The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 3 June 2014

Session 4

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HEALTH AND SPORT COMMITTEE
18th Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Karen Addie (Royal College of Psychiatrists in Scotland)
Dr Carole Allan (British Psychological Society)
Professor Marion Bain (NHS National Services Scotland)
Derek Barron (Royal College of Nursing Scotland)
Robbie Beattie (Association of Public Analysts Scotland)
Shaben Begum (Scottish Independent Advocacy Alliance)
Jason Birch (Scottish Government)
Brian Donnelly (Young Scotland in Mind)
Ailsa Garland (Scottish Government)
Isabella Goldie (Mental Health Foundation)
William Hamilton (Glasgow City Council)
Professor Peter Morgan (Rowett Institute of Nutrition and Health)
Joyce Mouriki (Voices of Experience)
Alex Neil (Cabinet Secretary for Health and Wellbeing)
Chris O'Sullivan (Mental Health Foundation)
Professor Hugh Pennington (Royal Society of Edinburgh)
Dr S Josephine Pravinkumar (NHS Lanarkshire)
Carolyn Roberts (Scottish Association for Mental Health)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The Mary Fairfax Somerville Room (CR2)

Scottish Parliament

Health and Sport Committee

Tuesday 3 June 2014

[The Convener *opened the meeting at 09:30*]

Subordinate Legislation

Health Care and Associated Professions (Indemnity Arrangements) Order 2014 [Draft]

The Convener (Duncan McNeil): Good morning and welcome to the 18th meeting in 2014 of the Health and Sport Committee. As is usual at this point, I ask everyone in the room to switch off mobile phones and other wireless devices because they can interfere with the sound system and disturb the meeting. The caveat to that, of course, is that members and officials are using tablet devices instead of hard copies of the meeting papers.

The first item on the agenda is subordinate legislation. We have before us today one instrument that is subject to affirmative procedure—the draft Health Care and Associated Professions (Indemnity Arrangements) Order 2014. As usual with affirmative instruments, we will hear evidence from the cabinet secretary and his officials. Once all our questions have been answered, we will have the formal debate on the motion.

I welcome the Cabinet Secretary for Health and Wellbeing, Alex Neil: we are pleased to have you here, cabinet secretary. He is accompanied by his officials. They are Jason Birch, who is senior policy manager of the regulatory unit in the health directorate, and Ailsa Garland, who is the principal legal officer of food, health and community care at the Scottish Government. Welcome to you all. I ask the cabinet secretary to make a few opening remarks.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you, convener.

At present in Scotland, England, Wales and Northern Ireland there is, across the nine statutory healthcare regulatory bodies, no consistency in legislation or guidance on the need for health professionals to have in place insurance or indemnity.

The Scottish Government and the health departments in the three other nations believe that it is unacceptable for individuals not to have access to compensation when they suffer harm through negligence on the part of a healthcare professional. In order to rectify the situation, the order will require all statutorily regulated practising healthcare professionals to have in place insurance or indemnity as a condition of registration with their respective regulators. Regulated healthcare professionals who cannot demonstrate that such arrangements are in place will be unable to practise.

The development of the order follows an independent four nations review—led by Finlay Scott, who is a former chief executive of the General Medical Council—which reported in June 2010. The key recommendation of the review was that

"There should be a statutory duty upon registrants to have insurance or indemnity in respect of liabilities which may be incurred in carrying out work as a registered healthcare professional."

The four health departments accepted the report and its main recommendations in December 2010, and undertook to introduce legislative changes at the next opportunity.

The order will also implement article 4(2)(d) of the 2011 European Union directive on patients' rights in cross-border healthcare, which requires member states to ensure that

"systems of professional liability insurance, or a guarantee or similar arrangement that is equivalent or essentially comparable as regards its purpose and which is appropriate to the nature and the extent of the risk, are in place for treatment provided on its territory".

It is important to note that the vast majority of regulated healthcare professionals are in receipt of cover by virtue of their employer's vicarious liability or via membership of a professional body that offers an indemnity arrangement as a benefit. However, it should be noted that it will be for individual healthcare professionals to assure themselves that appropriate cover is in place for all the work that they undertake.

The Scottish Government is committed to ensuring that people have access to appropriate redress, in the unlikely event that they are negligently harmed during the course of their care. Everyone should have that right. I am happy to answer questions to the best of my ability.

The Convener: I thank the cabinet secretary for those opening remarks. We have a question from Rhoda Grant.

Rhoda Grant (Highlands and Islands) (Lab): It is my understanding that, in order to ensure that everybody has indemnity insurance, it will be a requirement of their registration that they provide evidence of such insurance. Is that right?

Alex Neil: Yes.

Rhoda Grant: A person's taking a career break and not practising could become a barrier to their

reregistering. Once someone is trained, if they take a career break to bring up a family, or the like, there is a cost for keeping up registration, but there would be another cost entirely for keeping up indemnity insurance that they would not be using. Will there be special measures in place to cater for those people?

Alex Neil: I will ask Ailsa Garland to handle the detail, but the principle is that the order applies to practising healthcare professionals. If the person is practising, they will be required to have indemnity insurance. My understanding from the briefing—Ailsa Garland, as a lawyer, will confirm whether it is correct—is that a woman who has taken five or 10 years out in order to have a family would not be required to indemnify herself during the period when she is not practising.

Ailsa Garland (Scottish Government): The cabinet secretary is correct. The terms of the order relate to registered professionals who are practising as such. My understanding is that those who are not practising will not be required to keep up their insurance during that period.

Rhoda Grant: Would such people still be able to keep up their registration?

Ailsa Garland: Yes. A different category is in play there.

Richard Lyle (Central Scotland) (SNP): I welcome the order. I note that

"Provisions relating to the regulation of the majority of healthcare professions are reserved to the UK Parliament."

What percentage of professionals does the Scottish Government order cover?

Alex Neil: It will pretty well cover all the 32 professions that operate in the national health service in Scotland, and they are covered by the nine regulatory bodies that are referred to. The professions include nurses, midwives, doctors, ophthalmic practitioners and dentists—the whole range of professionals. I cannot think offhand of any professional group in the national health service that would not be covered and is not listed among the 32 professions that are covered by the order.

Jason Birch (Scottish Government): That is correct. To clarify, there are seven professional groups for which the Scottish Parliament has devolved responsibility. We can supply details of those, if that would be helpful.

Richard Lyle: Thank you.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): If doctors are registered but not licensed, they will not be able to practise. I presume that Ms Garland's previous remarks cover that. If they are registered and then decide to license again, will they have to pay for the indemnity?

Ailsa Garland: Yes. You are probably aware that the order will amend various pieces of legislation that are already in place, so the wording is slightly different for different professional bodies. For example, in relation to medical practitioners, the order refers to

"A person who holds a licence to practise as a medical practitioner, and practises as such".

That is where the requirement to have indemnity applies.

Dr Simpson: At the moment, for those who are practising in a hospital setting, the hospital covers the indemnity. Who covers the indemnity of a general practitioner who is working on a locum basis and is employed by a health board?

Alex Neil: My understanding is that GPs all cover themselves, because they are independent practitioners. They are not part of a national health service policy because they are independent, but they must cover themselves.

Dr Simpson: I understand that that is true for independent contractors, but there is a group of professionals—dentists, doctors and possibly others—who are employed directly by the health board and are not independent contractors, in the general sense of the term, but are salaried doctors. Will they be covered by the NHS or will they have to pay for cover themselves?

Alex Neil: In the national health service in Scotland 4 per cent of GPs are salaried employees of the national health service. My understanding is that they would be covered by the national health service, because we cover our employees.

Ailsa Garland: That is my understanding. If GPs are employed by the health board, there would be an insurance arrangement through the health board. I am not absolutely certain, however, but we can check.

Alex Neil: We will double-check on GPs.

Dr Simpson: That is fine.

There are increasingly complex arrangements for employment. For example, some people are employed by a health board through an agency. In such cases, will responsibility for ensuring that the practitioner has indemnity lie with the agency, the practitioner or the health board that is purchasing services from the agency?

Alex Neil: Ailsa Garland will correct me if I am wrong, but my understanding is that it is clear in law that it is the duty of the doctor—the practitioner—if they are not employed by the national health service, to ensure that they are indemnified. Is that right, Ailsa?

Ailsa Garland: Under the new arrangements that the order provides for, it will be up to the practitioner to ensure that they have indemnity in place. That will be a condition of their licence or registration—however it is termed—with the relevant professional body. My understanding is that when a practitioner works for someone else, normally insurance is in place through their employer, but it will be for the practitioner to check that that is the case. Whatever the circumstances in which a person practises, they will require to have insurance in place.

Dr Simpson: My final question is on the same lines and follows Rhoda Grant's question about career breaks. It is, of course, possible for a person to be taking a career break and to be sued for earlier negligence. Will it be a requirement that such practitioners carry indemnity beyond the point at which they are practising? Will someone who is no longer a member of the Medical and Dental Defence Union of Scotland still be covered?

Alex Neil: Again, Ailsa Garland can correct me if I am wrong, but my understanding is that, in such situations, what matters is the date on which the alleged harm took place and whether the doctor was indemnified at that stage. If a doctor is indemnified and legal action goes on for two or three years, the indemnification covers the costs of that action right through to conclusion.

Ailsa Garland: That is certainly what I imagine would be the case. As with any insurance policy, what matters is that the person was covered when the event occurred, even if they are no longer insured. I assume that the situation would be similar to one in which a person had had a car accident and no longer had the car, but the insurer's liability continued. That is how I understand the system would operate.

Jason Birch: That is my understanding.

Dr Simpson: A number of staff might be employed jointly by two organisations. Given that health and social care integration is coming along, there will be people who are employed by the NHS and by a local authority, and some people might be employed by a new employing authority. Will those people all be covered as they are at the moment under the NHS?

Alex Neil: Initially, the integrated authorities will not employ any medical staff directly, but the legislation allows them to do that, so it will happen over time. An arrangement would need to be reached by the health board and the integrated authority about which of them would cover the indemnity. Under the legislation, the practitioner—the health professional—will still have to be indemnified.

Dr Simpson: Thank you very much.

Gil Paterson (Clydebank and Milngavie) (SNP): Will health boards or the Government have oversight of practising professionals who will now be responsible for providing insurance for themselves? Will they need to register that they have secured that insurance?

Alex Neil: No. The NHS must ensure that anyone who carries out work for the NHS is indemnified. It is entirely the responsibility of those who are in private practice themselves to ensure that they are indemnified. In such circumstances, we have no regulatory authority at all.

The Convener: Colin, do you have a question?

Colin Keir (Edinburgh Western) (SNP): My question was on the retrospective aspect, which Richard Simpson has covered.

Bob Doris (Glasgow) (SNP): My approach to the issue is similar to that of Richard Simpson, although I come at it from a different angle. I note that you have consulted stakeholder groups on the proposed arrangements. The NHS and the organisations of health professionals and practitioners will have been included in that process.

09:45

An insurance scheme is only as good as the policy that is taken out. Does the Scottish Government have any control over the quality of the indemnity scheme that is taken out? Are there one or two large providers who specialise in the kind of scheme that healthcare professionals would sign up to if they were practising privately, or are the professionals within their rights to shop around to find the best deal in the same way as people do for other forms of insurance?

Alex Neil: No. The health boards are responsible for ensuring that their employees are indemnified because the boards, rather than me as the minister, are the employers. The responsibility of boards is entirely within the law and is to ensure that people are indemnified. Obviously, a board is entitled to shop around for the best deal—boards indemnify through various organisations and companies.

However, regulation of the indemnifiers of the insurance is a reserved matter and is part of the financial services regulatory regime and not part of the healthcare regime. In other words, a health board would, I hope, commission an insurance or indemnification policy only from a licensed, respected and respectable insurance company.

Bob Doris: That is what I thought would happen in relation to NHS boards. I hope and expect that boards would be very robust in respect of indemnity policies for staff who work in the NHS. I am thinking more about the private sector and

areas of healthcare provision in which it is possible that bodies might shop around to reduce their margins. You, as cabinet secretary, and the Government would not have any control of that—you would not be able to say when a policy does not cut the mustard. A private healthcare professional could be required by law to have a policy that might not be robust enough for the claims that could be made against it. Although we must hope that that would never happen, it is a significant issue, in practice. Would financial services regulation at UK level deal with that?

