the health board has not known anything about it?

Dr Mathewson: I am sorry—I think that I might have misunderstood your question. Are we talking about procedures being carried out in primary care or about GPs' role in monitoring the treatment time guarantee?

Ian McKee: I am sorry if I am not making myself clear. I am talking about a treatment such as a minor surgical procedure that is carried out in primary care, which will now be subject to a 12-week waiting time guarantee if the GP and the patient agree to the treatment. As I understand it, that treatment will be treated in exactly the same way as procedures carried out in hospital. Under the bill, the health board has an obligation to monitor the treatment time guarantee and ensure that, if it looks as if it might not be met, it is met elsewhere. Will that not involve more bureaucracy?

Dr Mathewson: Yes. If the bill is enacted, there will have to be a mechanism to allow notification of the procedure to be carried out and its completion. However, in most general practices it is likely that patients will not have to wait anywhere near 12 weeks for a minor surgical procedure, which often can be done, if not immediately, then fairly quickly.

Ian McKee: But you are aware of all that.

Dr Mathewson: Yes.

Ian McKee: And you have discussed it with the Government.

Dr Mathewson: Not yet.

Mary Scanlon: So far, our discussions have focused on the treatment time guarantee. In its submission, the General Medical Council says:

> "The fundamental existing legal right of patients to refuse treatment appears not to have been included. ... the Bill does not ... recognise the distinction between patients with capacity who have a legal right to consent ... or refuse ... and patients who lack capacity."

That seems to me to be a very serious issue. I am not a lawyer, but does the fact that there is no legal right to refuse in the bill not put at a disadvantage patients who refuse treatment or do not wish to comply with the recommended treatment?

Dr Mathewson: The short answer to that is yes.

Mary Scanlon: Are you saying that patients will not be allowed to refuse treatment, which is a right that they have at present?

Dr Mathewson: Perhaps I am not in understanding mode. Patients would be disadvantaged by not having the legal right to refuse treatment, or a patient with incapacity would be disadvantaged if the bill were to go through.

Dr Simpson: Perhaps I might intervene, convener. The matter is probably covered in section 18(1)(c), which refers to

“any other enactment or rule of law”.

As patients will retain common-law rights to refuse treatment, I do not think that what Mary Scanlon suggests will be a problem.

Ian McKee: Moreover, according to section 6(1), we are talking about

“an agreed treatment”.

The Convener: Committee members seem to be giving evidence now. Once I let them loose, Mary, there is no holding them back. I am getting medical opinions to the right of me now.

Mary Scanlon: There are too many experts. However, as the GMC is not giving evidence, I thought it appropriate to ask the BMA, the RCN and the Royal College of General Practitioners for their views on the issue.

The Convener: Before we proceed, I want to pick up on capacity, which is surely an issue in all walks of life. One of the main concerns of any professional is whether a patient has the capacity to consent to anything, whether that capacity is of a temporary or a permanent nature. Therefore, I do not think that we need it in primary legislation—it is just there.

Dr Mathewson: It is part and parcel of everyday doctor-patient exchanges.

The Convener: That is the ex-lawyer speaking to the ex-medical practitioners. Have you finished, Mary?

Mary Scanlon: The RCN and the BMA have not responded, but maybe they do not want to respond.

The Convener: Well, that is grand.

Ross Finnie: Can I ask a supplementary question? Mary Scanlon has properly asked these witnesses about the GMC’s evidence, but I would like to ask them what they think section 18(1)(c) means.

Dr Simpson: I say, for the people in the public gallery, that the section states:

“Nothing in this Act prejudices ... any other enactment or rule of law.”

Michael Matheson: I presume that that means the Adults with Incapacity (Scotland) Act 2000.

Theresa Fyffe: That is what I understand.

Dr Simpson: And the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Convener: And the rule of law, which is not necessarily in statute but may be judgments.

Thank you very much. That concludes this session. Our witnesses may change places, but I will keep us on the record because time is rolling on and I want to say something.

Members asked what happens to the reports that are published under the Scottish Public Services Ombudsman Act 2002. Section 15 of that act, “Reports on investigations”, states:

“(1) After conducting an investigation, the Ombudsman must—

(a) if the investigation is pursuant to a complaint, send a report of the investigation to the persons specified in section 11(2) and to the Scottish Ministers,

(b) if the investigation is pursuant to a request, send a report of the investigation to the persons specified in section 11(4) and to the Scottish Ministers,

and must lay a copy of the report before the Parliament.”

The phrase “before the Parliament” means in the Scottish Parliament information centre. The report will also be publicised in the *Business Bulletin*.

Helen Eadie: It will be on the website as well.

The Convener: That is separate from parliamentary procedures. In terms of the Parliament’s procedures, what I have said is what is meant by that phrase. I hope that that answers the question that members raised.

Dr Simpson: That is very helpful. Thank you, convener.

The Convener: As the next witnesses take their seats, I advise members that, after this evidence session, I will suspend the meeting for five minutes before we move on to the final items on the agenda, the most important of which is the Alcohol etc (Scotland) Bill at stage 2.

The witnesses in the final panel represent patient groups. I also welcome John Gallacher, the secretary of Unison, who was meant to be on the previous panel but was unavoidably detained. We have before us Shelley Gray, director of policies and campaigns at the Long Term Conditions Alliance Scotland; Carolyn Roberts, head of policy and campaigns at the Scottish Association for Mental Health; and Delia Henry, director of the Royal National Institute for Deaf People Scotland, who was on the radio this morning. Beside them are Jim Elder-Woodward, board member of

Inclusion Scotland, and Bill Scott, who is here to assist him. Completing the panel are Mhairi Thurston, lecturer in counselling at the University of Abertay Dundee, and Dr Allen Thurston, reader in education at the University of York, both of whom are representing the Royal National Institute of Blind People Scotland. When we go through our questions, I will ask you to self-nominate. You do not have to answer every question if you do not feel that it pertains to you. If you just want to agree, say, "I agree."

Dr Simpson: I will direct my question to John Gallacher from Unison and, as he has listened to the earlier panel's evidence, give him the opportunity to comment on any of the issues that were raised. The philosophical point that we were discussing with Bill Mathewson is contained in the third paragraph of Unison's written submission:

> "We are concerned that whilst creating little by way of new rights the Bill assembles those rights which do exist in a manner that suggests a relationship based on contract, rather than mutuality."

We are all pursuing mutuality. Would you like to comment on the point about contract and mutuality? Also, you say the bill creates

> "little by way of new rights",

which suggests that it creates some new rights; I would love to hear what they are.

John Gallacher (Unison): Thank you, convener. I apologise for the delay in my arrival.

The concept of mutuality is relatively new in NHS Scotland; it has been bandied around for the past year or so. We have had a strong tradition of staff engagement in policy and decision making in the health service; mutuality is about engaging the patient voice. There is a plethora of patient voices here this morning.

Various aspects of involving patients in service planning and delivery have been put into operation. There is the experimentation with elected health boards. Patient engagement forums have played an increasing role at board level. We believe that the concept of mutuality is about putting patients at the heart of planning and delivering the health service, not as customers who pitch up to—God forbid—purchase a service, and not in the same sense as users of other services. It is about the population and the staff who work in the health service having the right to co-manage and co-produce—to use the jargon—the services that are delivered.

Much of our submission is about the introduction of a litigious, commercial culture that we do not want in NHS Scotland. Significant legal challenges are already being made to decisions. Complaints have been made about staff, for example, and there are other challenges.

To answer your specific question, we do not believe that the bill would introduce any substantive new rights. It would simply assemble rights that exist in other pieces of legislation and can be enforced elsewhere. The only right that would be introduced is the right to seek judicial review, which it is clearly beyond the resources of most individuals to do. We do not believe that the bill will bring any significant new legal benefit to individual patients. We want the concept of mutuality to be introduced without introducing litigation into the debate.

Dr Simpson: That is very helpful. I have a small supplementary question and I might come back to the issue later if we have time.

One of my concerns is about whether enshrining all these concepts in primary legislation, which is difficult to amend, will in any way reduce staff rights. For example, when I was a practising consultant psychiatrist, some patients were extremely aggressive and difficult. They were not just not complying with treatment, which was their right, and they were verbally and physically abusive to staff. We denied some of those patients their rights to access general practice. If they wished to access a primary care service, they had to go to a particular special unit elsewhere. Those were extreme cases, but I am slightly concerned that, because the bill finds it so difficult to tackle responsibilities—we all understand that—it will put some staff at a disadvantage by creating new legal rights for patients. Do you have any comment to make on that?

11:00

John Gallacher: Yes. Violence and improper behaviour towards staff are huge problems in the health service. A particular case springs to mind from Edinburgh. A patient who is in prison has to attend for dialysis and, every time he attends, he routinely physically and verbally abuses staff. As you say, the withdrawal of treatment is usually done only in extremis. It is unusual for clinicians or general managers to decide that treatment can be withdrawn. We do not believe that patients' responsibilities are stressed highly enough in the framework that is set up.

The other staffing issue is that the bill seeks to enshrine rights at a time when staffing resources in the health service are shrinking. The committee will be aware that, in this year alone, some 3,790 staff are being withdrawn. Far from what is written in the press, the NHS budget will not be featherbedded or protected in the next comprehensive spending review. Boards in Scotland are already planning for significant reductions next year of up to 4 per cent in efficiency savings. The number of staff losses will grow significantly. That means that, at the very time when there might be rights to assert, the staff who are left to deliver services under increasing pressure will suffer ill treatment, which is unacceptable.

Ross Finnie: Good morning. Unison expressed concern in its written evidence about the advantages of enshrining patient rights in a bill. Inclusion Scotland expressed concerns about the use of the words “have regard to”. Long Term Conditions Alliance Scotland seeks an additional code of practice. The others before us generally appear to support the bill. How will we benefit by enshrining our rights in the bill, when section 18(2) expressly states:

> “Nothing in this Act gives rise to—
>
> (a) any liability to pay damages,
>
> (b) any right of action for specific implement,
>
> (c) any right of action for interdict,
>
> (d) any right of action for suspension”?

I am not getting into the argument about whether we need rights, but what is the benefit of bringing the rights that exist into this bill, given that it outlines those specific exclusions?

Shelley Gray (Long Term Conditions Alliance Scotland): This was picked up on in the previous panel. Many of these rights are already in codes of practice and so on, but it is clear that they are not being implemented sufficiently. If the bill prompts work to embed patient rights throughout the NHS—the Government has talked about increasing advocacy services and introducing a programme of training for NHS staff as a result of the bill—and to embed a culture of rights in the NHS, that would be of major value. Some elements of the bill, such as the expectation that staff will communicate with patients in a certain way, could be strengthened, such as by stating that information will be provided in an accessible way. If the expectation was all there in one bill, that would make a difference.