Alex Neil: It is fair to say that the regulatory bodies themselves keep a close eye on the situation in order to ensure that those who operate in the private sector are adequately and properly indemnified. That is not the role of the Scottish Government, because we do not control the private sector. I am, however, absolutely sure that the regulatory bodies will monitor that to ensure that the policies that are taken out are adequate to cover any possible claim.

Bob Doris: You have probably given the final bit of assurance that I needed. I suppose that it is within the right of any regulatory body or registration scheme to deregister a practitioner if they think that the practitioner does not have appropriate indemnity. That would be a check and balance within the system.

Alex Neil: There are two points to make. I would have thought that a private practitioner who has not indemnified themselves—in particular where there is evidence that that is deliberate and they have not just forgotten to renew their policy—would fall foul of the regulatory bodies, which would affect their ability to continue in the profession. That ability might even be called into question most obviously by the General Medical Council. For example, we have seen some quite high-profile cases in which cosmetic surgery has gone seriously wrong. A private cosmetic surgeon who has not been indemnified, and who must in law be indemnified, would risk being struck off.

Bob Doris: That is helpful.

Richard Lyle: Richard Simpson made a point earlier about doctors who are employed and doctors who work independently. What about out-of-hours doctors who work for the NHS for a fee and might only work for a couple of days, or appear for one night and then never be seen again?

Alex Neil: My understanding is that such doctors would be indemnified through their board or through NHS 24.

Richard Lyle: Excellent. Thank you.

The Convener: That concludes the committee's questions. Agenda item 2 is the formal debate on the Scottish statutory instrument on which we have just taken evidence. I remind members, as I usually do at this point, that because it is a formal debate they should not put questions to the minister, and that officials may not speak.

Motion moved,

That the Health and Sport Committee recommends that the Health Care and Associated Professions (Indemnity Arrangements) Order 2014 [draft] be approved.—[*Alex Neil*.]

The Convener: No member wishes to contribute to the debate. Cabinet secretary, I do not expect that there is any need to sum up the debate.

Alex Neil: It might be useful to point out something. The order is an affirmative instrument. Assuming that there are no difficulties with it in the chamber, it is expected that the Privy Council will formally endorse it at its meeting on 16 July. The legislation would in that case become effective as of 17 July this year.

The Convener: Thank you for putting that information on the record.

Motion agreed to,

That the Health and Sport Committee recommends that the Health Care and Associated Professions (Indemnity Arrangements) Order 2014 [draft] be approved.

The Convener: I thank the cabinet secretary and his colleagues.

I suspend the meeting to set up for our panel of witnesses for the Food (Scotland) Bill.

09:51

Meeting suspended.

09:54

On resuming—

Food (Scotland) Bill: Stage 1

The Convener: Item 3 is a round-table evidence-taking session for our stage 1 consideration of the Food (Scotland) Bill. As usual with such sessions, I will give precedence to the panel members. I see this as an opportunity for committee members to listen to others' comments, so I ask for patience from my colleagues.

If it is okay with everyone, we will go directly to questions. If panel members can introduce themselves the first time they speak, it might give us more time for the discussion. Is everyone happy with that?

Members *indicated agreement.*

The Convener: Thank you. Rhoda Grant will ask the first question.

Rhoda Grant: Some of the evidence that we have taken about food standards Scotland suggests that it should take a lead on health protection issues such as nutrition and tackling obesity in Scotland. Should that be the role of the proposed new agency? Should it cover other aspects? If so, would that require more resources?

The Convener: Who wants to take that one?

Professor Peter Morgan (Rowett Institute of Nutrition and Health): I am director of the Rowett institute of nutrition and health at the University of Aberdeen.

Food standards Scotland could be a very good vehicle for leading on nutritional issues relating to diet and health. The UK Food Standards Agency was developed with the intention of providing leadership in that area, and it gained a lot of public confidence as a place where the public could go for sound nutrition and health advice. Now that it has been split up, there is more confusion, and I think that food standards Scotland could take on that role in Scotland.

However, in order to take on that function, the proposed new agency needs to get access to some of the knowledge that was present in the UK Food Standards Agency and which has since been lost. For example, websites that provided information to consumers would have to be restored, which I guess would be a resourcing issue. I imagine, therefore, that if the new agency is to be set up properly, resources will be needed for the infrastructure to provide that information to the public.

As I have suggested, food standards Scotland could be a good vehicle for providing diet and health information to the public, but a broader question is whether it should take on a role that it perhaps did not have before: giving advice on obesity. That is difficult, because obesity is a complex issue that is not solely diet related. It would be helpful if food standards Scotland could take on a leadership role on diet-related obesity issues, but we need to recognise that some aspects of obesity would have to remain with the health department, given the clinical relationships that are also involved.

In short, food standards Scotland could take a lead role on giving advice on diet and nutrition, but I reserve my judgment on the issue of co-ordinating research, which I am sure we will discuss later.

Professor Marion Bain (NHS National Services Scotland): I am the medical director of NHS National Services Scotland. In that respect, the point of most relevance to this debate is that one of our organisations is Health Protection Scotland.

On Professor Morgan's point about the possibility of having more impact on health-related issues in Scotland, especially obesity, it is important to recognise that the national health service—and, in particular, one of our sister special boards, NHS Health Scotland—already plays a major role in that area. We would need to be clear about the relative responsibilities and how we can build on the best aspects of all the different organisations.

Dr S Josephine Pravinkumar (NHS Lanarkshire): I support the comments that both speakers have made. As an independent body, food standards Scotland would be in a good position to lead on public health nutrition, and it should work with boards and local authorities to strengthen the work that is already taking place and to support the various partnerships.

10:00

Professor Hugh Pennington (Royal Society of Edinburgh): The most important thing, if food standards Scotland is to have any type of role in providing public advice, is that it must be seen as an independent organisation. It must keep its independence in particular from industry, and even from Government in a sense. However it works, the bill must maintain that independence. I know that the organisation will be funded from Government, but that independence is needed so that the public can trust it. That is crucial, and it must be borne in mind as the bill is progressed to ensure that, in the public perception, the organisation has a strong link with the public rather than with official bodies.

The Convener: If none of the other panel members wants to come in, we will move on. It did

not take us too long to get to the independence question, but that is what happens in the Scottish Parliament.

The nature of funding for the body was a theme that arose in last week's evidence session, and it raises questions. The make-up of the board was also discussed. Would any of you like to comment on the board make-up or on the funding mechanisms? I may be wrong, but I took from the evidence that we heard last week that, although there will be some core funding, areas such as research will be bidding for funds. How do we create independence for the body when it is funded in such a way? How strong can the board be in representing consumers? Do any of you have a response on that?

Professor Pennington: The make-up of the board will be crucial. The individuals on the board must be seen as trustworthy people who will not be afraid to speak out on issues even if they are going against Government policy. I know that it is sometimes very difficult when one is in that position, but the public must see that degree of independence as part of the body's essential nature.

Clearly, the body will be seeking research funding. On a historical point, when the Food Standards Agency UK was set up, it lost research funding that was already in the system. There was a change to the system, and the agency lost out on that funding, which was a great pity. I hope that the new body will have an adequate research budget. That is very difficult to define, of course, but one of the body's highest priorities must be to commission research and maintain links with other funding bodies so that it can influence them if necessary—perhaps indirectly—to push funding towards issues of great public health importance that are capable of resolution in real time.

As a microbiologist, I know that there are many such issues. We have made progress through research on our understanding of campylobacter but, unless we understand it even more, we will not make much more progress in controlling what is the most common cause of bacterial food poisoning in Scotland.

Professor Morgan: The question of independence raises a number of issues. One is the independence of the body itself, which will be separate from the original Foods Standards Agency UK—previously, of course, it was part of the overall system. In becoming independent, the body must be able to stand on its own two feet, but it is important to recognise that it needs to work in partnership with other bodies. Those links are crucial and need to be sorted out. The body cannot work in isolation from the Food Standards Agency UK, and it cannot work totally independently of Public Health England. However, it needs to have its own identity and its own understanding of how it will move forward.

Hugh Pennington is right to say that there was a great loss of research money when the Food Standards Agency UK was disbanded. The money for nutrition research certainly disappeared, although there is still evidence of some money for food safety research. The issue is where the new money will come from; we have to be clear about that. The way I understand the situation is that, previously, the Food Standards Agency UK had quite a sizable pot of money for research, which disappeared. The Food Standards Agency in Scotland had a small sum of money that was targeted towards research into Scottish-focused issues. That would need to be maintained.

However, the wider research funding opportunity, which comes from other Government sources such as the rural and environmental science and analytical services division, is a different budget and we need to be clear that it is different. It would not be a good idea to raid that budget to put resources into food standards Scotland, because the function of the RESAS budget is different from what the function of food standards Scotland's budget will be.

If food standards Scotland requires research money, we need to consider where it will come from. There is a debate in my mind about what sort of research food standards Scotland should do. For example, I am not so sure that it is a great idea to have a legislative body commission research. It will need a budget for short-term research to answer its own specific questions, but I would keep the budget for strategic research needs independent.

Robbie Beattie (Association of Public Analysts Scotland): I am from the Association of Public Analysts Scotland.

One part of the issue is to do with the budget. A third of the budget relates to operations. Will the body serve industry or the public? Will it be a consumer champion or not? There may be conflicts in the structure. If it is going to look at cutting plants and meat plants, is it going to be helping industry or the consumer?

Bob Doris: We have been talking about the independence of food standards Scotland, but I wonder about the powers that it will have. The bill has a kind of general powers provision, which says:

> "Food Standards Scotland may do anything which it considers necessary or expedient for the purposes of or in connection with its functions."

The functions are laid out in the bill.

Our witness from Which? last week raised the issue that food standards Scotland will not have

statutory access to food testing results from industry, and there was a belief that such statutory access would be very helpful. When industry carries out testing, the information should be passed routinely to either the FSA at UK level—which is now going, of course—or the new food standards Scotland. Do panel members agree with that? Would the power to compel industry—large supermarkets and producers—to provide their food testing results be welcome?

The Convener: Any takers?

Professor Pennington: The more information the body has, the better able it will be to discharge its function, although there is an issue about the relationship with industry and getting information in that way. I sit on the fence on the question of food standards Scotland having overriding powers to get information of that kind but, in principle, yes, it would be useful to have that sort of information.

Dr Pravinkumar: It would be useful to have that information up front to help prevent outbreaks and it would boost the public's confidence about the monitoring that takes place and the information that is available for auditing and improving standards. That would be helpful.

Professor Pennington: A fair amount of testing is done on a fairly random basis. One needs to look carefully at whether the right kind of testing is being done on the right kinds of foods, and so on, because most of the results will be negative. My experience has been that that kind of testing is of value, but it is of relatively limited value in giving good public health protection. Other issues are probably more important, such as how well businesses are run. A lot of that falls down to local authority enforcement officers doing inspections, and so on.

There are fundamental philosophical issues to do with the role of testing. Testing is essential and it is necessary, but it has to be focused. It has to be done almost by looking at something where it is thought that there might be a problem and focusing on that rather than having a general testing programme, which can be quite expensive and produce quite small returns. Professional judgment is crucial when it comes to who is doing the testing on what and so on.

Robbie Beattie: There is an issue with allowing industry to do its own testing. Cadbury's was caught short because it was putting salmonella in chocolate. If we rely on industry to look after its own shop, we risk having problems. Similarly, in the case of horsemeat, the industry was looking after itself but was looking only for what it wanted to look for and did not find horsemeat. It is necessary to have an independent body that is willing to take the challenge on and horizon scan for the unknown unknowns, as it were. If we rely on industry, it will just tell us what we want to hear.

William Hamilton (Glasgow City Council): I am business regulation manager for environmental health at Glasgow City Council.

I will pick up on the broader question about powers. To fly off at a little bit of a tangent, I have a rather unpopular view about the enforcement role. I would like to see a slightly more aggressive role being taken, to be honest. As I am an enforcement person, perhaps that is in my blood.