Ross Finnie: Do you need the bill to do that? The health secretary could issue a direction under the 1978 act calling for that to happen. Why do we need an act of Parliament that implies that you have some legal right, when section 18(2) removes it?

Shelley Gray: It is about individuals having rights, but it is also about the expectation on staff working in the NHS not just to tell people about their rights but to do things proactively such as providing information in accessible formats, supporting people’s right to access advocacy, communicating with them and so on. We think that having that in a bill would help.

Jim Elder-Woodward (Inclusion Scotland): Good morning. I am rather perturbed by the paternalism of professional bodies in relation to the use of the word “mutuality”. By mutuality, I understand that there is equality between the two groups; otherwise, mutuality cannot exist. When Theresa Fyffe was talking about mutuality this morning, I wondered whether her argument could have been used against equality for women because it would upset mutuality between men and women—although obviously, it does not.

Mutuality arises only when both sides are equal and both sides have some resource. I think that having a right gives the patient a resource so that they can come to the table on a mutual basis. We know that disabled people face a vast amount of inequality in health. People are left unhelped to feed, and disabled people are not given the same access to screening as other people—there is a whole host of areas in which inequality exists. If we are to work on the basis of mutuality, each person around the table needs to bring a resource with them. For patients, the resource will be the Patient Rights (Scotland) Bill when it comes into force in 2011 or whenever.

The Convener: So you are saying that the bill will redress an imbalance.

Jim Elder-Woodward: Yes, it will redress an imbalance. We cannot have mutuality if one actor is less resourced and less empowered than the other.

Dr Allen Thurston (University of York and Royal National Institute of Blind People Scotland): I guess that the question is really: what might the bill add? I have looked at the history, and our main evidence obviously relates to communication in accessible formats for blind and partially sighted people. There is already legislation, such as the disability discrimination legislation, which should ensure that people who are blind and partially sighted receive information in an accessible format.

Written into the professional standards of the Royal College of Physicians, the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society are statutes that say that their professionals should communicate with blind and partially sighted people in an accessible format. However, the RNIB has now produced four reports—including reports in 1998 and 2008, and one in 2004 from Guide Dogs for the Blind—and 12 years on we still have the same problem. Although all the professional bodies state that communication in an accessible format is part of professional standards and behaviour, 12 years on and four reports later, not a lot has changed. There are issues of confidentiality, for example—if you have to hand someone a letter to read it to you, your confidentiality is breached.

Perhaps there is a need for something to focus the minds and change the behaviour of the professional bodies that work with people who require information in an accessible format. It is not for me to say what is the best way to do that—Parliament will have its own ideas—but something has to change. It is unfair to continue with the way things are.

Ross Finnie: I happen to agree with you, but I also think that it is up to you to tell us what is the best way forward. I suppose that we have the ultimate decision and power in that respect but a question has crystallised around the bill that the Government has proposed. You and your organisation have raised very real concerns that the various things that have been implemented are not actually being done. As a parliamentarian taking evidence from all the organisations before me—including, at the moment, the RNIB—I have to wonder whether we need to address the situation through the bill, which expressly removes access to law in so many ways, or whether we take some of the subsidiary work that the Government is very properly carrying out and introduce a range of other documentation that sets out the various rights. My concern is whether we actually need a new bill.

Dr Thurston: Despite the regulatory and professional conduct standards of the bodies in question, despite the laws that have been introduced and despite the fact that this has been a persistent problem for a long time, nothing has changed. Perhaps the bill is required to change practice.

Ross Finnie: So what would it do?

Dr Thurston: It might well focus the minds of those who work with patients. To some extent, I am a one-trick pony; my main interest this morning is about protecting patient confidentiality through communication in accessible formats. There are wider issues, which you have debated with other witnesses, but I guess that I want the focus to be put back on to the chain. Perhaps the doctor thinks that the patient has been communicated with in an accessible format and does not give it much thought once the patient has left the waiting room and the letter has been printed off by the receptionist or passed on by the nurse. We need something that will focus the minds of all the people in the chain on ensuring that none of its links is broken and that we do not have situations in which patients get letters that they cannot read or, as far as the RNID is concerned, in which appointments cannot be made because the people at the other end do not have the right machinery.

The Convener: I should clarify that although nothing in the bill can be enforced, it does not affect pre-existing provisions. We are not saying that all current rights will be wiped out.

Delia Henry (Royal National Institute for Deaf People Scotland): As we say in our written submission, the important issue is the practical implementation of the bill's provisions. I am encouraged that we are having this debate, but I have to say that, when I reread our submission, I was struck by the fact that it highlights fairly basic principles of communication in respect of people who are deaf and hard of hearing and talks about a fairly basic lack of access to health in certain fundamental areas. For example, people have to get someone else to make phone calls for them because health departments—even audiology departments—expect people to contact them by phone. I am sure that everyone around the table finds that shocking, but the fact is that we regularly hear such stories.

In the work that we carried out to inform the submission, our members kept telling us that they did not want to make complaints but simply wanted to access health in a quality way. That notion of quality underpins our submission and we need to think seriously about whether the bill can enforce that. As I say, our membership and organisation support the practical implementation of the bill's principles and hope that they help to make a level playing field for patients and to ensure that health care professionals and patients work in a mutual way to deliver a good-quality health service.

11:15

Ross Finnie: What has been said highlights the dilemma for me. I do not in any way disagree with the point that there is a need to make some of the existing statements work—Delia Henry said something not too dissimilar, and her written submission also makes that point. What is less clear—although it is not Delia Henry or Allen Thurston who is less clear—is whether setting that out in a bill that does not give any new rights is the appropriate way to ensure that that happens. That is the difficulty. It is about the vehicle. I have no difficulty at all with the purpose that Delia Henry wants to achieve for her members and the purpose that Allen Thurston has identified. That is not my problem. I am clear that we need to do something slightly differently so that their members get a better kick at the ball. However, I am not clear whether the bill is the right way of delivering that. That is the dilemma.

Mhairi Thurston (Royal National Institute of Blind People Scotland): One finding of the survey that was conducted for the RNIB was that people do not complain. Largely, there is no voice from blind and partially sighted people about not receiving information in an accessible format. That is where the bill could provide a benefit. In a way, there is no complaints culture among blind and partially sighted people. Although complaints procedures are in place, people do not use them because they do not have enough energy or they do not want to be troublemakers or cause waves. The mechanism in the bill takes away the onus to complain and puts in place rights. That legal framework might help.

Ross Finnie: Let me pursue that for one second. You say that the bill will help by putting in place a legal framework. To return to my colleague Michael Matheson’s point, normally if I confer on you a right, I also confer on you a right to have recourse to a court of law. However, that is not how the bill is drafted, and that is the difficulty. I am not sure that you want that, but are you telling me that your members would be better off if they had a right to go to law?

Mhairi Thurston: The point is more that, rather than have the onus on them to go to law, there should be an awareness on the professional and clinician side. In a perverse way, it is about emphasising the responsibility on the clinician side, rather than the patient side, if that makes sense.

Jim Elder-Woodward: I would take Ross Finnie’s big step and allow patients to go to law. There is an argument for that. How else can we underpin the power of the patient to be at the table on a mutual basis? The patient needs to have power behind them to equalise the relationship between them and the professional. The bill has big holes in it. One of them is a lack of awareness of how to spend the £500,000 on advocacy. To empower certain patients, they need an independent advocate, and I do not think that £500,000 a year is sufficient for a national advocacy service. If we are to have patient rights officers, we need to equalise that by having independent advocacy in each board area. I am talking about how to empower patients in the professional-patient relationship. I agree that the bill does not go far enough in the empowerment of patients.

Dr Simpson: My supplementary fits well with Jim Elder-Woodward’s point. If I understand the witnesses correctly, they are saying that the problem lies in the fact that people do not exercise their rights. There are rights in existence. The Disability Discrimination Act 1995 alone gave enormous rights—

Jim Elder-Woodward: Ah!

The Convener: Wait before you come in. Richard Simpson has stirred a hornet’s nest by mentioning the DDA.

Dr Simpson: —which are not being enforced. The message that I am getting is that it is not working.

I just do not see how spending £1.6 million on patient rights officers will help, because their role is one of signposting, not advocacy. If the current situation is that the people whom the witnesses represent do not know to complain, they will not even get to the patient rights officer. The problem lies at an earlier stage. It is about ensuring that it is communicated to people, clearly and precisely and in the correct format, what their rights are and how they can take them forward. The IASS works quite well, but funding is being cut from half the service, so if we are serious about the issue, that is where the money should be going, not on the new patient rights officers.

The Convener: I think that you are giving evidence, Richard.

Dr Simpson: There was a question: do the witnesses agree?

The Convener: There was a question only because I prompted you.

Jim Elder-Woodward: What a leading question!

Dr Thurston: The results of our survey indicated that blind and partially sighted people were aware of their rights—nine out of 10 of them knew that they had a right to receive information in an accessible format, but only one out of 10 actually received it, and the proportion who complained was even smaller. It is about disempowerment—it is more to do with the fact that people are disempowered when it comes to the complaints procedure. People know that they have rights; they know that they are there. The point that Mhairi was making is that a top-down approach is necessary. It is the hospitals and the clinicians that need to change what they are doing. We are not necessarily calling for more things that people can complain or sue about; we are calling for something that addresses systemically the wrongs that are occurring in the NHS at the moment.

Dr Simpson: I gather that there has been a 20 per cent increase in the number of complaints in England since the new constitution and the patients charter came in, so perhaps something is happening.

The Convener: I say to the witnesses that they have to be less than subtle if they want to enter the discussion, as my eyes are trying to see everything.

Shelley Gray: I echo what Allen Thurston said. One of the key things about the present situation is that the onus is on organisations such as ours to highlight issues such as the failings that are happening, which include people not being given information in the way that they need it or communicated with appropriately. I am not a legal expert, but I think that one advantage of the bill would be that it would put an onus on the NHS and the Government to monitor how effectively it was implemented, which would pick up many of the issues that our organisation has put a lot of time and work into picking up. That would be a key benefit of the bill.

Mary Scanlon: Carolyn Roberts has been sitting quietly and patiently, so I—

The Convener: She will not be doing so for much longer, now that you are targeting her.