I feel that there is a need for a more interventionist approach to nutrition and obesity. We engage fairly peripherally with quite a lot of initiatives that encourage and support healthier eating, but it is a great source of frustration to me that there is no final step that can be taken to push the issue slightly more. For example, there is a scheme in Scotland that advises the public about food safety compliance and there is a move in the bill to make that a mandatory scheme. I wonder whether its scope could be broadened to include a broader compliance or performance issue for businesses that relates to their nutritional performance and the kind of food that they sell. We could perhaps work out some kind of profile for businesses.

The Convener: Does that relate to your evidence about food sales in and around schools and young people?

William Hamilton: It would do. I do not want to pre-empt any discussion of those issues. However, to be honest, such sales lead me to think in the way that I described. My colleagues and I experience frustration, because the evidence is there but there is not very much that we can do.

Bob Doris: That is helpful, because I was going to come on to that issue.

Very briefly, in relation to the general powers provision and testing with industry, I hope that the approach could be based on partnership rather than confrontation. As the witnesses have said, there is no point in testing things that you know are safe. Supermarkets and large producers that are ethical in their practices would be keen to work with FSS or the FSA to identify the higher-risk areas so that an inspection regime can be put in place around those. It would be good to see that being done. The approach does not always have to be confrontational, and I hope that there is a way forward based on partnership.

Mr Hamilton has helpfully allowed me to come on to my other question, on enforcement powers, so I thank him for that. An issue that I raised last week is that the policy memorandum states that, currently, when food is seized that is safe but in relation to which the vendors are guilty of food

fraud, if you like, there is power to seize the food but not to destroy it, and it could, in theory, go back into the food chain. The bill appears to put a stop to that.

With reference to some of the more general powers, such as the duty to compel the reporting of breaches at outlets and the duty to give inspection outcome displays much more prominence in outlets, Mr Hamilton has talked about maybe introducing a cluster of other powers. This is a good opportunity for witnesses to put on the record any additional powers that they would like to be included in the bill. I add the caveat that I imagine that some breaches are by small businesses that are trying to do their best but are not complying. I would not like those businesses to be driven out of business but would like them to be supported to perform better. What additional powers do people want to see in the bill, particularly on enforcement? Mr Hamilton had started to give some suggestions about that.

The Convener: Mr Hamilton, is it the case that if you seize food for one reason or another—it may have been labelled incorrectly, for example—you give back that food?

10:15

William Hamilton: Generally speaking, we do not seize food on the basis that it is not what it says it is on the label—our powers extend only to seizing food that is deemed to be potentially unfit for consumption, so there is a safety imperative to do that. The bill would introduce a food standards power that mirrors those powers exactly. That would be very welcome. I am assuming that the powers would remain the same and that authorisation from a sheriff to destroy the food would be needed.

The Convener: Do the panellists have any response to Bob Doris's question about additional powers and his challenge to strengthen the bill? Of course, there are no guarantees that that would happen.

William Hamilton: I work in enforcement, so it is only natural that I would say that there should be more enforcement powers. I respect the view that there is always the potential for inappropriate use of powers but, if anything, there is a suggestion that some of the powers are not being used adequately. I take that point on board. However, there is a case for making mandatory the food hygiene information scheme, which is a welcome part of the bill.

Information is already available to the public through freedom of information. However, a more meaningful scheme—in other words, one that is mandatory for business—would be helpful. There are certain doubts about how helpful such a scheme would be; in our opinion, that would be a relatively inexpensive way to proceed. As I said, I would quite like to see the expansion of that scheme's scope.

On powers, food premises licensing is an additional issue that is quite close to my profession's heart. Powers on that exist in the Food Safety Act 1990, but I would be crucified if I did not mention the issue on my colleagues' behalf. There is quite a strong appetite for that, primarily to prevent the emergence of unsuitable businesses as a matter of course.

Professor Pennington: I agree absolutely with what has been said about the mandatory display of the scores on the doors as it were. That has been progressed in Wales. There were supposedly going to be some problems with doing that, but they have not amounted to very much. I am very much in favour of that power being included at this stage rather than it being left to ministers to come forward with at an appropriate time, because that would very much be in the public interest.

Robbie Beattie: There is perhaps a move towards industry testing. Under the 80:20 rule, 80 per cent of your problems could come from 20 per cent of your estate. There was an E coli outbreak in Fife that related to a small restaurant, the E coli outbreak in Wishaw related to a small butcher's shop, and there was a case in Glasgow. Lots of problems are coming out of small areas. You are expecting industry to self-police. That might be okay for organisations such as Tesco and Asda, but who will look after the small guys who are causing a lot of the problems and killing people?

Dr Simpson: When the committee visited Aberdeen, it was mentioned that the proposal is not to have the five-point scoring system that is used in Wales because it is not clear how a score of three or four would be judged and what the public would understand by that. Instead, the idea is to have three levels. At the first level, a health improvement notice would be issued, but should it be displayed? If so, how quickly should that be done, and how long should the individual be given to rectify the situation before they are required to display the notice? The second level is when a business has passed the health inspection, so the premises are regarded as hygienic. The third level, which 1,000 businesses have reached, is the gold standard, which is an exceptional standard to reach. That seems quite a good system. I seek comments, in particular, on how quickly a health improvement notice should be displayed.

William Hamilton: As you have described very well, the scheme in Scotland is quite simple compared with that in England, and it is less problematic. In reality, there are only two statuses in the food hygiene information scheme, one of

which is "improvement required". A very small minority of premises are deemed to require improvement. The vast majority are given a pass; in other words, they are considered to be of a satisfactory standard.

I am sure that my colleagues would love to make this much more complicated or more impenetrable for the public, but in reality it is very simple and straightforward: the scheme is completely flawed, because it is not mandatory. Without contradicting what I have already said, I would look for the scheme to be carried forward as it is, but I would like its scope to be enlarged. It is all very well saying that a business is clean and well operated, but if it serves, in the main, deeply unhealthy food, perhaps that gives us an avenue in.

I do not know whether that entirely answers your question.

Dr Simpson: Not quite, because my question was about how long people should have before they must comply with a health improvement notice or display the notice, which will have an effect on their business.

William Hamilton: The key is to be aware of the fact that the display of the notice is for public information; it is not an enforcement tool. We have enforcement mechanisms that require a business to comply within a given period of time. If the business presented a risk, it would probably be closed immediately. If there were serious issues, it would probably be subject to a notice, and it would be allowed 14 days to rectify them.

I think that, under the scheme, the display of the notice would be pretty much instantaneous—there would be a requirement to display it straight away. If the business could sort things out straight away, it would obviously be allowed to change that.

Dr Simpson: From this and previous discussions, I understand that the UK Food Standards Agency's funding was split and that it was underfunded. We heard in Aberdeen that a number of Scottish units—Rowett is the main one—are involved in the research, but the Scottish research is, I understand, complemented by research at big units in Norwich and Cambridge. Moreover, research funding comes from councils such as the Biotechnology and Biological Sciences Research Council, the Wellcome Trust and others.

Recommendation 33 of the Scudamore report is:

"FSA Scotland and the Scottish Government must urgently identify the scientific capacity and capability it would require to deliver official controls in the future, so that decisions could be made about what needed to be available in Scotland and what needed to be available elsewhere. This should then be used to inform more strategic investment decision."

During last week's evidence session, we heard from Jim Wildgoose that there are 15 UK scientific advisory committees. Can the witnesses outline where we are now and where we will go with the new body? We have already heard about the rural fund, which should be separate. Will we still have scientific advisory committees and systems, given the split that has occurred in England? What would happen with all those aspects of research and the relationship with the current complementary system if Scotland were an independent country? Dr Wildgoose made it very clear that the Scottish Food Advisory Committee would cease to exist. What are the implications of that for Scotland, irrespective of what happens post-September?

Professor Morgan: If the Food Standards Agency in Scotland becomes a separate body, it will have effectively dislocated itself from what went before, although I suppose that, in many ways, that has happened as a result of the fragmentation of the Food Standards Agency in England.

Advisory committees were set up to take on various activities. There are advisory committees on nutrition, novel foods, pathogens and toxicology, for example. I do not see any advantage in duplicating those committees. They already exist to bring together the best people from across the whole of the UK to give advice. Setting up a separate set of bodies would just be duplication for no positive benefit, and the same people who are already on the existing committees would probably be used. I think that the best thing that we can do is harness the information and use the existing advisory committees.

The question then is how we do that. Previously, under the old set-up, the Food Standards Agency Scotland was part of the Food Standards Agency, which was the parent body, so all the relationships were built in. Now that the FSA has become fragmented, we need to revisit the mechanisms to see how a new, independent body would be able to influence and get advice out of the committees. I do not think that that would be impossible, but it would require us to look at the mechanisms to ensure that they were fit for purpose.

I cannot imagine any reason why what I suggest should not be possible. Certainly, the advisory committees that I know of do not see themselves working for just one body; they just give advice, and there is no reason why that advice should not be given to Scotland as well as to England. The mechanisms are important. For example, there would have to be a conversation between food standards Scotland and Public Health England,

which has the secretariat for nutrition advice, about how food standards Scotland would get proper representation and advice in that area.

I would not duplicate committees. At the end of the day, all advice is about synthesising information from the maximum number of sources. Any committee should come to a good consensus for everybody.

Many places are funding research on different nutrition or food safety topics, and the advisory committees will filter that research. I am not convinced that food standards Scotland would need to do more research independently. Plenty of research is going on and the only question in my mind is whether it would need to do specific things to deal with specific policy needs. Sufficient research is going on in other areas to allow the advisory committees to pull together the required information. As I said, I am not convinced that a body that is the advisory committee and the enforcing body should also commission research. I think that there could be a conflict and that those functions should be kept separate.

I do not think that there is an issue about the new body getting advice. The mechanisms are there, potentially; certainly, the advisory committees are there. The mechanisms need to be examined to ensure that they do what we want them to do. There is plenty of research going on, although no doubt many of my colleagues would argue that we have lost the Food Standards Agency in the UK and that its research budget has never been replaced. Nevertheless, a lot of work is going on in the UK and across Europe, and the advisory committees can pull it together and give advice through food standards Scotland as an independent body.

Professor Pennington: I echo Peter Morgan's comments about advisory committees. One that is of particular interest to me is the advisory committee on the microbiological safety of food, which existed before the Food Standards Agency was set up and which has worked extremely well in producing a consensus view on problems and the best solutions to them, which can then be embedded in legislation. Its chair used to work in Scotland—she is now a professor in Liverpool—so she knows the situation well.

Peter Morgan made an important point about maintaining a formal link between the advisory committees and what happens in Scotland. They need to avoid ignoring special Scottish problems—there are one or two such problems, and I will come on to one in a moment. It is really important that that link is maintained, with, if possible, advisory committees having Scottish representation or a Scottish voice—someone who knows the Scottish scene. Like Peter, I do not see any reason why that could not be done. The negotiations might be quite complex and difficult—negotiations between different Government departments are always difficult, because they always look after their own patch. However, if it is done sensibly and with the right aim, which is clearly to protect public health, I do not foresee any problem.

10:30

I may take a different view from Peter on this, but I think that it would be really important for the Scottish food body to have its own research budget. It may have to respond to a particular need in Scotland to look at a particular problem, albeit that, from a microbial point of view, the situation is not caused by an organism that exists only in Scotland. Sometimes things have to be done quite quickly to get to grips with a problem and find out what it is. If we do not have our own research budget, it might be difficult to do that timeously.

For example, work was commissioned on the back of the Wishaw outbreak in 1996, and work had been commissioned previously in relation to similar outbreaks. Although particular Scottish issues were being considered and Scottish input was required to do the research, the results of that research applied internationally—they did not just apply in the UK but were of international importance. It would be important for the body to have a research budget on which it could call if it needed to do or commission research to inform its own policy.

I was a founder member of the Scottish Food Advisory Committee. One of the advantages of that committee was that, to an extent, it held head office in Aberdeen to account. We saw ourselves as independent members of that committee. We were part of the Food Standards Agency but we could ask questions that perhaps head office—well, I will say no more. We could raise issues and stimulate policy development.