Mary Scanlon: Carolyn, I am not sure whether you were here for the discussion earlier in the meeting about patient rights in relation to the treatment time guarantee. I think that you were extremely diplomatic and courteous in your submission, but is it not the case that every mental health patient in Scotland—apart from children—whom you represent will be excluded from what the bill provides? I will obviously ask whether you agree with me and what your concerns—

The Convener: Excuse me. I do not want such questions to become infectious.

Mary Scanlon: As far as mutuality is concerned, are there any aspects of the bill that would benefit adult mental health patients?

Carolyn Roberts (Scottish Association for Mental Health): We support the Patient Rights (Scotland) Bill. I have been quiet so far because everyone else was making the points that I would have made.

The Convener: I thank you for that.

Carolyn Roberts: Our main concern is about access to mental health services, which is excluded from the 18-week target, and from the Patient Rights (Scotland) Bill. That has a knock-on effect: because there is not the same guarantee about access to mental health services, less is done to gather waiting time statistics in that area. I am sure that the committee is aware that it is difficult to get information on how long people wait for adult mental health services because there is no requirement to meet any of the current waiting times guarantees. We are concerned that the lack of provision in the bill in that regard could perpetuate the situation.

We see benefit in the bill, but we are disappointed that there is little in it for adults with mental health problems. That could be addressed, either by extending the treatment time guarantee to mental health services or by including a section in the bill to say that the position will be reviewed later. A number of options could be considered. At the moment, however, we are disappointed that mental health services are not mentioned in the bill.

Mary Scanlon: I made a freedom of information request two years ago regarding psychology services in Easter Ross, in the Highlands. Patients there were waiting for four years and seven months to see a psychologist, and I do not see any benefit for them in the bill.

The final point in your written submission is:

> "The Scottish Government must give further consideration as to how it can ensure mental health service users are also able to benefit from such guarantees, and have their human rights upheld."

I am no expert in human rights, but does the bill bring forward some form of discrimination, bearing in mind that some patients have more rights than others? Adult mental health patients have no rights under the bill. Are you alluding to some potential legal challenge, on the basis that equal rights will not be upheld under the bill?

The Convener: Could I clarify the point? Patients have rights; what they do not have are rights specifically concerning mental health services. They have rights relating to services being patient focused and providing optimum benefits.

Mary Scanlon: But nothing that relates to the bill—there is no treatment time guarantee.

The Convener: Indeed—that is specific.

Mary Scanlon: There is a right to be treated with dignity and respect, as we would always assume, but as far as the bill is concerned, adult mental health patients are excluded.

The Convener: Yes—we accept that as regards treatment time guarantees. I am making it plain to anybody listening that the bill is not called the patient rights (but not including people with mental health issues) bill. It relates to some aspects, but not to guarantees about treatment times—that is the point.

Mary Scanlon: And that is at the core of the bill.

Carolyn Roberts: I take all the points that have been made. We had some discussions with the bill team while the bill was being drafted regarding its human rights implications, and we are pleased that there was mention in the policy memorandum of article 12 of the International Covenant on Economic, Social and Cultural Rights with regard to

> "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health",

so there is some recognition of human rights in there. However, we are concerned that the bill perpetuates what started with the 18-week guarantee—most mental health services are excluded from it. That could be addressed, however—there is still room to change the bill so that it could be of assistance to people with mental health problems.

I take the point that only the treatment time guarantee excludes mental health services. The other areas of the bill would benefit people with mental health problems as much as they would benefit other people, as long as there was proper training for the patient rights officers so that they had some awareness of mental health. The exclusion from the treatment time guarantee is, however, a disappointment for us.

Jim Elder-Woodward: We are particularly concerned about the remoteness of the PROs, in that there will be only one or two of them per health board, and there will not be any in local hospitals. They will be very remote, and their remit in providing information will be limited. There is nothing in the bill to say that they will facilitate the provision of information from professional to patient. We feel strongly that the PROs will not be able to do their job effectively.

11:30

Helen Eadie: As a consequence of previous Governments' decisions, we already have an independent advocacy support service in Scotland. I am interested to know the witnesses' perceptions as to why the service is not working. The service is there as a result of a Government decision and it is funded by health boards, although it was established by Citizens Advice Scotland. What is it about the service that is not working but which you think the bill could change, given that such change is proposed?

Jim Elder-Woodward: I do not think that the service is well enough organised. It is also there to give information and advice; it is not there to advocate and it is not there to facilitate dialogue between professional and patient. If the independent advisory and support service is to be developed, it needs to be beefed up, it needs to be local, it needs to be visible and it needs to be beside the patient, not miles away in some office.

Helen Eadie: Is that not a matter of monitoring, managing and getting feedback about the existing service? I know from my work as an MSP that the independent advocacy support service does advocacy work in my area. I do not know about the experience of other MSPs on the committee, but it certainly works in that way in my area.

Jim Elder-Woodward: It does not in mine.

Helen Eadie: Is that not an issue about Government monitoring, evaluating, assessing and putting right the problems that exist in a service that is already enshrined in legislation? We would not be introducing something new; it already exists. The bill would duplicate something that is already in place.

Mhairi Thurston: You have made a really good point, but the findings of our survey show that there is an onus on the patient to pursue and activate the service. In the case of our client group, the patient is often quite disempowered and weary from living with a condition that excludes them from society. The thought of pursuing advocacy is sometimes an option that they do not want to take. They do not have the strength or the stamina to pursue that, even though the service may be accessible. We have said that it will be of benefit if the Patient Rights (Scotland) Bill introduces more systemic change, which means implementation by clinicians and a greater emphasis on clinicians tackling the problems that we highlighted in our report.

Helen Eadie: I am totally in sympathy with your concerns, as, I think, all committee members are. However, we face a challenge, which is why we need answers from you. The DDA and all the different acts are there—I have campaigned for years, for example, to get accessible railway stations for my community; such access is enshrined in legislation. However, the bill has no means of enforcement, so it does not give me or my constituents any power. The question that we are struggling with is whether a piece of legislation that does not give you any way to enforce it is worth the paper that it is written on. That is what you have to persuade me about this morning.

Mhairi Thurston: If I may, convener—

The Convener: It is lovely to have someone who defers to me, as I am so unused to it. You can come back—teach members something.

Mhairi Thurston: There is almost an analogy with a nuclear deterrent. If we have it in place, will it make a difference?

The Convener: The nuclear deterrent clause—or is it mutual deterrence? [*Laughter*.]

Helen Eadie: In what way is the bill a deterrent? There is nothing that I can enforce if a clinician does not do something that they should do. Where does that leave us? Where is the bomb?

The Convener: I do not want us to get frivolous—it has been a long session—but I think that that word might just bring security in here. [*Laughter*.]

We seem to have ended that discussion, but Mr Elder-Woodward wants to come in. Let us get sensible again.

Jim Elder-Woodward: I just want to make the distinction between giving advice and advocating on behalf of someone. There is a difference between independent advice and support services and advocating on behalf of a patient to have his rights secured. If a patient has no rights, there is no need for an advocacy service and we might as well all go home now.

It is difficult to have a right that is not enforceable. Disabled people have a big book about a foot high of United Nations rights that are not enforceable. I could quote article 2 and article 25 of the United Nations convention on the rights of disabled people, which give me the right to equality in the health service, but because that is not in domestic legislation, we cannot enforce it. The bill gives one more right on top of the rights in that big book. The only thing that it will do is highlight the need to treat disabled people and patients with respect and dignity. I am sorry, but no amount of patronising talk from doctors and nurses about wanting to give dignity and work in mutuality with patients will satisfy me unless I can come to the table empowered to assert my dignity and my rights. That is important to disabled people.

The Convener: I was going to stop there because I think that that is a powerful argument, but Dr Thurston has indicated that he wants to speak. I am sure that he will make a powerful point, too.

Dr Thurston: I thought you were going to stop there, convener. I just thought that I would go into extra time.

The problem is how to bring about systemic change within the NHS in order to ensure that these things happen for people who are either deaf or blind or partially sighted. Self-regulation by professional bodies has not been working for a long time, so I would turn the question around and ask what will change without the bill and without something happening. Nobody in the NHS is self-employed. The employees work for a large, systemic Government organisation that is paid for by taxpayers. What change will happen without an overarching bill that says, “This is how you need to behave if you are employed by us”? It is not necessarily about empowering individuals to go to law or to seek compensation; it is about trying to bring about systemic change throughout the NHS.

Helen Eadie: When you spoke earlier about issues of confidentiality, you said that you are here as a one-trick pony. I sympathise with that, but the issue is that we already have the data protection legislation. What is wrong with that in terms of protecting patient confidentiality?

Dr Thurston: Perhaps people in the NHS do not see it as applying to them. There are Caldicott guardians in the system who protect patient confidentiality in the transfer of electronic information, but I guess that there is a disconnect between people seeing the disability discrimination legislation and the data protection legislation and their understanding how it applies to them in their job. Perhaps it is the bill’s job to bring those things together and say, “This is how the legislation applies to you in the NHS. You can improve care and outcomes for patients by behaving in this way.”

The Convener: I think that we will stop there because we have pretty well exhausted all sides of the argument. I thank everyone for giving evidence. I suspend the meeting for five minutes.

11:40

Meeting suspended.

11:47

On resuming—

Subordinate Legislation

General Pharmaceutical Council (Appeals Committee Rules) Order of Council 2010 (SI 2010/1614)

General Pharmaceutical Council (Fitness to Practise and Disqualification etc Rules) Order of Council 2010 (SI 2010/1615)

General Pharmaceutical Council (Statutory Committees and their Advisers Rules) Order of Council 2010 (SI 2010/1616)

General Pharmaceutical Council (Registration Rules) Order of Council 2010 (SI 2010/1617)

General Pharmaceutical Council (Transfer of Property, Rights and Liabilities, Fees and Grants) Order of Council 2010 (SI 2010/1618)

Pharmacy Order 2010 (Registration—Transitional Provisions) Order of Council 2010 (SI 2010/1619)

Pharmacy Order 2010 (Approved European Pharmacy Qualifications) Order 2010 (SI 2010/1620)

Pharmacy Order 2010 (Appeals—Transitional Provisions) Order of Council 2010 (SI 2010/2150)

Pharmacy Order 2010 (Commencement No 2) Order of Council 2010 (SI 2010/1621)

The Convener: We resume with item 3, which is consideration of nine negative instruments relating to the regulation of the newly established General Pharmaceutical Council. The instruments cover various aspects of the function of the council, the regulation of the pharmaceutical profession and the commencement of certain sections of the Pharmacy Order 2010 (SI 2010/231). Members have a copy of each of the instruments as well as a cover note from the clerk summarising their purpose. The Subordinate Legislation Committee made reference to minor drafting errors in some of the instruments but, as the errors do not affect the operation of the instruments I do not propose to go through them one by one. Are members content not to make recommendations on any of the instruments?

Members *indicated agreement.*

Alcohol etc (Scotland) Bill: Stage 2

11:48

The Convener: Item 4 is day 2 of consideration of amendments at stage 2 of the Alcohol etc (Scotland) Bill. Members have in front of them a copy of the marshalled list and the groupings of amendments for debate. I welcome the Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon. As the committee has other agenda items that it needs to get through, I will bring consideration of amendments to an end at around 12.45, by which time I hope that we will have reached the end of section 9. We hope to get there today and have a short meeting next week.

Section 7—Occasional licences: modification of mandatory conditions

The Convener: Amendment 18, in the name of the cabinet secretary, is grouped with amendments 19 and 20.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): This technical change responds to a point that was made by the Subordinate Legislation Committee. Amendments 18 to 20 will have the effect that regulations made under the Licensing (Scotland) Act 2005 to modify mandatory conditions of occasional licences will be subject to affirmative resolution procedure. That will ensure consistency with the power in the 2005 act to make regulations in respect of mandatory conditions of premises licences, which is already subject to affirmative resolution procedure.

I move amendment 18.

Amendment 18 agreed to.

Amendments 19 and 20 moved—[Nicola Sturgeon]—and agreed to.

Section 7, as amended, agreed to.

Section 8—Off-sales: sale of alcohol to under-21s etc

The Convener: Amendment 21, in the name of the minister, is grouped with amendment 22.

Nicola Sturgeon: An alcohol licensing regime that did not have a public health objective would these days seem very incomplete, but the novel nature of that objective in the Licensing (Scotland) Act 2005 might be hampering its effective use. Those involved in the licensing process fully understand the crime prevention objective and the role that we expect the police to play in providing information and opinion to assist boards in their decision-making responsibilities. The police role in licensing is long standing and familiar to boards and the licensed trade.

However, it appears that boards are having more difficulty working with the public health objective. We are therefore seeking to provide assistance through this group of amendments that will amend the 2005 act. Amendments 21 and 22, which have been welcomed by directors of public health, seek to increase the role of health boards in the licensing system. The amendments will require licensing boards to consult the relevant health board about licensing policy statements and overprovision assessments and will require licensing boards to notify the relevant health board of applications for premises licenses and major variations. They will also require a member of each local licensing forum to be nominated by a health board. That will help the health board’s voice to become a natural part of alcohol licensing, which will help to develop the cultural shift in Scotland that I know we all support.

I was interested to note that other parties commented that licensing boards should give increased attention to matters of public health. I consider that amendments 21 and 22 are an important step towards embedding public health considerations in the licensing process.

I move amendment 21.

Dr Simpson: If section 8 is deleted later, which I will move an amendment to do, how will amendment 21 be affected? In addition, why does amendment 21 seek to amend a section on the sale of alcohol to under-21s?

Nicola Sturgeon: The amendments will bring in a new section after section 9, so I am not sure that the deletion of section 8 would impinge on that. Perhaps we can get some clarification of the technicalities of that before we get to the debate on section 8.

Dr Simpson: I am just slightly concerned that if my amendment is agreed to, I will undermine something on which I agree with you, which is the involvement of health boards and the support of the public health interest.

Nicola Sturgeon: I will let my legal advisors discuss that point with me.

I have been told that Richard Simpson is right: if his amendment is agreed to, it will remove the amendments that we are dealing with now.

Dr Simpson: Only amendment 21, I take it; not amendment 22.

Nicola Sturgeon: Yes.

Dr Simpson: That does not really answer my question as to why amendment 21 would amend a section that deals with the sale of alcohol to under-

21s. Why has it been placed there and not separately?

Nicola Sturgeon: Because it relates to the detrimental impact assessment, which is pertinent to the amendments on under-21s.

Dr Simpson: Okay.

The Convener: Are you okay with that—or at least with that explanation?

Dr Simpson: Yes.

Ross Finnie: I welcome the extension in relation to amendment 22. While the cabinet secretary has not yet moved amendment 22, I understand that it can be debated, so I seek clarification on it. I am slightly puzzled by subsection (4) of the new section that amendment 22 would insert. Licensing boards will benefit by having health boards comment on policy. However, subsection (4) relates to the notification of application-specific matters. Whereas I can see a health board having information that it can use to comment on policy, I am less clear as to how a health board will have information that will be application and premises specific. Can the cabinet secretary help me with that?

Nicola Sturgeon: Obviously, a health board's view on, for example, overprovision assessments would be important, so notification about a particular application and a health board's view on the effect of that application on public health issues would be important.

Ross Finnie: I am sorry, cabinet secretary, but perhaps I did not express what I meant very well. Amendment 22 goes through various sections of the 2005 act. I wholly understand that the health board will be well placed to contribute with respect to overprovision and formulating policy, but I am less clear that, in relation to section 21(1) of the 2005 act, which is on notification of an application, a health board would be well placed to have information that would allow it to comment on a specific application.

Nicola Sturgeon: That is a policy decision that we made. It is fair to say that we do not expect health boards to comment as a matter of course on every single application that is made. Nevertheless, we thought that, if a particular application in a particular local context would give rise to public health considerations, it would be important for the health board to be able to make those views known by being notified of the application. That is the intention behind the proposal. The aim is simply to ensure that the health board voice is heard in all aspects of licensing and the licensing regime.

The Convener: The question is, that amendment 21 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

Abstentions

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 3, Against 0, Abstentions 5.

Amendment 21 agreed to.

The Convener: Amendment 31, in the name of Richard Simpson, is grouped with amendment 32.

Dr Simpson: Amendments 31 and 32 would ensure that the age at which young people can buy alcohol remains at 18. It would be unfair if young people were able to consume alcohol only in a bar or restaurant, and could not buy a bottle of wine to have at home while they watch television. We are all aware that binge drinking is a problem for some young people, but that cannot be tackled by discriminating against all young people, even in a specific area. We are also convinced by the evidence that young people under the age of 18 currently access alcohol and that those who are under 21 would not be deterred from accessing it.

Kathy Klas of the Alcohol and Gaming Commission of Ontario highlighted as one consequence of having alcohol licensing jurisdictions that border one another and have varying purchase ages the tendency for customer migration in the specific restricted age bracket. On US states that border Ontario, she said:

> "Consumers have migrated across borders when legal drinking ages have varied. There are often influxes into Ontario locations of young drinkers and inexperienced drinkers from jurisdictions with higher legal drinking ages. Some might say that that encourages excessive or irresponsible consumption. In turn, we have found that people have migrated outside Ontario to bordering jurisdictions in which the legal drinking age is 18."—[*Official Report, Health and Sport Committee*, 23 March 2010; c 3016.]

The legal drinking age in Ontario is 19.

Tom Roberts referred to an alcohol policy event that Children 1st had recently held with young people. He said that young people felt stigmatised by approaches to alcohol policy that focused purely on their age group and confirmed that Children 1st did not support a change in the off-sales purchase age. Chief Constable Pat Shearer of the Association of Chief Police Officers in Scotland expressed support for the provision in the bill, but cautioned:

> "I would not say that it was a significant tool."—[*Official Report, Health and Sport Committee*, 17 March 2010; c 2985.]

Effectively, it could penalise law-abiding young people.

12:00

The Scottish Government has pointed to the success of pilot projects such as the under-21 alcohol purchase ban that was introduced in 2008 in Armadale in West Lothian, where I have worked, in which alcohol off-sales to people under 21 were banned on Friday and Saturday nights. However, I am not convinced that the findings of the research in any way justify a policy that could disadvantage many young people in Scotland. Investigations of the impact of the Armadale project have shown that even if the ban was responsible for a reduced number of calls to the police about youth disorder, the reduction was minimal, with five calls in the week before the trial and four during it. Moreover, it cannot be shown that any of the project's impacts was directly attributable to alcohol-purchasing restrictions rather than to the increased focus on disorder by the authorities for the project's duration. Indeed, the Royal Statistical Society has branded the statistics as "insignificant" and "disappointing". Finally, with regard to the Stenhousemuir pilot, Chief Inspector Bob Beaton, who led the experiment, was reported in *The Scotsman* of 2 October 2008 as saying:

> "It's difficult to separate the strands to say which have been most successful."

I cannot remember whether it was in evidence to the committee or whether we were told about it privately, but the committee heard about a programme in St Neots in Cambridgeshire that achieved a proven track record over a period of time. It did not involve legislation; instead, the community collaborated with all agencies, the industry and retailers on what seems to have been a highly successful model. I am genuinely concerned that if the model in the bill were promoted in Castlemilk but not in the surrounding areas, there would be a high chance that people would simply move across the city. I do not want to single out Castlemilk but, having worked in the area and seen some of its problems, I believe that it would be one of the areas where the provisions in the bill would be applied.

If an under-21 can drink in a pub, they should be able to buy off-sales alcohol. After all, they should not be discriminated in this way, given that they are old enough to fight for their country. The proposal is another example of a rather poor tool that will punish the responsible and well-behaved because of the irresponsible and badly behaved. We need a rapier to deal with these antisocial problems, not a club.

An off-licence that persists in selling to young people under 18 should have its licence removed. The fact is that increasing to 21 the age at which someone can buy from licensed premises will not deter those who seek to break the law. Indeed, how is it that, as we discovered from a recent parliamentary question, the number of recorded offences of confiscation of alcohol from persons under 18 in Lothian has been zero for the past two years? What are we doing to enforce the existing law?

Finally, when we took evidence from Young Scot and the National Union of Students, both promoted responsible consumption and neither supported section 8. As a result, I propose that section 8 be removed.

I move amendment 31.

Helen Eadie: In addition, I point out that the Subordinate Legislation Committee, of which Ian McKee and I are members, expressed concern

> "that the Scottish Government could offer no further justification for seeking such a broad power. From the evidence received, it is clear to the Committee that the provision is intended to address a specific issue; that is, to impose conditions restricting the purchase of alcohol at off-sale premises for people aged under 21. In this context, the Committee is not convinced that an order-making power is required to achieve this policy objective. Should the Scottish Government wish to pursue this policy, the Committee considers that a specific amendment to the 2005 Act would be a more appropriate means of implementation."

Given those comments, I suggest to the committee and the cabinet secretary that any such changes to the Licensing (Scotland) Act 2005 should be made through primary legislation, not through regulations.