One of the great advantages of the committee was that we met in public throughout Scotland—we went from Shetland to Dumfries—which was a useful way of communicating with the public. It might have been quite expensive, but committee members felt that it was a really important way of talking in public about issues, hearing people's views and—because there were question-and-answer sessions—being held to account. If that committee is not to be replicated, it is really important that the board of the new body also has frequent interactions with the public, as well as having appropriate interactions with people in the Scottish Government.

Professor Morgan: I clarify that I agree with Hugh Pennington that food standards Scotland

would have to have some budget for research to respond timeously to important projects for policy reasons. I am really arguing that I do not think that the body should be involved in co-ordinating or taking a lead role in directing research in the general area.

The Convener: I think that it was Dr Wildgoose who last week raised the issue about the need to be very careful about that. Are you aware of, or have you been involved in, any work to ensure that we continue to link into those scientific committees at the UK level? What has been done to ensure that your concern is addressed?

Professor Morgan: I know people who sit on those committees, on which, as far as I am aware, there is still an opportunity for members of food standards Scotland to sit as observers. However, if we want to use those committees for what they can actively do, which is to respond to questions that Scotland may wish to have answered or to provide advice, the linkages need to be re-examined, because they were set up under the old UK Food Standards Agency and have not been re-examined in the context of the new world. If we want to ensure that we have formal arrangements under which we can utilise the committees, first to examine issues that are important to food standards Scotland, and secondly to provide outputs, we need to examine those linkages.

The Convener: The bill gives us an opportunity to set up a separate Scottish committee. Is that contradictory? What would that committee do?

Professor Morgan: If we are talking about advisory committees on specific issues relating to scientific research, I see no point in duplicating the existing committees, because we use the experts across the UK already. If we are talking about a committee that functions a bit like the SFAC, that is a slightly different issue, because it would take an overall view within Scotland. That approach would still be possible, but it is not the same as research advisory committees.

Professor Pennington: I absolutely agree with that. The scientific advisory committees are the crucial ones that we want to have formal links with. The SFAC is slightly different, because it was engaged not in research but in public communications. It looked at issues in a broad way, slightly outside the box, but all the people on it were selected because they brought different strengths in relation to food.

I would like to see that sort of body existing in one form or another, just to get those people round the table at frequent intervals to advise the board, which will be busy with things such as running the organisation, to ensure that nothing is missed and that concerns are properly addressed. It would not be a scientific advisory committee, such as the advisory committee on the microbiological safety of food, which has quite a different role and which does extensive, in-depth studies of particular problems.

There is one important reason why it is important for the Scottish body to have input into the advisory committee on the microbiological safety of food that has not been mentioned yet. The committee looks in depth at particular issues, and issues may arise that are seen as more important in Scotland than in the rest of the UK. Therefore, it would be useful for Scotland to have that voice, to persuade the larger body to conduct an in-depth study using resources that might be beyond what the Scottish body can employ.

Bob Doris: I note that the bill gives a permissive power to form committees, not a prescriptive one. My reading of the bill is that, if FSS feels the need to form a committee, it is free to do so. That is the expectation, rather than the bill prescribing set committees. Knowledge transfer across the UK, Europe and the globe involves finding expertise at the most appropriate level. We are talking about various committees at the UK and Scottish levels and about whether the witnesses are content for the bill to have a permissive, rather than a prescriptive, power. I simply want to know the witnesses' views on the nuts and bolts of the bill.

I see heads nodding—that is fine.

Professor Morgan: That would make sense.

Dr Simpson: Both Dr Pravinkumar's paper and Health Protection Scotland's paper talk about research. In particular, Health Protection Scotland's paper talks about further opportunities, but it did not specify what they might be. I am interested in that. Has Health Protection Scotland further thoughts about that?

Professor Bain: Health Protection Scotland recognises a number of areas that relate to food in which it would be important to do further research. I do not think that that cuts across anything that has been said. A lot of those things need to be done nationally and internationally. I am not an expert in the area, but my colleagues talked about bacterial counts in food, for example—I am sure that other members of the panel would be able to speak about that more accurately. My point was that we do not want to lose that focus. There are still a lot of areas where significant research is needed if we are to protect the public's health better, and we want to ensure that that research is not endangered in any way.

Dr Pravinkumar: We also referred to research on unique challenges for Scotland. Professor Pennington has referred to particular food safety issues that might emerge in Scotland, but there are other issues, such as obesity and food

poverty, that might come up, and we referred to such things when we mentioned further opportunities for research.

Robbie Beattie: Dr Simpson raised a point about Scudamore recommendation 33, which is about official controls. I saw that as a red flag to the Government and the FSA to deliver official control laboratories, because the network in Scotland is creaking, and we are looking to join up the scientific services of the four official control labs. That point has still to be addressed.

That feeds into the question whether, if Scotland is going to have its own FSA, it is also going to have its own national reference laboratories or whether we will still use the laboratories in England. We still need to understand that—of course, such laboratories would also feed up to the European reference laboratories.

Dr Simpson: I have to say that I am finding it hard to reconcile the two views in the Association of Public Analysts Scotland paper. Over the past 10 or 12 years, the budget for public analysts has more than halved. You recommend the creation of a centralised national public analyst system instead of the system being under the control of local authorities, but local authorities themselves have said that they want to keep the individual bodies.

Professor Pennington has also pointed out that testing is going to produce a lot of negative results, and that things need to be focused. I am trying to get my head round the question of how much we should be doing on that, whether we should have a national system and Mr Beattie's point about whether we need our own reference laboratories for everything or whether we should just rely on the UK national reference laboratories.

Robbie Beattie: Local testing is useful, but testing on a national scale will allow us to buy larger pieces of equipment and to employ DNA sequencing and all the other new techniques that are coming through, such as the use of isotopes to establish authenticity and provenance. That work cannot be funded at local authority level. As you pointed out, sampling has halved, and laboratories are finding things difficult now that their funding is drying up. They need to diversify, but they are scrabbling around for money.

The point is that you do not want an emergency to happen and no one to be there to respond to it. We need a continual supply of work to keep up capacity and expertise and ensure that public analysts can respond to emergencies. The need to keep things ticking over is one rationale for having a national service.

The FSA is trying to pump-prime things by putting in moneys from its co-ordinated food sampling programme. However, the agency is also looking at feed, and none of the local authorities that I work with actually submitted any samples in that respect. In fact, they would not even take the free money that the agency was providing for that purpose, because the trading standards service did not have the capacity to deliver those samples.

Another issue is the reduction in the number of local authority officers on the ground who take samples, which means that that aspect is also being diluted. There are a lot of competing pressures, and a small local authority lab is going to be in a David-and-Goliath situation if it tries to keep on top of huge multinational companies such as Nestlé and Cadbury.

The Convener: Does anyone have any comment to make on the back of that?

Dr Pravinkumar: A proportionate risk-based approach should be taken, and access to specialist testing is absolutely crucial to prevent any negative impact when an outbreak happens that requires the rapid response that people expect.

Professor Pennington: From a microbiological point of view, I point out that, for a long time now, we have had reference labs in Scotland for organisms such as E coli 0157. Those labs, which sit outwith the Food Standards Agency, work well, but the proposed new agency needs to keep a very sharp eye on their funding, because they provide a national service. The slight bee in my bonnet that I have always had is that they should not only provide a reference and typing service in relation to organisms that have been isolated in hospital laboratories, but have a research function of their own. Indeed, it is quite wrong for a reference laboratory not to have such a function.

The point has been well made that the costs of providing services such as DNA sequencing have increased. The costs are coming down, but they are not yet at the level where they can be ignored and not be seen as substantial. I would expect the new agency to look at that issue as soon as it begins work and to ensure that an appropriate service is provided across Scotland—and that, if it does not think that such a service is being provided, it will say as much to the appropriate bodies.

10:45

Aileen McLeod (South Scotland) (SNP): My question is about research funding. Scottish research is well renowned for its excellence, and Scotland will continue to attract research funding and to participate in international research collaborations, regardless of what happens following the referendum on independence in September.

What opportunities will the new body have to lever in other sources of research funding, such as funds from the EU's new horizon 2020 programme? One of the grand societal challenges that horizon 2020 seeks to address is around how we ensure sustainable food and feed security and safety.

Will food standards Scotland have a crucial role in identifying areas for future research around diet, nutrition and obesity, which we have already discussed, working with key partners in academia, on the industry side and among other research institutes? The key issue is around the other sources of EU funding that we could lever in.

Professor Morgan: I agree with you entirely: Scotland is one of the best places in the world to do research and it always punches above its weight. It exploits funding from the European Union very well, and I can see great opportunities for Scotland coming through the horizon 2020 funding. The lead for that research will come primarily from academics. I would not argue that the new body should co-ordinate research, but it should have a definite role in trying to influence what research is done. That is where we would need to have a forum in which food standards Scotland could have an influence on the sort of research that should be taken up. That would influence the academics with regard to the funding that they may seek, within Europe or elsewhere.

If there is support for research from industry or Government, that makes research applications even more compelling. That is how it will work. If food standards Scotland can present its ideas and take them through some forum in which they can influence the direction of research—in Scotland or beyond—that will be very good. It will certainly be helpful in focusing academics on what they view as the key priorities.

Nanette Milne (North East Scotland) (Con): Professor Pennington has mentioned the functions of the FSS board a number of times. We have heard comments from the Royal Society of Edinburgh, in particular, about the size of the board and the suggestion that the minimum number of three members is not enough. What are the witnesses' views about the size of the board, and who should be on it?

Professor Pennington: I chaired the RSE committee that came up with the recommendations. We felt strongly that the minimum size was a bit on the small side for the board, although we did not want it to be too large.

The board will not necessarily be representative, but it will have a fundamental representative nature, with people coming from completely different areas of expertise and background knowledge, representing consumer interests and so on. We thought that three was a bit on the small side for getting those interests represented on the board, considering what the board members could contribute to the way in which the organisation runs. Our concern was to have that breadth.

There is an incredible array of problems to address. Some of them are much more simple to resolve. We have done quite well with regard to some of the microbiological problems, including Salmonella enteritidis; we have a vaccination programme for chickens, which works quite well. However, with some of the other bugs that I am interested in we are no better off than we were 10 years ago in relation to the levels of human infection. Some of the infections concerned are very serious. There are some incredible problems around nutrition, too, involving poor or inadequate diets, as well as the superabundance of food.

There are some connections between those problems, but many of the links are not straightforward when it comes to finding answers. That is why we feel that, philosophically, it would be much wiser to have a larger board than a smaller one.

Nanette Milne: What about membership of the board?

Professor Pennington: The individuals will represent those particular areas of expertise and their personal qualities will be important. They will have to have shown already that they are able to fight their corner, to put it crudely, with regard to influencing nutritional policy.

One important issue that arose when I was on the Scottish Food Advisory Committee was how we could persuade the public to act on something that everyone—even the public—knows is good but which no one is doing anything about. That is a common interest. One example is obesity, as everyone knows that being overweight is not good for your health, and another is the need for people to wash their hands. How can we persuade people not to eat too much and to wash their hands? That can be difficult, so we need members on the board with the wisdom to communicate such things to the public in an effective way that delivers. Otherwise, the body will just be a talking shop.

Nanette Milne: Should there be any industry representation on the board?

Professor Pennington: I do not think that industry is all bad, but there would be an issue with the body's credibility if it was seen to be getting close to industry, even if it was doing so for the best reasons. One must remember that many parts of industry do not want to have food problems associated with their products. I have had heads of big supermarkets speaking to me just before a board meeting that is held in public

about the problem that they have had with an outbreak. They are desperate, because they do not want their brand to be destroyed or damaged by that sort of thing. They have a vested interest in protecting their business rather than necessarily in protecting public health.

I do not think that having board members who are clearly associated with industry would be a particularly good idea. That is not to say that we might not have senior officers on the board who have substantial industry experience, but we should not have people with current experience.