Michael Matheson: Members may be aware that there was a six-month trial of a 21 limit in the Stenhousemuir and Larbert area of my constituency. The mechanism proved to be an effective way of tackling a specific problem of underage drinking in the area. Over the six-month period, there was a significant reduction in antisocial behaviour, violence and a variety of other criminal activities that had often been associated with drunken behaviour. It was a voluntary scheme that local off-licence owners could opt into. All but two off-licences in the area opted into the scheme, which they found to be valuable and helpful.

I recognise that such schemes are not necessarily a significant tool in dealing with the issue—no one would suggest that they are—but we should not take what could be a useful tool at a particular time out of the box so that it is not available to be utilised.

It is often suggested that such schemes inevitably create displacement, but that did not happen during the six-month trial in the Stenhousemuir and Larbert area. In addition, it is often stated that benefits were gained in that area of my constituency because of a significant increase in police resources in the community, but nothing could be further from the truth. In fact, people such as Bob Beaton can confirm that one consequence of the scheme was that some of the officers who normally covered Larbert and Stenhousemuir were, because of the reduction in the number of problems that were reported to them, redeployed to other areas, where they were involved in other activities.

I understand that some members have reservations about applying such a policy at national level, but we should give local licensing boards the opportunity to use the tool when they see fit, on the basis of local circumstances, for a period of time. The evidence from the longest trial of the policy in Scotland demonstrates that it can be an effective tool for dealing with some issues relating to alcohol misuse.

Mary Scanlon: It is worth putting on record a point that the Scottish Grocers Federation made:

> "Banning the sale of alcohol in off sales to under 21's is counter-intuitive to other Government legislation which permits an 18 year old to sell alcohol, obtain a personal licence as a designated premises manager"

and

> "train others to sell alcohol responsibly".

I seek clarity from Richard Simpson on the issue. Can he confirm clearly that his amendments 31 and 32 will create a consistent approach to the purchase of alcohol by young people in Scotland aged over 18 in both on-sales and off-sales?

The Convener: Richard Simpson will answer the question when he winds up.

Ross Finnie: I have consistently opposed the proposition that we should attempt at national level to increase the purchasing age from 18 to 21 for off-sales. I understand that the Government has changed its position to allow more local discretion in the matter. However, I am still concerned about how the distinction will be made. Mary Scanlon makes the point that there is a curious inconsistency—if a person cannot consume the product, it is difficult to understand why they should be responsible for managing it.

Michael Matheson makes a reasonable case for allowing local discretion, up to a point, but I am not sure how we would measure the success of the policy and ensure that it was working. The fundamental issues behind the problem—namely, discounting and cheap offers—are great attractions that distort the marketplace. The bill seeks to address those issues. There is much more evidence on the attractiveness of such offers than on the behavioural patterns of people aged 18 to 21. I will support Dr Simpson's amendments 31 and 32.

Ian McKee: I support what Michael Matheson said, so I will not repeat his points. I would also have been concerned if the proposal was that there should be a blanket ban on people between the ages of 18 and 21 buying alcohol in off-licences throughout Scotland, but that is not what is now proposed. We are talking about a specific tool for a specific situation, so the anomalies that have been pointed out—for example, an 18-year-old being able to sell alcohol but not purchase it—will not arise in most of the country.

The proposal is to implement the restriction where a problem has been identified by the local police, the local community and the local licensing board. It is a tool to deal with the problem of people whose lives are afflicted by minors becoming intoxicated, which happens in very specific areas of Scotland. The situations with people in Canada or the USA crossing state boundaries, which Richard Simpson talked about, are different, because they involve large areas in which all youngsters between the ages of 18 and 21 are affected. We are talking about small, specific areas of Scotland. If we accept Richard Simpson's amendments 31 and 32, we will discard what could be a valuable tool in specific circumstances.

Nicola Sturgeon: I have listened carefully to the debate and, unless my persuasion skills are greater than I think they are, I can predict how the vote will go. However, I want to make the argument, because it is an important one to make.

We listened carefully to the views that were expressed about our original proposal. It was clear that the concept of a blanket ban on the sale of alcohol to people under the age of 21 was not going to attract support. Therefore, in the spirit of consensus that we have adopted throughout the bill process, we modified the proposal.

I continue to believe that there is a place for raising the off-sales age, where appropriate, as part of a range of local measures to address specific local problems. That is why section 8 has the effect of placing a duty on licensing boards to consider whether there is a detrimental impact of the sale of alcohol to those under the age of 21 in all or part of the area that they cover. It also gives chief constables and local licensing forums a role in asking boards to review their detrimental impact assessments. That approach is much more sensitive to local circumstances and it encourages licensing boards to make their own decisions, based firmly on the evidence from their area.

Amendment 31 proposes that licensing boards should not even have to consider whether there is any detrimental impact of off-sales of alcohol to people under 21 in their area. Amendment 32 goes even further, as it would prevent licensing boards from stating in their licensing policy that they would consider restricting the off-sale of alcohol to those under 21, even if their area or part of their area were plagued by antisocial behaviour, underage drinking fuelled by proxy purchasing or alcohol-related harm to young people's health. The amendments would remove local discretion and deny licensing boards the ability to tackle specific problems in their communities.

Richard Simpson said that if the policy were used by a licensing board in one area, people would simply move to another area to buy drink from off-licences. I believe that that is exactly the kind of thing that a local licensing board would consider as part of its assessment of whether to use the power. Further, when Labour was in government, it rejected strongly—and, in retrospect, rightly—the argument that Richard Simpson has used when it was used in relation to the dispersal powers for the police that were proposed during the passage of the Antisocial Behaviour etc (Scotland) Bill. Those who opposed that power said that having a dispersal order in one area would simply shift the problem to another. Labour—again, rightly, in retrospect—said that that was not a reason to block giving the police those powers. The same point applies to the powers that we are discussing.

Richard Simpson cited the St Neots project in Cambridgeshire. We were interested in that project, too, and my officials travelled to Cambridgeshire to speak to some of those who were involved in it. The strong message from the young people themselves was that although the initiative had stopped them drinking in public, it had not stopped them drinking, and instead they were drinking in each other's houses. I am not saying that there is no merit in that approach; I am just saying that it is important to see it in its overall context.

12:15

Richard Simpson also said that we should not characterise the problem of alcohol misuse as being all about young people, and I agree with him. Throughout this debate, we have striven to ensure that we did not do that. However, that should not blind us to the important fact that the consumption of alcohol by underage drinkers in unsupervised settings is associated with increased drunkenness and a risk of increased harm. Not only does it cause societal and community problems, it puts the young people themselves at greater risk. That is why the proposals deliberately apply to off-sales. They would not prevent people between the ages of 18 and 21 from consuming alcohol responsibly in a more controlled on-sales environment.

This is not an untried approach. Comment has been made about the pilots that have been run in Scotland, and I accept that there is a limit to the evidence that we have in that regard, although some of it is encouraging, as far as it goes. However, we have international examples to consider as well. In Sweden, the purchase age for beverages over a certain alcohol strength is 20, but restaurants and bars can serve alcohol to those aged 18 and over. In Norway, the minimum age to purchase spirits in shops is 20, but it is 18 for all other purchases. We have considered evidence from other countries, including a review of 132 studies that found strong evidence that increasing the legal drinking age from 18 to 21 can have substantial effects on youth drinking and alcohol-related harm, often for well after young people have reached the legal drinking age.

We need to take this issue seriously. We are not proposing a blanket approach. Michael Matheson put it extremely well when he described the proposal as another tool in the box for local licensing boards. One of the strong arguments that members of all parties have made in the context of some other aspects of the bill is that we should not see any particular initiative as a magic bullet. We need a strong package of measures. The initiative that we are discussing is simply another tool in the box—it is just one part of a package of measures.

There is a great need for us to take this issue seriously. In 2007-8, more than 2,000 individuals under the age of 20 were discharged from general hospitals with an alcohol-related diagnosis. That is serious. I am not suggesting that the proposal will solve that problem outright, but I believe that placing a duty on local licensing boards to consider whether there is any detrimental impact of off-sales of alcohol to people under the age of 21 is an important part of the package. I therefore ask the committee to reject amendments 31 and 32.

Helen Eadie referred to a distinction between primary and secondary legislation. With the greatest of respect, I think that she might have been talking about another section of the bill. All of the proposals that we are discussing at the moment are in primary legislation.

Finally, I point out that, if Richard Simpson's amendments are agreed to, amendment 21, which we dealt with earlier, will fall, as it relates specifically to the detrimental impact assessment, which is being introduced only to deal with the issue of the off-sale of alcohol to those under the age of 21. However, amendment 22, which allows the health board voice to be heard in the wider array of the process, will not be affected by Richard Simpson's amendments 31 and 32.

Dr Simpson: I thank the cabinet secretary for a cogent exposition of the situation. She said many things with which I do not disagree. We know the extent of the problem and what the difficulties are; I just do not think that the proposal is the right approach or the right solution.

The cabinet secretary says that the St Neots project was considered and that youngsters said that they drink in each other's houses. In response to that, I say that we will never be able to stop that. However, the important point about the St Neots experiment was that it reduced all the problems to which Michael Matheson referred. The community safety issue and the issue of people gathering together to drink, sometimes to excess, were dealt with. There was significant improvement in the crime situation in the community.

I would like to be able to give Mary Scanlon a guarantee that my two amendments—to delete section 8 and to insert a presumption against prohibition—will do what she said should be done. However, I suspect that we will not be able to stop voluntary agreements of the sort that occurred in Stenhousemuir. If the community comes together and decides to take action, not at the instigation of the licensing board and not with the licensing board implementing a prohibition, we will not be able to stop that. I accept that a mechanism is available if a community agrees to that. However, I return to the fact that my reading of the situation is that all the other measures, such as community support, youth workers and diversion, are of much greater importance and can be implemented without legislation.

The cabinet secretary rightly says that we have big and significant problems with underage drinking. Later, we will consider test and proxy purchasing, which are important in dealing with under 18s. However, that is not relevant to the issue that we are considering. At the end of the day, the bill as it stands is discriminatory and the basic approach is wrong. Someone who is 21 and six months might create just as much trouble as someone who is 18 years and a day, so going on the basis of age is a false premise. I will therefore press amendment 31.

The Convener: The question is, that amendment 31 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

The Convener: The result of the division is: For 5, Against 3, Abstentions 0.

Amendment 31 agreed to.

After section 8

Amendment 32 moved—[Dr Simpson].

The Convener: The question is, that amendment 32 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)

The Convener: The result of the division is: For 5, Against 3, Abstentions 0.

Amendment 32 agreed to.

Section 9—Premises licences: variation of conditions

The Convener: Amendment 49, in the name of Mary Scanlon, is in a group on its own.

Mary Scanlon: Amendment 49 relates to variations and appeals. It would allow a premises licence holder whose licensed premises are subject to a proposed variation a right to be heard and to put any arguments against the imposition of the variation, in whole or in part, before the licensing board makes such a variation. The Law Society of Scotland is concerned that a variation under proposed new section 27A(1) of the 2005 act, as will be inserted by section 9(1) of the bill, will apply to all licensed premises without the licence holder being afforded the right to be heard. It is also concerned that licence holders are not afforded the right to appeal against a decision to vary. The Law Society is of the view that a suitable mechanism must be put in place to afford protection to premises licence holders who object to a variation being made under the new provision and that it is essential that a proper appeals procedure be introduced.

I move amendment 49.

Nicola Sturgeon: I agree with the principles of Mary Scanlon's amendment 49. It is important that a safeguard be put in place for businesses to ensure that their voice is heard before a licence condition is imposed. We have concerns, however, that the amendment has technical deficiencies. In particular, we need to be sure that it will work alongside the various licensing procedures that have been put in place by the 2005 act and the various orders and regulations that have been made under it.

In that light, I ask Mary Scanlon to accept my assurance that we will examine the amendment carefully and work with her to lodge amendments at stage 3 that will deal with the issue in a technically competent way. With that assurance, I ask her to seek to withdraw amendment 49.

Mary Scanlon: I am delighted with the cabinet secretary's response. I accept the fact that there are technical difficulties, and I accept her assurance that they will be examined and further amendments lodged at stage 3. In light of that, I seek leave to withdraw amendment 49.

Amendment 49, by agreement, withdrawn.

Section 9 agreed to.

After section 9

Amendment 22 moved—[Nicola Sturgeon]—and agreed to.

The Convener: Amendment 23, in the name of the minister, is in a group on its own.

Nicola Sturgeon: Scotland has a rich tradition of events and festivals, which are good for our communities and our tourism industry. Many of those events can sell alcohol through the use of occasional licences, which give a fair, flexible and low-cost option for our hospitality and entertainment sectors as well as for local community groups who might want to cater for one-off events. There is nothing wrong with any of that.

Licensing boards and the police have brought to our attention the fact that some applicants are seeking to use the occasional licence process to apply for consecutive occasional licences as an alternative to a premises licence. That effectively allows them to circumvent parts of the licensing regime, including overprovision assessments and the mandatory requirements to train staff.

Of course, we do not want to remove the flexibility in the licensing system that occasional licences give because they benefit those who run and attend one-off events. However, the use of occasional licences as a way of getting around having a premises licence deprives communities of the opportunity to comment on applications, it deprives licensing boards of the opportunity to make considered decisions on new applications, and it reduces the opportunity to ensure that appropriate action is taken when premises are badly run.

Amendment 23 provides that licensing boards must not grant occasional licences if it would exceed the occasional licence limit. The occasional licence limit for voluntary organisations is the limit that is already provided for in the 2005 act. In other cases, the occasional licence limit will be set in regulations. Ministers are not required to make regulations setting an occasional licence limit, but should the use of occasional licences as a spurious substitute for premises licences become more widespread, we want to be able to consider what restrictions would be appropriate while protecting legitimate use of occasional licences.

I move amendment 23.

Mary Scanlon: I am minded to support amendment 23, but the point has been raised with me that local organisations such as village halls enjoy the flexibility that they have at the moment. Has any consideration been given to the likely impact on small rural village halls of the limit on the number and duration of licences?

Nicola Sturgeon: The intention of amendment 23 is not to affect the kind of organisation that Mary Scanlon has mentioned. We are talking about shops, pubs and commercial organisations that should be applying for premises licences but are trying to circumvent what goes with that by repeated use of occasional licences. We are absolutely clear that we do not want to take away the ability of community groups or one-off events to get occasional licences, but we do not want the system to be abused and used as a get-out-of-jail-free card in the licensing regime. I hope that that reassures Mary Scanlon.

Amendment 23 agreed to.

The Convener: Amendment 51, in the name of Mary Scanlon, is in a group on its own.

Mary Scanlon: Amendment 51 relates to convictions and licence reviews, and seeks to allow the police discretion about whether a conviction is sufficiently important to justify a premises licence review hearing with all that that entails.

Amendment 51 intends to remove what appears to be an unintended or typographical problem in section 44 of the 2005 act.

12:30

There are many applicants for and holders of premises licences who have many businesses throughout the United Kingdom, who will inevitably incur convictions on occasions. Those are often related to health and safety legislation and may not be significant in regard either to the premises licence holder or to other licensed premises. Nevertheless, there is a requirement in Scotland to advise every board under which the premises licence holder holds a premises licence of any such conviction. The premises licence holder or court advises relevant boards of any conviction. Each board must advise its chief constable, who either tells the board that he cannot confirm that the offence is not relevant or who confirms the offence and may then not recommend a variation, suspension or revocation of the premises licences in that board area.

However, if a board receives from the appropriate chief constable a notice under section 47(4)(b) of the 2005 act, it is obliged to propose a premises licence review in respect of the premises licence holder, regardless of the nature of the conviction. Some organisations have claimed that that is wasteful of resource for all concerned and that a reasonable exercise of discretion would mean that only matters of relevance would be heard by a board. Examples of that could include breaches of the Alcoholic Liquor Duties Act 1979, the Gaming Act 1968, the Food Safety Act 1990 or the Licensing (Scotland) Act 2005 rather than offences such as speeding. Amendment 51 would mean that a review hearing would require to be held only when the chief constable recommended it: it would not be initiated automatically.

It is fairly obvious that I did not write the amendment. It has been produced by an organisation in the hospitality industry.

The Convener: I ask you to move the amendment, which you say is not in your own words.

Mary Scanlon: I move amendment 51.

The Convener: Does anyone wish to enter the fray?

Nicola Sturgeon: The situation that Mary Scanlon seeks to address is the result not of a typographical error, but of a policy intention. I am afraid that I do not agree with her amendments and I will set out the reasons for that.

I assume, from Mary Scanlon’s introduction, that there is absolutely no disagreement about the proposal that a licensing board should review a premises licence when the police recommend that the licence be varied, suspended or revoked following a licence holder or, in some cases, a connected person being convicted of a relevant offence or a foreign offence. The issue arises when relevant convictions come to light in relation to legislation on matters such as smoking, breastfeeding or health and safety, when the police might not consider it appropriate for them to make a specific recommendation on the variation, suspension or revocation of a premises licence.

Should the licensing board, notwithstanding that, still have the ability, in the circumstances of such convictions, to review the licence? My view is that the absence of a recommendation from the police should not prevent a licensing board from being able to review the licence if it thinks that it is appropriate to do so. It is about local discretion for licensing boards. The board would then be able to hold a hearing and take any action that it considered appropriate or, indeed, take no action. For example, when there is a conviction in relation to smoking, the police might not consider that it merits a recommendation. Nevertheless, in the view of a licensing board, it might make it appropriate to vary the conditions in the licence relating to child access. There are some good reasons why the licensing board should retain its local discretion.

Some large commercial outfits—some supermarkets, for example—are looking at the current situation legally as a way of not having to notify licensing boards about health and safety breaches. I do not think that we would want to encourage that. Therefore, I ask Mary Scanlon to seek to withdraw amendment 51 on the basis of what I have said. If she presses it, I ask members to vote against it.

Mary Scanlon: The cabinet secretary’s response has been very helpful. As I said, amendment 51 was lodged on behalf of an organisation. Part of scrutinising the bill is to seek clarity on issues around which there may be ambiguity or misunderstanding among outside organisations. I thank the cabinet secretary for her response. I am pleased with the clarification that has been given and seek to withdraw the amendment.

Amendment 51, by agreement, withdrawn.

The Convener: Amendment 52, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: With amendment 52, I am attempting to do on alcohol what the Parliament did on tobacco. I am not completely happy with the progress on detection of underage purchasing or of proxy purchasing. Earlier, I mentioned some of the elements that were coming through in reports.

It is not for us, as parliamentarians, merely to express concern; it is for people to say whether they are happy about what is happening in their locality. It is they who will make a judgment on that, and that should be the case. Through amendment 52, I want to ensure that licensing boards have to publish a general plan and a report on the implementation of that plan so that people will be able to see for themselves whether a determined effort is being made to tackle underage drinking.

It has been suggested that amendment 52 would interfere with the independence of licensing boards, which I do not accept. It has also been suggested in the letter that we received from the Association of Chief Police Officers in Scotland that the amendment would result in the police being instructed on the detail of operational matters. If that is the case, I would seek to lodge a further amendment at stage 3, but my reading of amendment 52 is that it does not seek to tell the police precisely how to undertake a programme to reduce underage drinking; it simply provides that there should be such a programme. It would be for the licensing board and the police to come to a conclusion on what and how many activities to undertake in respect of underage purchasing and proxy purchasing.

Too often, we cannot find out exactly what is going on. It is not good enough that we cannot get the answers that we need, so amendment 52 would give us an opportunity to do so. However, I note the concerns that ACPOS has expressed, particularly its concern that the Government has failed to acknowledge the loophole in section 105 of the 2005 act, whereby an adult can buy alcohol for and provide it to a person under 18 in a public place without the adult or the child or young person committing an offence.

The fact that responsible retailers are applying a barcode to the items of alcohol that they sell will enable those items to be traced back effectively to determine who carried out the purchase. That, along with an amendment to make an offence the passing on to an under-18 of alcohol that is then consumed in a public place, should perhaps be considered. I realise that amendment 52 would not do that, but I hope that the Government or a member of the committee might consider lodging such an amendment at stage 3 to tackle the concerns of ACPOS.

I move amendment 52.

Helen Eadie: I would like to speak in support of amendment 52. The BMA has supplied information, in which it says quite strongly that it would like the committee to support the amendment. Its view is that the existing age restrictions on the purchase of alcohol are clearly not enforced, because children as young as 13 report drinking alcohol on a regular basis. It has also told us that the recent Scottish schools adolescent lifestyle and substance use survey data suggest that children can access alcohol easily. The most common sources of alcohol are reported to be friends, relatives, shops and off-licences. Even though children as young as 15 report buying alcohol for their own consumption, prosecution rates for underage drinking and, more important, for selling alcohol to underage children are low. The BMA says that it would welcome stricter enforcement of age restrictions, particularly for off-sales.