Robbie Beattie: Hugh Pennington has just said that brands are desperate to try to hide what they may have uncovered themselves in order to protect their brand. Does that not run counter to the idea of the industry looking after its own testing?

Professor Morgan: I am slightly more catholic in my views. I certainly agree with Hugh Pennington on the size of the board. The membership must be greater than three, because we need appropriate representation in the new body of the key elements of what goes on, but the board must not be so large that it cannot take decisions.

With regard to representation, I feel strongly that the food industry, although it is lambasted for a lot of health problems, is the vehicle for improving public health. It is important that we engage with the industry to achieve that aim. I do not think that a single member from the industry would be able to subvert the whole board. In my view, we should engage with industry and have a member on the board, because that will be a positive statement to the industry that it can have an influence but not the sole say.

Professor Bain: I agree with what has been said, as it certainly makes sense. I agree that three would be too small a number, but we do not want the board to be too big because it would—from my experience of sitting on boards—become unmanageable.

Returning to our earlier discussion about the opportunities that relate to broader public health, the agency needs to move beyond health protection issues to address the nutrition and obesity agenda for Scotland, and link in with health inequalities. There is potential for the body to make a big difference through some of the work that it might focus on.

That leads us to suggest that there should be someone on the board with a strong public health background who can bring that experience to the agenda by identifying not just the obvious opportunities, but some of the less obvious ones to improve Scotland's health and reduce inequalities.

Professor Pennington: The Glasgow effect is something that we do not talk about very much, because it does not fill us with any great pride. I would like to see someone on the board who has experience of that kind of complicated issue—someone with that particular expertise. That should be a public health person who sees across the piece and sees how difficult the issues are, and how they clearly relate to other health issues.

We heard that the new body should have a very strong relationship with health because many of the issues, such as alcohol policy, overlap with health. I think that the RSE said that we should look at whether the new body should have input into that; it is bound to have an input in terms of fraud, because of the fraudulent sale of things such as vodka.

I agree that the public interest is crucial, as is a focus on the particularly Scottish problem, which I call the Glasgow effect. That is unfair to Glasgow, but I lived in Glasgow for 10 years and I know what the problem is. It is still there, and it is still writ large.

Richard Lyle: Willie Hamilton and Professor Pennington covered in part the issue of food fraud. What sanctions should there be for food fraud? Would you like to see more sanctions for food law offences, Mr Hamilton?

William Hamilton: Yes—again, I paint myself as a rather draconian enforcer here. Over a number of years, I have been pressing for a slightly more user-friendly regime of fixed penalties, which is a quick and easy method of approaching enforcement.

You mentioned food fraud. The only recourse that we have, even to relatively low-grade food fraud—a lot of it is very low grade—is prosecution. We have big problems with prosecution because the court system just does not support it. We suffer probably more than most, because we do not have the critical mass that would enable the court system to work in our favour.

Prosecution is not a great option, so administrative fines or fixed-penalty notices—call them what you will—would be a boon to us. I am familiar with the arguments against such measures—that they could be seen as fundraising—but I believe that the bill would deal with that. Any funds that were raised would go to a central pot, so it would not be seen as a money-making exercise for councils. That is the way to go. The system should not be draconian; it should be preventative.

The majority of food fraud that we encounter in Glasgow concerns the substitution of meat and fish. It is done on a relatively low scale, primarily to save money. It is food fraud—of course it is—but is not in the same league as the horsemeat issue

that we saw last year. It does not justify pursuing cases through the court and criminalising individuals, small butchers—very often in the ethnic community—and restaurants that substitute beef for lamb or whiting for haddock.

There is a need for a more streamlined, non-criminal sanctions regime, which would benefit us all, including the industry to a great extent. The industry calls for a level playing field, and we could deliver that better with a slightly more flexible system.

Professor Pennington: I have experience of a butcher who killed some people with his bad meat. He was also selling what he said was Welsh lamb but was actually New Zealand mutton, but he was not prosecuted; that was an incidental thing. I agree that we need a better way of sorting out the fraud problem, which is probably quite common.

Such fraud is not like the horsemeat problem, in the sense that it would immediately come up if we started testing on the basis of intelligence; it is a small thing, but perhaps quite common. Of course, one must remember the Shetland fish issue, which was on a grand scale, but that clearly needed forensic accountants rather than anybody else to bring the prosecution.

11:00

Richard Lyle: In your experience, Mr Hamilton, what is the average fine when something is found to be wrong in someone's premises?

William Hamilton: I am probably not the best person to ask, because my authority's policy is largely to avoid prosecution, for the simple reason that it has become incredibly ineffective. For example, we have one case for food hygiene offences that has been pending for well over two years. We have not heard a thing about it for several months, and it might not even come to court now—it has rather disappeared into a hole in the ground. We do not see that as an effective method of enforcing food law and protecting public health. I understand that the public might require or request prosecution to happen, but it is not really in our best interests, and I do not think that it is in the public's best interests, for that to be the main thrust of our actions. I am sorry, but I do not know what the average fine would be these days.

Richard Lyle: Would you welcome any changes that would prevent the frustrations that you sometimes feel?

William Hamilton: Very much so. There are certainly measures in the bill that will deliver that.

Bob Doris: I have a brief question that relates to my colleague Richard Lyle's line of questioning. Mr Hamilton has given useful evidence in relation to the need for fixed-penalty notices in the bill. He has given a fairly strong reason why they should go to a central pot rather than back to the local authority, which is so that there are no conflicts.

My question is for Mr Hamilton, as he is involved in enforcement. I must admit that I know very little about the use of fixed-penalty notices, but if a family-run fish and chip shop, which is the business's only outlet, is found to be substituting whiting for haddock and is given a fixed-penalty notice, the burden of that notice would be far greater than the burden for a business with a chain of 20 outlets across west central Scotland, which might have been caught doing that in only one of its outlets. Can fixed-penalty notices take account of the scale of the business network, or would there be a disproportionate effect on smaller retailers, producers and outlets? I wonder whether that has been done before. It is always dangerous to ask a question when you do not have a clue what the answer will be. I would want to ensure that the measure would have a proportionate effect on the industry.

William Hamilton: There are existing schemes under legislation such as the Environmental Protection Act 1990, which enables local authorities to serve notices. To be truthful, little consideration is given to the capability of businesses to cope with the costs. If a fixed-penalty regime or anything of that sort were to be introduced in food law, it would certainly have to be robust. Local authorities would have to be called to account and would have to demonstrate transparency, accountability and proportionality. There would also need to be a clear code of practice to cover the means by which notices would be served. Perhaps there would be a sliding scale for the level of fines. I certainly take on board the point that there is potential for such a system to be disproportionately punitive.

Bob Doris: I am not saying that there should not be fixed penalties—I am just trying to work out what the impact would be for various businesses. Your answer has been helpful.

Robbie Beattie: A review is happening in Europe just now of, to use the jargon, regulation 882/2004, on official controls and funding of them. At one stage, the review talks about taking action only with businesses that are over €1 million in size. It also talks about the number of employees in the business. If, say, the limit is 20 employees, what if there are two people in the kitchen who do not comply? Alternatively, if it is a hotel, would all the cleaners be included? I presume that the lawyers have looked at the bill to ensure that it will not cut across what is coming out of Europe. Additional penalties and offences might come out of Europe through the review of regulation 882/2004.

Bob Doris: That is a new one on me, so thank you for giving me that information.

The Convener: The committee has been out and about hearing evidence, and we had an evidence session last week and are having one this week. There are lots of opportunities in the bill, but I am still a bit uncertain about what the outcomes will be, particularly when I hear the evidence that we just heard that lots of powers and regulations will still come out of Europe—that is not going to change.

Powers of inspection lie with local authorities, but we do not know whether that will change. I heard yesterday from a local meeting that local authorities and health and social care partnerships are worrying about whether the health service or the local authorities will carry the health message. We heard evidence last week that the labelling regime, over which we already have powers that have not been used, could be slightly different.

As I asked last week, what is the point? What will the bill's outcomes be? Will the bill help us to tackle obesity, for example? Will it give us a new focus on E coli and other Scottish health problems? I want someone to tell me that the bill will make things better.

Professor Pennington: Can I give you a simple answer? The proof of the pudding will be in the eating. It will depend entirely on how well the new body works. In essence, it will be very similar to what we have already. The body will have a few more powers here and there and will be able to take a few more powers here and there, too. However, at the end of the day, it will be down to how well the body works. The composition of the board will be very important. We need to get the right people on the board to get the message across and sound a drum whenever necessary.

There are other big issues that are not and could not be addressed in the bill, such as local authority funding. Enforcement is done by local authorities, and the new body will have a role in ensuring that they are doing their work properly. However, it will be dependent to an enormous extent on how other people are comporting themselves. That issue is of critical importance. The same applies to the public analysts. We need to have a system across the country that is fit for purpose, and the new body will have a big role in keeping that going. That is why it is important that the body has very good, robust relationships with the Scottish Government so that if it sees a problem, it can appraise the Government of it, even if it is a problem that the body itself cannot do anything about. For example, it can raise the issue of ensuring that we have the right enforcement structure and that local authorities are appropriately funded and have the appropriate numbers of staff.

I gave evidence to a Welsh Assembly committee on the back of the public inquiry that I did on the South Wales E coli outbreak. I raised the question of local authorities and enforcement because there were problems with that. There were problems in other areas throughout the system, including the meat hygiene service and the procurement of food by the education authorities.

There are major opportunities for the board of the new body, but there are also major hazards. If the body does not have the right board calling the shots in the right way, the right level of funding and the right level of support from Government, we will not be as good as we are at the moment. I will leave it on that slightly negative yet positive note, in the sense that there is a way forward.

The Convener: I think that we all agree that to have the opportunity we need a new body.

We have reached the end of this evidence session. We have the witnesses' written evidence, but if you feel that there are other areas that we could have touched on this morning, you have the opportunity now to leave us with a last thought. If you are on your way home and something comes to mind that you feel that the committee needs to take into consideration, please email us. Robbie Beattie has a last word.

Robbie Beattie: It is a follow-up to what Hugh Pennington just said. You are asking the new food body to do more with less. It can be seen from the budget that you are depending on FSA UK putting some money back up to Aberdeen. There are a lot of imponderables there and you are asking the new body to do more. The challenge is how to do more with less. Is that possible, or does the new body need to be funded adequately to do the job?

The Convener: We will examine that in future evidence sessions. Thank you for your attendance and the time that you have given us this morning, which is very much appreciated.

11:10

Meeting suspended.

11:16

On resuming—

Mental Health

The Convener: Item 4 is this morning's second round-table evidence session. This one is on mental health. I wonder whether the witnesses will agree to introduce themselves the first time they speak in order to save time. [*Interruption*.] There seems to be a problem with the microphones, so we will have a slight pause to get it sorted out.

We have agreed, at least by our silence, that we will introduce ourselves the first time we speak. As usual with such sessions, I will, for preference, give the floor to our panellists.

The first question is from Richard Simpson

Dr Simpson: With the Mental Health (Care and Treatment) (Scotland) Act 2003, Scotland led the way in the UK, because all previous mental health legislation had been created by the UK Parliament and then tartanised. The introduction of the Millan principles was clearly very important at the time. Do you think that the proposed revisions to the act are appropriate? Have compulsory treatment orders and the community element of those provisions worked? What do those from whom we have received evidence feel about the McManus review and the proposed revisions?

Carolyn Roberts (Scottish Association for Mental Health): I am head of policy and campaigns at the Scottish Association for Mental Health.

As Richard Simpson said, the 2003 act was groundbreaking; it has human rights at its heart and contains a number of very welcome provisions. I believe that the new bill will be introduced later this month, but we have, with regard to the draft bill that we have seen, a number of concerns about elements of the McManus review that are not included. We felt that the McManus review was very comprehensive and thorough; it has, as members know, taken some time for a response in the shape of a bill to be put together.

SAMH has submitted a very thorough response on the bill, but I would like to highlight a few areas of concern. First, the consultation draft bill suggested that it would be possible to detain a person on the basis of only one medical report. We are very concerned about that.

Secondly, we want changes other than those that have been proposed to be made to the named persons provisions. The Scottish Government stated its intention that no one should have a named person if they do not choose to have one, but that would not be the effect of the provision in the bill.