Ross Finnie: I have a lot of sympathy for the thrust of Richard Simpson’s amendment. He said that we are interfering with licensing boards, but the 2005 act already sets out a framework for the kind of matters that a licensing board should properly consider in drawing up its policy. There are clearly issues about the policy statements and how they address the very real issue of underage drinking. Regardless of whether the wording is absolutely right, the thrust of seeking to have that as part of the policy statement seems worthy of support. I was not entirely sure whether it should have been in section 6 or section 12, but I am not going to pursue that, because I failed to lodge my own amendment. I support the principle of where Richard Simpson is trying to get to.

I perhaps have a slightly stronger view than ACPOS. I am not at all comfortable with the chief constable being responsible for the policy. There is a real distinction between chief constables and the police giving evidence to licensing boards, supplying information and commenting, and their actually being part of the process of preparing a policy that ultimately is the responsibility of the licensing board, not the chief constable. It goes beyond the chief constable just being associated with the process. ACPOS says in its letter that it is inappropriate for the chief constable or his representative to be engaged in the process. I think that the chief constable could technically end up being responsible for the policy, which is wrong.

I hope that the cabinet secretary is also minded to support the general thrust of amendment 52, but I think that the wording requires to be considered before we get to stage 3.

Nicola Sturgeon: I will pick up where Ross Finnie left off. There is a fair amount of common ground in this discussion. We certainly recognise strongly the need for effective enforcement of existing laws. Test purchasing has been one of the early successes of the 2005 act. There is no doubt that even better enforcement of the law is an integral part of our overall approach to tackling the problems with alcohol. We will certainly continue to support the police and licensing boards in that task as much as we can.

Against that background, I have some sympathy for Richard Simpson’s argument. However, we have discussed this matter with the police and licensing boards and we consider that amendment 52 as framed raises a number of questions that have not been sufficiently ironed out and thought through. To be fair, Richard Simpson has rehearsed some of those arguments. Given the role of licensing boards in initiating and deciding on reviews of premises licenses, there is a view that it is not appropriate for them also to be involved in formulating a programme of activity that includes their agreeing how police powers are to be exercised.

We also have concerns about how appropriate it is for the local licensing forums to be consulted on the exercise of police powers. I will not quote the ACPOS letter, because all members have seen it, but ACPOS obviously has serious concerns about amendment 52.

The deployment of operational tools by the police, such as test purchasing, bottle marking and seizure programmes should and must remain the choice and responsibility of the police. Often the police carry out such operations on an intelligence-led basis. Their attention to particular premises might stem from representations from the public or from other information about underage drinking in a particular area. Such a targeted approach ensures the best use of resources.

I agree that local licensing forums should be supplied with information on police action and its effects. I know that the police also support that position, as they are willing participants in the local licensing forums.

I am confident that as the new act beds in, licensing boards and the police will continue to develop their roles and will continue to use the powers that they have to their full extent. I am not convinced that amendment 52, in its current form, is helpful in ensuring that local licensing forums are properly informed and consulted. However, in light of the debate that we have had, and given the concerns that we have about the position of licensing boards in the process, but acknowledging the need for local forums to operate from an informed position, I am happy to offer Richard Simpson some assistance in developing an alternative amendment for stage 3. On that basis I ask him to seek to withdraw amendment 52.

12:45

Richard Simpson also mentioned the comment in the letter from ACPOS on the subject of proxy sales, and particularly its concerns about section 105 of the Licensing (Scotland) Act 2005. I should say for the record that the Government shares the concerns of ACPOS in that regard. We lodged a stage 2 amendment on the issue but, in a perfectly legitimate decision, it was deemed to be outwith the scope of the bill. We will look at how we can address the concern that ACPOS raised.

Dr Simpson: I am comfortable with what the cabinet secretary has said and the debate that we have had on the issue. I think that we are all of the same mind. It is a question of how we do it. I am happy to work with the cabinet secretary on drafting a more appropriate amendment, and on that basis I seek to withdraw amendment 52.

Amendment 52, by agreement, withdrawn.

The Convener: Amendment 53, in the name of Richard Simpson, is in a group on its own.

Dr Simpson: Members will know that I have asked a number of parliamentary questions on the subject of a national licensing forum. The gist of the replies was that the Scottish Government had no objection if COSLA wanted to set up a national licensing forum, but the Government would not do that and would certainly not pay for it. Until we received a letter from it in the past few days, COSLA had been silent on the issue, but it is understandable that it has now expressed concerns about both the costs and the reporting requirements.

The licensing forums are an important part of the delivery system of the 2005 act. I believe that they are still not working perfectly, although it is early days. Their membership, for example, is quite variable, and Young Scot and others have drawn attention to the fact that young people are still not represented on quite a number of the forums. The national licensing forum that is proposed by amendment 53 would put us in a position to look at the functioning of the 2005 act where that is problematic. The national forum would give advice to the forums themselves, the local community and the Government.

Next, we come to the issue of the public health interest. We will deal with that separately, but the general question of availability could be supported by the national licensing forum. Its job would be to collate and provide information and disseminate best practice either from existing collected data or from research. I accept that we do not want to impose an unnecessary burden on either the forums or the licensing boards by requiring them to collect enormous amounts of new data, but they should examine the data that the forums collect on such things as the number of licences that are suspended or cancelled, the way in which availability and other policies of individual boards vary, and the effect of those policies over time. They could also support the local forums in other ways. They could learn from best practice in individual forums and spread that out. Their job would be not to dictate but to provide the local forums, the boards and the Parliament with information.

COSLA has criticised the proposed membership in my amendment, but it is designed to ensure that all groups are represented so that, if any of them anywhere in the country feel that they are not receiving a hearing locally, the issues can be considered and raised for debate. I have suggested that the national licensing forum should be able to commission research to fill in gaps in knowledge and to provide the best advice.

As far as the burden is concerned, the national licensing forum should also be able to advise on the minimum appropriate data set that needs to be collected. On funding, I hope that we could seek, through the social responsibility levy if we choose to agree to it, a method by which funds could be recouped. That approach would avoid placing an additional cost burden on COSLA.

I move amendment 53.

The Convener: I have a question before I ask other members to comment. Proposed new section 9A(4)(i) of the 2005 act mentions the Scottish Consumer Council. Is that still its name?

Dr Simpson: It is now Consumer Focus Scotland.

The Convener: So that is erroneous. Do other members have comments?

Ross Finnie: I agree that, in some cases, the local forums that were established under the 2005 act are not functioning as well as they might, but I am not persuaded that the remedy for their malfunction is to create a national licensing forum. I am bound to say that, although I understand that it is important to get the local forums to work, the amendment has the slight sense of taking a sledgehammer to crack a nut. I originally believed—and I share COSLA's belief as now expressed in its letter—that it will create an unnecessary additional layer of bureaucracy in the forums.

There is also wording in the amendment that seems to interpose the national forum above local forums and to give it some supervisory role or overview of licensing boards. Amendment 53 would give a different thrust to how the forums will be run, and it seems to strike against having local boards and forums. Those who are appointed to forums or elected to boards are the proper people to carry out the duties. We might not agree with them, as many do not agree with what we do, but they are, like us, elected for the purpose. Amendment 53 is therefore slightly overburdensome and, in its present form, I cannot support it.

Ian McKee: I also have doubts about amendment 53. I fully understand why Richard Simpson lodged it, but I also have a gut feeling against the establishment of yet another quango, especially as, within a short space of time, the people who have suggested establishing another quango will probably be attacking the Government for having too many quangos.

I am bit concerned about the detail in relation to young people and how they are chosen, and whether it is right to discriminate in favour of them when it was wrong to discriminate against them. How would they be chosen and appointed?

My main objection to amendment 53, however, comes in the proposed new section 9A(6). Proposed new section 9A(6)(b) says that the national licensing forum may

> "carry out or commission such research in connection with its functions as it considers appropriate"

and proposed new section 9A(6)(a) says that those functions could be about

> "health issues ... relating to the consumption of alcohol".

That is a huge, open-ended commitment that could require a substantial amount of finance. A body that is commissioning and carrying out research into health issues in relation to alcohol could mean huge expense. We are running the risk of setting up a big body where there is not enough money to allow it to carry out the functions that we are asking it to carry out. It seems foolish to be establishing it in the first place.

Mary Scanlon: I, too, understand why Richard Simpson lodged the amendment. Despite what we have said about age, it is important to give local licensing boards the appropriate degree of local discretion and the ability to take local action.

I wonder whether it is necessary to have a national licensing forum. Richard Simpson talked about collating, providing and sharing best practice, but I wonder why we need an organisation to do that, given that we have 32 licensing boards in a country the size of Scotland that could work together with better collaboration to share best practice. Along with other members, we have been looking at reducing the number of quangos in Scotland to reduce the cost of public services, so from that point of view, I and my party are not in favour of creating another quango.

Has Richard Simpson done any research into the likely cost of the proposed organisation? Our difficulty is that a national licensing forum is not in the financial memorandum, and we did not take evidence on it at stage 1. I think that I agree with Ian McKee that it does not just appear to be cumbersome. I fear that, as an organisation, a national licensing forum could be hugely bureaucratic. So, although I understand the principle behind amendment 53, I will not support it.

Helen Eadie: As Mary Scanlon rightly pointed out, as parliamentarians we receive many representations from external organisations and have to take cognisance of some of their wishes in this process. We have received submissions supporting the proposals, particularly from Alcohol Focus Scotland, which has advocated the creation of a licensing forum since its establishment several years ago. In June 2010, the regulatory review group recommended the introduction of a higher level alcohol and licensing forum to examine the more strategic and longer term issues around fees, for example.

Alcohol Focus Scotland, I and others believe that, as well as monitoring the implementation and on-going performance of and other issues in relation to licensing legislation and beyond, a national licensing forum would be particularly useful in providing a focus for local licensing forums to raise issues that emerge in local areas. After all, we should keep it in mind that we are not always seeking a top-down approach for organisations and that we also want them to share information and understand emerging issues. As a result, the forum would not only work like a commission and monitor the operation of legislation, but ensure that we engage with our local licensing boards.

I am not aware that that kind of engagement process is going on in Scotland. My husband serves on a licensing board and the only information that I get is via him or the newspapers. That is simply not adequate. We need a more structured approach to a serious issue that we need to have regard to, which is why I am very happy to support Richard Simpson's proposal. I say to Mary Scanlon and Ian McKee that I agree that we should not have a million—or even hundreds—of quangos, but some things in life are so important that they require this kind of forum, which, as I have pointed out, will also have an advisory function. We need to get rid of quangos that are not important; this forum does not need to be a quango, if that is the right name—it could be a commission, for example—but it is important that Scotland has an arm's-length, independent body that can share and facilitate the sharing of information.