We have a number of other concerns about the absence of advocacy, which was a real strength of the original legislation. I do not think that the right to advocacy has been fully realised and we are disappointed not to see more of that in the new bill.

We will obviously wait to see the revised version, but those are a few of our initial concerns.

Joyce Mouriki (Voices of Experience): I am from Voices of Experience. I want to add to what Carolyn Roberts has said. Obviously we agree on all the issues that Carolyn has raised, but I would like to add that we had been looking for the onus being placed on an individual to drive completion of the advance statement, which would mean that somebody from the care team would have responsibility for that. That is a really good idea in the context of the recent talk about capacity being challenged. The idea is that we seek every opportunity for supported decision making, as opposed to taking decisions away from the service user.

Derek Barron (Royal College of Nursing Scotland): I am associate nurse director for mental health in NHS Ayrshire and Arran, but I am here as a front-line Royal College of Nursing Scotland member.

Our concerns relate to nurses' holding powers and the proposal to change the length of time for which they can hold a patient. We do not agree with it because of reciprocity and the fact that the 2003 act was based on rights. We see the proposal as infringing rights. There is no need to extend the time for holding; the nurse's holding power is for two hours, and if the doctor arrives before the end of the two hours, the nurse can detain for a further hour.

To change the 2003 act to say that a nurse can have the power to detain someone, even when there is a doctor present, will not place on the service the reciprocity that is within the 2003 act. Holding will become a workforce issue as opposed to being about tending to someone who is being considered for detention, which means that they are unwell, and we should prioritise that. RCN members do not agree with the proposal.

The mental health nursing forum in Scotland, which is a group of senior mental health nurses, also discussed the proposal and also disagrees with it. There is no need to change the 2003 act's provision, and none of us understands where the proposal came from or what the driver for it is.

Chris O'Sullivan (Mental Health Foundation): The Mental Health Foundation agrees with all

those points, and we have echoed them in our submission.

The two issues that I came here to concentrate on today are equity and equalities, and mainstreaming mental health. Both deserve to be explored in discussion of the draft bill, so that they can widen the discussion within the bill process.

The draft bill appeared to many stakeholders to be extremely technical. As Richard Simpson pointed out, in the process of creating the 2003 act, Scotland paid regard to the differences in mental health services in Scotland and the work that had been done on various national programme activities. It is fair to say that, from our perspective, the paradigm has shifted in the past 10 years; a new bill—potential new mental health law—deserves to be examined in the light of how the paradigm has shifted.

We would like discussions on the bill to focus on people who are the subject of inequalities, on how the bill's provisions will be applied, on how the provisions of the 2003 act are applied to people from inequality groups—asylum seekers, refugees and young people, for example—and on where their right to advocacy and so on works.

We would also like the bill to revisit sections 25 to 31 of the 2003 act, which deal with the obligations on local authorities to promote recovery and access to other services, including employability and education, all of which are bound up in issues around welfare reform and other things that, I am sure, will come up today. They deserve an airing so that local authorities can mainstream their work on mental health in the context of single outcome agreements and other activities that are new since the 2003 act.

Shaben Begum (Scottish Independent Advocacy Alliance): We are concerned about the lack of mention of independent advocacy in the proposed mental health (Scotland) bill. One of the strengths of the 2003 act was that it was the first legislation in the UK to give people the right of access to independent advocacy.

What happens in practice throughout Scotland does not, however, reflect people's rights under the legislation; access to advocacy has been really patchy over the past few years. Some groups still do not have the levels of access that they should have. We have produced various pieces of research: most recently, the Mental Welfare Commission published some research yesterday, which said that people with dementia still do not have access to advocacy. Lots of people still do not know about advocacy. The commission discussed units that had not had any input from advocacy for the past six months. We are concerned about such developments.

It has been said that advocacy safeguards people's rights and ensures that people have access to the right kind of support, care and treatment. We think that an opportunity has been missed. There needs to be something to strengthen people's right to access independent advocacy and to remind local authorities and health boards about their duty to ensure appropriate levels of access, so that people with learning difficulties, older people, people with dementia and children and young people do not fall into the gaps in provision that we see all the time.

We are in the process of producing some new research. One of the target groups has been mental health service users, in respect of whom the process has been disheartening and depressing. A number of people have said that they wished that somebody had told them about advocacy years ago, because it would have made a huge difference to their lives and they might not have been in their current situation. That highlights the role of advocacy in prevention and in avoiding situations becoming more difficult and complex.

Advocacy helps people on the road to recovery. When advocacy is involved, people have a stronger sense of control and more choices, and they have the ability to make better decisions, which we hope can prevent situations from escalating.

We are really concerned that the draft bill does not recognise the importance of advocacy.

Dr Carole Allan (British Psychological Society): We strongly support the principles of the proposed mental health bill. To reflect some of the previous comments, I say that the bill is tightly drafted, and it seems to be meeting a legislative framework—understandably—rather than reflecting developments and changes that have taken place over the past 10 years in how mental health services are delivered. We would like those to be reflected in the proposed bill through expansion of mandated treatment, which includes, for example, input to families by way of psychological care, where that is appropriate.

Developments in England in mental health legislation have expanded the role of other clinicians in providing specialist reports, and the role of the responsible clinician has now developed. The British Psychological Society has supported appropriately qualified psychologists in taking on that role. Appropriately qualified nurses are also taking on that role in England. We particularly note the suggestion that one report could be used, and we echo the concerns about it that are in other consultation responses.

We appreciate that there may be resource issues, but there is an opportunity through the

proposed legislation to consider more widely who can provide a second opinion. For instance, some issues within learning disability are more clearly psychological—for example, where there may be neuropsychological difficulty—and so would sit well with the expertise of psychologists. We are keen for that to be considered.

The Convener: Do you want to add some comments, Mr Barron?

11:30

Derek Barron: I do not completely agree with Carole Allan on turning the role of the nurse into what would previously have been a mental health officer role. The MHO role provides a safeguard, so I am not sure that we would support nurses taking on the role that they take down in England.

Dr Allan: That is a legitimate view, but what will be helpful is information coming from England about how things are working, who has taken on the roles and whether safeguards are in place. That is to be investigated and evaluated. That is simply a comment; I cannot speak on behalf of nurses and would not dream of it.

Dr Simpson: That has been a useful introduction. I should have declared a couple of interests, as a fellow of the Royal College of Psychiatrists in Scotland and as someone who has a chair in psychology at the University of Stirling.

The named person concept is interesting. I wonder whether others would like to comment on it, because the roles of individuals are definitely changing; if you go back 40 years, a nurse's role was quite different to what it is now, and the range of roles has also become quite different. The same is true for psychologists. In 1979, a person could not see a psychologist without being referred by a psychiatrist. I did some research that showed that that was complete nonsense, and the system then changed. Should the bill be drawn in such a way as to allow the possibility of extended roles for a limited number of nurses with specific qualifications, and for psychologists and others to provide a second report, if we retain the second report?

Derek Barron: Unsurprisingly, I absolutely support the extended role for nurses. In Ayrshire, we have advanced nurse practitioners in Crosshouse hospital who do away with the need to have a psychiatrist overnight. We have on-call consultants, but not junior doctors, so I absolutely agree with that provision. However, to take, in the bill, a step away from that protective element requires careful consideration. I understand the point about specialists and advanced practice, but I would be cautious because what we currently have is rights-based legislation that protects individuals; if nurses and doctors are too close in one team, that could be a risk that needs active consideration.

Joyce Mouriki: We are well aware that the general practitioner provision for the second report has not worked particularly well, so to substitute another professional in that role is fine. What Derek Barron is talking about is the need for a second report and an MHO safeguarder, and the need not to confuse the two reports—not to use the MHO's report as the second report, in any circumstance. That should be the inviolate bit of the legislation.

Karen Addie (Royal College of Psychiatrists in Scotland): I am from the Royal College of Psychiatrists in Scotland. I point out that I am not a practising psychiatrist.

I know that there are huge problems with getting the second report from GPs, particularly in rural areas and in areas that are short of junior doctors. Derek Barron mentioned getting junior doctors on call overnight. We have big recruitment problems in psychiatry and we have gaps in particular bits of the country and in particular specialties, so that needs to be looked at.

Dr Allan: I would like to make a final comment about having a second independent report. The British Psychological Society has supported psychologists in England with extra training and mentoring. The Scottish Government could seek information and intelligence about development of those roles. I am reflecting some of the resource considerations that have been flagged up.

Part of the core role of a psychologist is to be able to assess situations and to produce a report that is helpful to a tribunal. My thinking about the process is that it could be beneficial.

Chris O'Sullivan: I will make a point that might broaden out the discussion. It relates to what I said about mainstreaming mental health across a wide range of competencies and to anti-stigma work.

In the olden days, it was solely the duty of psychiatrists and latterly MHOs to deal with mental health in a legislatively defined manner. In 2014, people in a wide range of legislatively designed roles are compelled to act on people's mental health. There is the role of practitioners in self-directed support, for example, which is in the recent act on that.

We want the widest possible workforce involvement in and understanding of the complexity of mental health. We want practitioners from the broadest range of professional backgrounds to act in their sphere of professional responsibility in a way that promotes rights and encourages people's self-advocacy and the best

possible outcomes for their recovery. If that means that mental health legislation should include options to widen the range of workforce roles that have a statutory responsibility, it would probably be good to have that, alongside a wider recognition of the impact on mental health of a range of professions in different communities and through different policies.

Carolyn Roberts: There are two points on professional roles. I support Derek Barron's point about the mental health officer's role, which is fundamental and provides safeguards. We are concerned that the number of trainee mental health officers has been falling in recent years. That is an important point that I would welcome consideration of by the committee.

Dr Simpson asked who should be able to provide the second of the two reports. As we consider the bill, it will be important to define the second report's purpose, which will drive who should be able to provide it. We have focused on the fact that it is a GP report. We are quite positive about GP participation because it is reasonable to expect that in many cases the GP will have a relationship with the individual. The GP might be able to provide wider information, beyond that about the person's immediate state, for example information on experiences, a previous condition or family circumstances. All those issues are relevant.

We are keen for GPs to retain a role. I understand that there are often practical difficulties in getting them to participate, but I would be concerned about changing a process that has such positives purely on the basis of resources and availability. I would prefer us at least to make efforts to address the resource-driven issues before changing the system. Something like 1,200 compulsory treatment orders are made every year and there are about 4,000 practising GPs, so the resource issues should not be insurmountable.

The Convener: The focus is on the crisis, but the committee spends a lot of time discussing preventative initiatives. In reading the committee papers at the weekend, I was shocked to see some of the differences in waiting times for psychological therapies. The waiting time in Glasgow is seven weeks, but in the NHS Forth Valley area it is 17 weeks, which is just within the 18-week target. As at March, 2,700 or so people had waited more than 18 weeks.

We are looking at the point of crisis, but surely we should look at how we reduce the number of people who get into crisis. We have not mentioned children yet. In the past, we have had evidence that thousands of children present to social work staff suffering from emotional abuse and lack access to specialist support.

Brian Donnelly (Young Scotland in Mind): I represent Young Scotland in Mind, which is a forum of mainly voluntary sector organisations that work with children and young people. This is probably a relevant moment to raise issues that affect children and young people. To be honest, a host of things are absent from the proposed bill in relation to children and young people. Our members do not feel that the bill talks to them or addresses the issues that affect children and young people. Waiting times for children and young people are especially poor.

There are issues around defining an adult as someone over 16. The United Nations Convention on the Rights of the Child says that someone is a child up to the age of 18. On the back of the Children and Young People (Scotland) Act 2014, those who are looked after and accommodated can get a service up to the age of 25.

Historically, the period between 16 and 18 is poor in any service, but we are looking at a particularly vulnerable group here, especially children that have been looked after, who are disproportionately affected by poor mental health. Almost half of them leave care with a diagnosed mental health condition. Those are the people who fall through the cracks and come to adult services at the point of crisis.

There is a real lack of community-based engagement with third sector preventative work. A lot of sporadic things are going on but it is not usually joined up with the budgets of the bigger services. Sadly, the draft of the bill that we have looked at does not really do a great deal to address that. Our members feel that the issues that affect children and young people and their needs are absent from the bill. Children and young people are not an add-on group; they are not an equalities group. They represent an entire population. They are affected by parental mental health. One of the biggest indicators of a child or young person's mental health and wellbeing is their mother's mental health. There is a considerable gap there.

The third sector has lots of ideas in relation to that. It is looking for partnerships and wants to see more community-based work. It would like to see more links between child and adolescent mental health services and schools. Information on issues such as self-harm does not exist in schools. We have surveyed our members on that and those are significant issues.

That is just skimming the surface. The opportunity to take a more preventative approach would be well supported and echoed by those in the children's sector.

Karen Addie: Could I add something on psychiatric recruitment? In the past couple of

days, I have had an update from our child and adolescent psychiatry faculty. Recruitment of psychiatric trainees to higher specialist training—that is the last two years before becoming a consultant—is becoming an increasing problem across all psychiatric specialties, and doctors in general in Scotland. It is anticipated that there will be an increasing shortfall in consultant numbers. Those people see the most ill and the most severe psychiatric illnesses, but there will be gaps in that psychiatric workforce.

Recently, six ST4 vacancies were advertised in child and adolescent psychiatry and only one was filled. There were three vacancies in Forth Valley for consultant jobs. Last week, all three candidates withdrew. There are expectations around legislation and about beefing up the services and reducing the waiting times, but there will definitely be problems with the psychiatric workforce. I do not want to depress anybody any further.

Dr Allan: I want to pick up on Brian Donnelly's comment about CAMHS links and schools. Paradoxically, there are cuts to educational psychology, and workforce planning predicts that over the next four or five years about a quarter of psychologists who are linked to schools will retire. Local authority budgets are strained and under threat and posts are not being filled. I am sure that members are aware that postgraduate funding for educational psychology has been completely withdrawn. The problem is the opposite to the one that Karen Addie delineated: people want to become educational psychologists. It is an enormously popular career route for people but there are bottlenecks in our system.

These are people who work with some very disadvantaged children. We need CAMHS links in schools, but let us think about an integrated and joined-up system that delivers the support that educational psychologists can provide to these very vulnerable groups.

11:45

Chris O'Sullivan: I will make a couple of points about young people's mental health. We have acquired some knowledge over the past few years, both in Scotland and in the wider UK. For example, we had a programme called right here, which worked with 16 to 24-year-olds in five centres across the UK. We recognised that when it came to mental health, there was a gap in both service provision and in citizenship for 16 to 24-year-olds. That programme has developed some interesting recommendations, which I am sure we will have an opportunity to feed into the committee later on.

Our work with young people has shown us something that came up in the Christie review about co-design and the importance of involving people. It has highlighted the value of the imagination that young people bring both to defining their problems and to innovating solutions that perhaps the adults in their lives and those of us—I say "those of us" when I should perhaps say those of you—in positions of power do not bring to the same extent. I hope that the committee will take evidence from young people and others.

I bring to the committee's attention a project that NHS Greater Glasgow and Clyde invited us to work with Young Scot on, working with young people to see how the board could involve digital in its young people's mental health strategy, because it recognised that young people were operating pretty much seamlessly online and offline and that their demand for their mental health services to include online dimensions was reasonable. NHS Greater Glasgow and Clyde was also mindful of the fact that young people engage in all sorts of strategies—both positive and negative—to help them to manage their distress prior to the point at which they might need CAMHS. That is an issue more widely, in that we must ensure that options are available for all population groups to self-manage distress and to find their way to support downstream from the specialist services, such as CAMHS, which are so bottlenecked.

Joyce Mouriki: Obviously, the community situation is not good, but I would like to keep people's minds on the top of the pyramid and the fact that our young people tend to be sent down to England for specialist services in particular circumstances. We should also keep our eye on that.

Karen Addie: I absolutely agree and I thank Joyce Mouriki for bringing that point up. I remind the committee that, in particular, there is no in-patient provision for forensic adolescent beds and CAMHS/learning disability in Scotland and that patients tend to get shipped across the border at great cost. There is not only the financial cost but a human cost for those people's families and those who are trying to support them. It is also quite difficult to get them back once they have been sent.

Chris O'Sullivan: I will bring another population group to the committee's attention. People with long-term conditions are not one of the specific inequality groups, but they make up a large population in Scotland. Having a long-term condition is strongly associated with having a greater risk of poor mental health or mental health problems. For example, 30 per cent of people with diabetes develop depression and someone is twice as likely to have depression if they have coronary heart disease. If someone has coronary heart disease and depression, they are twice as

likely to die of their coronary heart disease. That in itself makes a compelling argument for addressing the mental health of people with long-term conditions.

In 2011, the King's Fund did a very interesting study on the economic costs of mental health problems. From its economic modelling, it discovered that mental health problems raised the total healthcare costs by 45 per cent for each person with a long-term condition and a comorbid mental health problem, which equates to about £1 in every £8 that is spent on long-term conditions being spent on the mental health aspect.

There is a need to recognise and engage with that issue more in Scotland. We, the Royal College of General Practitioners and a range of others have done a lot of work on the provision of peer support in managing long-term conditions and mental health problems. Good studies are also being done on mental health support in cancer and other areas. This area has great potential to address some of the challenges raised in Scotland by both long-term conditions and the complexity and multimorbidity that are so often behind the health inequalities that we know are so acute in this country.

Bob Doris: That is really interesting. It would be useful to put on record that we are listening to what you are saying about workforce planning, vacancies and recruitment. It is a complicated web, and I think that all the committee members have taken that point on board.

The search for solutions often leads us back to the preventative approach and the need to ensure that mental health issues are not exacerbated by other issues. I can give a slightly tangential example. I do a lot of work with the continence management service in NHS Greater Glasgow and Clyde, and a lot of the older population first present with mental health issues because they have become housebound as a result of continence issues, after which the other issues kick in. There is always a trigger, whatever that is for each aspect of the population.

I know that there has been positive work in relation to that in NHS Greater Glasgow and Clyde. There are a variety of examples of partners working together when mental health issues kick in. For example, the Notre Dame Centre in Glasgow does excellent work with kinship care children in particular, although it could be better funded. Last week I was in Possilpark looking at a new link worker service for GP practices as part of the deep end project. The service is focused on moving the practice of some of the softer empathy skills that are needed in healthcare away from front-line GPs to other workers. Neither of those initiatives involves straightforward clinical referral processes for mental health.

There seems to be a patchwork quilt of good practice out there in the services for young people, older people and those who are suffering from the effects of welfare reform. It is a huge thing to ask any Government, or any local authority or health board, to co-ordinate that good practice in a coherent way. I am looking for a steer in that regard. We can talk about mental health strategy, but the solutions are very often local and unique to each area. How, then, do we share best practice throughout the country? Can you suggest some other things that we could be doing? I would find that helpful as an MSP.

The Convener: There are a lot of hands up in response.

Brian Donnelly: The point is very well made. People from a social care background have a different focus: children who have experienced abuse, neglect or violence at home get a social care service that may be about prevention or managing risk but is not always about managing the impact of that trauma on their life as they go on.

The challenge in dealing with young people—I am not the first person to say this—is that the thinking takes place in silos. We have adult mental health over there and community stuff over here, and the area of children and young people is completely different, with different money and ministerial responsibility.

There must be a way of looking at what people are doing locally, mapping that out and spreading it around. If someone works in a school where self-harm is an issue, they should know where to look. What will point them in the right direction? Are there voluntary sector services in that area that could come and work in partnership with the school, rather than the school just using the tried-and-tested medical and professional routes?

It has been said a million times—and I know that it is an easy answer—but the funding and the thinking tend to be very top down and to have a narrow focus. We need to not be scared to throw that open and start talking about what communities have. We need to look at community assets and to map them across the whole spectrum of social care.

For children who are in school now, health and wellbeing is a core part of the curriculum for excellence, and it is the responsibility of all teachers. The Children and Young People (Scotland) Act 2014 asks all paid professionals to share concerns about welfare, not just wellbeing. That is a significant change in terms of what professionals have to act on. It is not just about risk any longer—it can be, for example, that a child's mum was hospitalised at the weekend and the child is not getting fed. The professionals will

have to share those concerns. The work must be joined up; otherwise, we will just keep on doing the same stuff over and over again.

Dr Allan: I do not have a complete answer to the challenge that Bob Doris outlined, but I am hoping that the integration of health and social care will start to provide us with some answers.

The point is well made that, as the population ages, we will all be dealing with comorbidity and complexity—and comorbid physical and mental health problems coalesce together. The Kings Fund and Lord Layard have been eloquent about the costs and the difficulties. For example, it is extremely difficult to engage someone in managing a long-term health condition if they are also anxious and depressed—and ignoring that is not an option. In addition, the issue is about managing chronic conditions. There is no pill that will sort out everything; rather, it is about the lifestyle choices that people find it very difficult to make when they are poor and up against it—taking more exercise, stopping smoking and drinking a lot less.

A stepped care model is needed. A huge amount can be done in the community and there are fantastic projects in that regard. In addition, there are levels of complexity. You would not expect a tertiary care service to deliver the broad interventions.

I refer you to my declared interests. NHS Greater Glasgow and Clyde has invested quite a lot of money in psychology support for acute services. More psychologists are working on obesity than on addiction problems in Glasgow, which is quite something. The problems associated with obesity are huge in the west of Scotland. The model is psychological but not all the treatment is given by psychologists. They carry out outreach work in the community but more complex cases are seen in a hospital, including cases where people may progress on to surgery.

We think about the levels of care, but the bulk of care will always be dealt with in a community setting using a range of providers who are close to where the client or patient is.

Chris O'Sullivan: Bob Doris asked for solutions. None is immediately apparent, but I have some thoughts.

First, a mental health impact assessment of Government legislation—of the policy and the practice—should be carried out. We can demonstrate and the evidence supports the fact that most public policy decisions have a mental health dimension. Understanding and framing that through the legislation and the guidance can be very helpful in enabling workforce groups and the people implementing the legislation in local authorities to make the time to include mental health.

Downstream of that, it is very useful at ground level to assume a mental health dimension in any inequality or health interaction—in fact, that should be assumed in most public service interactions. Bob Doris mentioned continence services. That is a perfect example of a non-mental health service that, when it recognises its ability to encounter and engage with mental health, has the potential for great benefits.

All public service employees in Scotland should be minimally equipped to deal compassionately with disclosures of distress. Therefore, any public servant should be able to recognise the signs that someone might be experiencing distress, have a conversation about that with them in a confident and comfortable manner, and help them—if the person wants them to—to make the first step on addressing the distress. Irrespective whether that is in a continence service, a welfare advice service, a noise abatement team or whatever, people on the ground should be professionally competent in that regard.

Linked to that, peer support has a great role to play. We have considered where that support fits in mental health and there is a good evidence base on that. We have done work to transplant mental health peer support to those with long-term conditions and to carers. An element of that occurs in professions, too. Therefore, helping people to professionally use their own experiences and be comfortable in doing so is a potential avenue to follow.

I completely agree with Dr Allan that complexity is where it is at. We are no longer able to conceive of a situation where people go to a GP or a social worker, or they have any other public service interaction, with one problem that requires one appointment or one appointment for each issue. People exist in a web of complexity that usually includes mental health, long-term conditions and other social issues.

We need to gear our policy environment and our practice environment to engage with complexity and help people to unpick that. Some promising practice already enables that, from things such as deep end and the PCAM—patient centred assessment method—complexity assessment tool, which has been developed in Edinburgh and Stirling and is being trialled at the moment. There are also some approaches in the current mental health strategy to engaging with distress, trauma and other things that we hope will show promise over the next few years.

12:00

Derek Barron: I will echo somewhat what Dr Allan has said. Integration allegedly is the answer. That is the whole purpose of integration—of what we aim to do.

Right now we have different organisations doing different things, and sometimes different organisations doing the same things twice. In the North Ayrshire shadow integration board we had a discussion about the money that the health service is spending on learning disabilities and out-of-area placements and what our local authority colleagues are spending on learning disabilities. We considered the potential to bring those things together and do them better and more cheaply, which would mean that we would have more money to do other things and to increase what we do.