The Convener: I was just thinking of breakfast at the Eadies and all those discussions about the role of licensing boards. It sounds exciting.

Helen Eadie: It is pillow talk, convener.

The Convener: Too much information! The day wears on.

Nicola Sturgeon: It was about this time last week that you started talking about being married to Ross Finnie, convener. A pattern is emerging to these meetings.

Richard Simpson's amendment 53 seeks to establish a national licensing forum. I am compelled to remind members that there used to be such a forum and that it was abolished by the previous Administration in early 2007. Dr Simpson was not in the Parliament at the time, so he cannot take responsibility for the move, but in light of that recent decision the amendment seems rather odd.

Since that decision, those charged with making the 2005 act work have been rising to the challenge and acting in the best interests of their communities. It is true to say that some are still finding their feet, which is inevitable given the major change that was the 2005 act, but the police and the licensing standards officers, in particular, have organised themselves in a way that allows them to share good practice and find common solutions to problems. For example, the Scottish Government is represented on the ACPOS licensing group and we attend meetings of the national licensing standards officers liaison group. We also have very good links with stakeholders, including licensing boards, licensing lawyers and the licensed trade, which has allowed us to have frank and helpful discussions that have led to improvements to the 2005 act.

13:00

I agree with those around the table who have said that we should encourage the sharing of best practice. Obviously, licensing boards deal with their own local situations, but many problems are common throughout Scotland. As a result, it is important to encourage the spirit of joint working, and I certainly do not depart from that view, but a national forum has to be something that licensing boards want. They have to take the initiative on it rather than have it foisted upon them. It needs to be authoritative and impartial rather than a disparate collection of industry representatives with competing and conflicting views; it must be efficient; and it must not replicate work that has already been undertaken elsewhere. With the greatest of respect to Richard Simpson and his intentions, I simply do not think that amendment 53 will achieve that. Organisations such as the Convention of Scottish Local Authorities and licensing boards themselves should establish and drive a national forum and we have said that the Scottish Government is willing to engage fully with any efforts in that direction.

We are also keen to avoid establishing a new statutory national public body, which, as members have pointed out, would involve both set-up costs and annual running costs that have not been estimated. I have very real concerns that establishing the forum as a new public body will result in an increase in public body numbers and incur the cost and bureaucracy of a ministerial appointments process in appointing the chair and members. As Mary Scanlon and others have said, such a measure runs counter to our efforts to slimline and simplify the public sector landscape and reduce the number of quangos. The amendment also seems unnecessarily restrictive in relation to the membership of forums and, as I said, I am concerned about the potential to replicate some work that is already under way.

I have absolutely no difficulty with encouraging licensing boards to work together, but I do not believe that creating a new statutory non-departmental public body, quango or call it what you will, and all the bureaucracy that goes with it, is the right approach. I remain firmly of the view that a national forum has to be developed and owned by those whose responsibility is to make the licensing regime work on a day-to-day basis and not imposed on them by the Parliament or Government.

As a result, I ask Richard Simpson to consider withdrawing the amendment. If he presses it, I ask the committee to reject it.

Dr Simpson: Without rehearsing all the arguments, I simply make the important point that Alcohol Focus Scotland, which was involved in the initial training and the regulatory review group felt that such a move was appropriate. For two years—since Kenny MacAskill gave his answer that if such a body was needed COSLA should set it up—I have waited patiently for some response in that respect. I am genuinely concerned—not about uniformity of local practice, because I do not think that that is what we are seeking—but about ensuring the spread of best practice and the identification of particular issues. Issues such as Glasgow licensing board's difficulty in preventing the extension of sales areas in supermarkets need a forum in which they can be discussed and debated and a method of tackling the problem can be suggested. I simply do not think that we have that at the moment.

I accept Mary Scanlon's point that I have not costed the proposals, but I do not think that they will be particularly expensive. Indeed, the costs could be met from the social responsibility levy without biting into it too much.

I will press amendment 53, convener.

The Convener: The question is, that amendment 53 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Eadie, Helen (Dunfermline East) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

Against

Finnie, Ross (West of Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Matheson, Michael (Falkirk West) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 53 disagreed to.

The Convener: The end, as someone, somewhere once said, is in sight.

Amendment 54, in the name of Richard Simpson, is grouped with amendments 55 and 56.

Dr Simpson: I lodged amendment 54 mainly to put on record my continuing concern that two issues with regard to the working of the 2005 act are not being fully addressed and that, as evidence to the alcohol commission established by Labour suggested, people are finding it difficult to address.

As we know, the 2005 act contained a couple of unique provisions that are not included in any other act that I know of anywhere else in the world. One provision is that, in exercising its functions, the licensing board should be able to take into account the public health interest. It seems to me that they are finding that extremely difficult, and the purpose of the first part of the amendment is to seek the provision of clear guidance from the Government on what that constitutes, so that licensing boards have a greater ability to use the public health interest, in particular to limit availability.

The second issue is irresponsible drinks promotions. All the debate, discussion and enforcement in respect of licences appears to me to have been in relation to the on-trade. I know that provisions in the bill refer to the off-trade, but I am not convinced that there is a sufficient description of what we could, I think, all agree are irresponsible drinks promotions. For example, in all our debates we have said that supermarkets that sell alcohol as a loss leader are behaving irresponsibly. They tell us clearly that they are doing it not because they want to—in fact, they would rather not do it—but because there is competition between them and they therefore have to do such loss leading to achieve sales. Loss leading to achieve footfall seems to me to be the height of irresponsibility.

My amendments are intended to seek information from the cabinet secretary as to whether she believes that the current legislation fulfils the objectives that we all sought with the 2005 act. If it does, or if guidance should or could be issued that would achieve those objectives, I will withdraw my amendments; otherwise, I will press them.

I move amendment 54.

Mary Scanlon: My understanding is that licensing boards already have the power to issue guidance. Is it the case that licensing boards could be encouraged through collaboration, best practice and so on to take more account of public health issues? Are the amendments necessary? Could more recognition of public health not be achieved within the current guidance?

Helen Eadie: The evidence that we have received, which is perhaps pertinent to your point, Mary, is that the guidance written to accompany the 2005 act requires to be completely rewritten because it is primarily aimed at the on-sales sector and does not adequately take account of the shift towards home drinking, the fact that the majority of alcohol sold in Scotland is bought from the off-trade sector or the fact that most alcohol bought from the off-trade sector is bought from large supermarkets. The changes in our drinking behaviour need to be more adequately reflected in the licensing legislation and guidance—guidance from the minister as opposed to guidance within the local licensing boards, Mary. Licensing boards require further guidance on how to consider the public health interest. We talked previously about the public health—

Mary Scanlon: We are having a little chat here—forget the rest of you.

Helen Eadie: Sorry, convener.

The Convener: I feel that we should leave the room and leave Mary Scanlon and Helen Eadie to their conversation. Never mind—press on.

Helen Eadie: I am responding, through you, convener, to the points that Mary Scanlon raised and which perhaps dwell in the thoughts of other committee members. I apologise to the convener if there have been any thoughts otherwise. It is important that the public health objective is addressed when a licensing board decides to grant or renew a licence and public health needs to be more of an issue in local licensing decision-making.

I hope that Richard Simpson's amendment will encourage licensing boards to implement the guidance fully. As MSPs we all know, and we all find it testing at times, that people totally ignore guidance that is issued by ministers. Having said that, it is important to get the message out that we want some clarity in the Government's guidance on the matter.

Nicola Sturgeon: I agree with Mary Scanlon that the amendments are unnecessary and do not allow us to do anything on the public health objective that cannot be done currently.

Amendments 54 and 55 require any guidance that is issued under section 142 of the 2005 act to include guidance on the ways in which licensing boards can promote the licensing objective of

"protecting and improving public health".

As I indicated in relation to an earlier group, I agree with Richard Simpson that the public health objective may be the licensing objective that licensing boards have had most difficulty in applying to their policies and decision-making processes. The committee will be interested to know that Alcohol Focus Scotland is working with licensing boards on the issue. The amendments that we have lodged to enhance the role of health boards will be of assistance in that regard.

We are also in the process of reviewing and revising the guidance that is already issued under section 142 of the 2005 act. Helen Eadie is right to say that the current guidance distinguishes between on-sales and off-sales, but it does so because it reflects current legislation. The purpose of revising it is to ensure that it reflects both the changes that are made by the bill—which, as members are aware, takes away some of the anomalies between on-sales and off-sales—and the changes that were made by the Criminal Justice and Licensing (Scotland) Act 2010. The process of revision is under way. I assure Richard Simpson that we will work with health organisations to ensure that clear and comprehensive guidance is issued in the near future.

Amendments 54 and 56 require any guidance that is issued under section 142 to include guidance on irresponsible promotions as defined in schedules 3 and 4 to the 2005 act. The previous Administration deliberately did not provide guidance on irresponsible promotions—in particular, a list of promotions that would be irresponsible promotions under the 2005 act—in statutory guidance, because it was concerned that that could result in parts of the licensed trade developing new promotions that did not fall within the list of promotions that were set out in the guidance but could still be considered to be irresponsible promotions under the 2005 act. This would have the potential to create a conflict between the guidance and the 2005 act that would not be in the interests of the licensed trade, licensing standards officers or licensing boards.

I tend to the view that the previous Administration's decision not to issue guidance that included a defined list of promotions constituting responsible promotions was right. It is much better to allow licensing boards to decide on a case-by-case basis whether a promotion is an irresponsible promotion.

I ask Richard Simpson to accept my assurance that revised guidance under section 142 of the 2005 act will include guidance on the application of the public health objective, to note my comments and the reasons that I have given in relation to amendments 54 and 56, to withdraw amendment 54 and not to move amendments 55 and 56.

Dr Simpson: On the basis of the assurances that we have been given and of the fact that we have got on the record our general feeling that the public health objective is proving difficult to meet, I seek leave to withdraw amendment 54.

Amendment 54, by agreement, withdrawn.

Amendment 55 not moved.

The Convener: Do you wish to move amendment 56?

Dr Simpson: I agree not to move the amendment, but I may want to return to the issue to which it relates.

Amendment 56 not moved.

The Convener: That ends today's consideration of the bill. I thank the cabinet secretary for her attendance. I am afraid that committee members must stay nailed to their chairs.

13:14

Meeting continued in private until 13:18.

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