I do not mean to be glib, but part of the answer is integration. Otherwise, why are we doing integration? It is not a magic wand, and it will take us a lot of time to get there, but that is the purpose of it. If that is not the purpose, we are wasting our time.

We are going to work together on things. On our shadow integration board we have the third sector, voluntary organisations, carer groups and user groups. Round that table we need to work out what we need locally and how we tailor services to local needs, which might be for children, older adults or any care group in the middle. We need to look at the totality of the situation.

Without being glib, part of the answer is integration.

The Convener: Is that not Brian Donnelly's point—that it is easier said than done? Even leaving out local authorities, we see that adult services, children's services and community services—all with the same professionals—are working in silos.

Brian Donnelly: There is the mental health silo, there is the children's silo, and then there is the children's mental health silo as well.

The Convener: So it is challenging.

Derek Barron: We all report to a single director. All those silos meet at one point: the director, who is responsible to elected members, the population and the health board. It will all meet in integration, whereas right now it does not meet in a single place. If one person is accountable for it, it is easier to say, "Well, you have to balance your responsibilities."

The Convener: What we do not have is what Chris O'Sullivan described as a mental health impact assessment. We are not measuring the outcomes, but we can easily identify the inputs—all the salaries that we pay.

Bob Doris: I did not expect anyone to have all the answers. I wanted to tease out some of the good things that are going on and where we have to go further.

It is a long time since we looked at single outcome agreements. Is there a mental health outcome indicator in single outcome agreements? That will, I hope, progress on to local plans, in terms of integration and the like.

Chris O'Sullivan: We have worked with several local authorities. At the beginning of single outcome agreements, Glasgow City Council asked us to help it to engage some of their departments that were not explicitly about mental health and the delivery of mental health outcomes, in terms of its obligations under sections 25 to 31 of the 2003 act and under the single outcome agreements to reduce suicide and improve subjective wellbeing.

We have developed a programme of work that we did with Glasgow and have subsequently done with the three Ayrshire local authorities and now with Highland. It is called our mainstreaming mental health programme. For each area, we interview service leads about where mental health fits in with their work and we encourage them to connect their single outcome obligations—both the explicit mental health ones about suicide and wellbeing and their implicit ones, which are many and varied. We create a space for those people to come together to discuss that, to realise what their role is in mental health, and to create a mini-action plan to develop that.

It makes for some interesting discussions. The guy who runs the lighting strategy says, "What's lighting got to do with mental health?" You ask, "Well, why are you doing this lighting strategy?", and the guy goes, "Well, we want to connect communities and get people to be able to walk safely at night." "What does that do for them?" "It makes them feel more comfortable where they are." "Well, what does that do for their mental health?" "Oh, I see."

The guy in Ayrshire who ran the team that does house renovations when people are in hospital said to us, "We're not mental—why are we here?" The team thought that they were coming to mental health training to learn about mental illness. I asked him, "Why do you do what you do?" He said, "We change people's houses for them when they're ill so that when they come out of hospital their houses are better. We're better than some councils because they just do the bedroom and the kitchen whereas we do the garden." "Why do you do the garden?" "So that people can get outside and see their neighbours so they don't lose touch." "Oh, I see." By the end of the day,

they were talking about using their own time to work with some people with mental health problems to build a garden that everybody in the community in that part of Ayrshire could be involved in.

We often find that, at the practitioner level, it is about flicking the switch and making people realise that mental health is not a psychiatrist's job but a competence that we all have. At a strategic level, it is about getting a service lead to recognise that his obligations under a single outcome agreement have lots of relevance to mental health and are not just relevant to the suicide and wellbeing section.

The Convener: Karen, do you want to comment?

Karen Addie: Only to say that SAMH has also done a lot of work on this issue, so Carolyn Roberts wants to come in.

The Convener: You are being prompted to come in, Carolyn.

Carolyn Roberts: Which I very much want to do, convener. Thank you, Karen.

When we have looked at single outcome agreements with a view to finding out how much they incorporate mental health, we have found that, as Chris O'Sullivan has said, that tends to be very much driven by areas where there are HEAT targets. We have seen indicators within single outcome agreements about suicide and psychological therapies. Those are good and important things, and one reason why targets are helpful is that they get issues on to people's agendas, but that does not really reflect mental health in its broader sense.

Scotland has done a great deal of good work in developing mental health data and we now have a lot of information on outcomes and what is happening. In particular, there is a set of both adult and children's mental health indicators that can be used to set outcomes, so we could do a lot of work there.

I also agree that, in response to the initial challenge, the answer lies with integration. We have a promising opportunity in front of us as we integrate health and social care, although I point out that the third sector does not report to a director in the same directorate, so things are not quite as straightforward as we might think. There is, however, a good opportunity.

Our concern is to ensure that, when we create the new bodies and new structures, the individual is still at the heart of them. We have a concern because we are going to create new structures and processes, which can make it easy to lose sight of the person who is at the heart of it all. There is a real opportunity to do better joint working and integrate, but we need to take a great deal of care to ensure that we do not simply further lose individuals in structures.

Joyce Mouriki: Others have brought the discussion back to the point that I was going to make originally. I will say two things to help with Mr Doris's question.

First, we are one of the lead partners for commitment 1 of the mental health strategy, which is to do a mapping of mental health services across Scotland, including voluntary sector contributions; the scope is a wee bit wider this time than just the par-for-the-course, statutorily delivered services.

My second point is about all the good work that is being done on person-centred care and the collaborative that has been set up across health and social care to get that into the system. At the first national event that I went to, the people in the room said, "Let's look to mental health to take a lead on this", because quite often we have already engaged across health and social care to drive a patient pathway.

Finally, I suppose that people have come down to the idea that what we need is person-centred outcomes for the individual, which brings us back to Carolyn Roberts's final point. No matter what is in the outcome agreements, let us not forget that what we are looking for are outcomes that the person wants for their own life—and that is a whole life, not just a mental health life.

The Convener: I suppose that the next question is about what happens when issues are identified. Our briefing states that the Mental Welfare Commission for Scotland identified a 7 per cent increase in detentions. We have the information, but what will make a difference? It is a sad point, I suppose, that this is reactive, but even in that reactive sense, how do we engage with the Government and the agencies that are responsible to question that 7 per cent increase in detentions?

Derek Barron: I think that the figures from the Mental Welfare Commission, whether on that issue or others, ask a question—the why question. It is absolutely right to ask that question, as you have just done.

We have talked about nurses' holding powers. I would like nurses' holding powers to be used more often—I would like to see that figure go up, because that gives people protection under the 2003 act. An increase in detentions is not necessarily a bad thing, because detention brings with it protection. We in the health service have a statutory responsibility to protect the individual. That is partly about advocacy and partly about having an MHO looking over the health professional's shoulder to ask whether what they are doing is right or wrong. Detention brings with it

a protection. To me, the figure that you mentioned asks a question. Let us understand the why.

Carolyn Roberts: I think that the figure that the convener cited relates to emergency detentions. That is a good example of how we can use the excellent data that the Mental Welfare Commission produces to make improvements. The reason why we would be concerned about an increase in the number of emergency detentions is that they do not offer the sort of protections that come with a short-term detention certificate. With a short-term detention, a mental health officer is involved; there is a lot more protection. That shows how important it is that such data is gathered. It allows us to consider why certain things are happening.

On the figure that the convener mentioned, I noticed that it was much less likely that an emergency certificate would be used when an intensive home treatment team was available. That tells us something about the kind of services that we need if we are to make a difference, which is useful to NHS boards in doing their planning. I certainly hope that such figures are considered.

The Convener: We have almost come to the end of our session; we will have an informal session just after the meeting. This has been a broad session that has reflected much of what was said in the written evidence. I now give the witnesses the opportunity to put on the record any points that they feel that they absolutely need to make.

If, on the way home, you think of something that you wished that you had said, as is often the case, let us know. You do not need to do so in a formal way; you can just email us. We are quite happy for the clerks to receive any additional comments about the session and points that people wish that they had made.

Does anyone wish to take up that offer? How did I know that Chris O'Sullivan would?

Chris O'Sullivan: You have given me a platform today. [*Laughter*.]

There is one issue that we have not had a chance to touch on but which we and others would be grateful if the committee were mindful of—the implementation of self-directed support in relation to mental health, which many of us are working on. We are finding that the implementation of self-directed support for people with mental health problems has been somewhat complicated, and we would like close attention to be paid to that issue over the coming months.

As the evidence on implementation has grown, we have seen some examples of poor implementation and some examples of good implementation, and concerns have been raised by service users and service provider organisations—at some point, those concerns will need to be aired.

The Convener: I appreciate your taking the opportunity to put that on the record. I reassure you that, if you write to the committee to outline those concerns, we will maintain an interest in the matter.

Shaben Begum: To back up what Chris O'Sullivan said, one of our concerns with self-directed support is that a number of companies have been set up that will charge people directly for advocacy support. They are trying to encourage a move away from local authorities and health boards funding advocacy directly towards charging individuals a percentage of their social care package for advocacy support. Such a system would perpetuate the inequality and difficulties that are experienced by people who might need complicated support because of their situation. We are extremely concerned about that.

12:15

The Convener: We would certainly welcome information about that. We are at an early stage in the process, but if those issues are already emerging, the committee will do all that it can to bring them to the Scottish Government's attention.

Brian Donnelly: Under the new Children and Young People (Scotland) Act 2014, all ministers are obliged to give due regard to children's rights in any policy or legislation that affects children and young people. That is relevant to children and young people whose own health and wellbeing is affected, but decisions that are made about parents' treatment and care also have a direct impact on them. As signatories to the UNCRC, we have to give due regard to the impact on children's rights—the children of prisoners as well as the children of people who are hospitalised are affected, and a children's rights impact assessment may have to go with that. I just wanted to throw that in at the end of the discussion.

Dr Allan: I would like to comment briefly on a point that I will also cover in writing. I am sure that the committee saw reports in the papers about how poor NHS dementia care can be. I intend to write to the committee about the psychological support and development that can be put into that type of care to improve it. There is a relative disparity, as only 37 psychologists are employed in older adult services in Scotland, out of a workforce of 700. It is an incredibly popular specialty for psychologists to work in, but there are no jobs for them. I feel strongly about the care of older adults—I am getting older myself—and

about people who are dementing, but I will write in about that.

The Convener: We would welcome that. It is something that the committee will want to look at anyway, given our past work and our inquiry into care for older people.

Derek Barron can have the last word.

Derek Barron: Dr Allan brought up yesterday's report, and I should point out that the East Ayrshire community hospital was held up as an excellent example of how to integrate buildings and outside spaces in the care of older adults who have dementia. Since we are on the record, I thought that I might as well plug the good work of East Ayrshire community hospital.

The Convener: You make an important point, not just for your own service, but in recognition of the fact that there is much going on in the national health service that is good, despite that disappointing report.

I thank all the witnesses for their precious time this morning.

12:17

Meeting suspended.

12:21

On resuming—

Annual Report

The Convener: Agenda item 5 should take only a moment. We have to agree the annual report, which is in the standard format that is used by all committees. The annual report is a simple record of what the committee has done over the parliamentary year: it is just a statement of facts. I seek the committee's agreement to publish the annual report as set out. Are there any comments?

Bob Doris: Do not worry, convener—I will not delay you unduly; we are all keen to finish the meeting. However, I think that it would be wrong not to draw attention once more to the work that we did on the review of access to new medicines. Everything that we did on that was worth while, but the work that we did in partnership with the Government and other stakeholders was really positive. It is in the annual report—frankly, this just gives me an excuse to mention it again.

The Convener: Is there an issue about where that work sits in the report? Do we need an extra sentence or two on it?

Bob Doris: It might be worth giving it a bit more prominence. However, to be fair, I really just wanted to put on the public record the work that we did on the review.

The Convener: That is fine.

Do I have the committee's agreement to publish the annual report?

Members *indicated agreement.*

Meeting closed at 12:22.

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