OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Health, Social Care and Sport Committee

Tuesday 7 May 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 7 May 2024

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
15th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Hilary Cass (Cass Review)
Meghan Gallacher (Central Scotland) (Con)
Heather Kelman (Food Standards Scotland)
Geoff Ogle (Food Standards Scotland)
Dr Gillian Purdon (Food Standards Scotland)
Ash Regan (Edinburgh Eastern) (Alba)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 7 May 2024

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 15th meeting in 2024 of the Health, Social Care and Sport Committee. I have received no apologies.

Agenda item 1 is a decision on taking business in private. Do members agree to take items 4 and 5 in private?

Members *indicated agreement.*

Gender Identity Services for Children and Young People

09:00

The Convener: Agenda item 2 is an evidence-taking session with Dr Hilary Cass on her review of gender identity services for children and young people, which was commissioned by NHS England.

Dr Cass, the chair of the Cass review, is joining us remotely and I welcome her to the committee. We will move straight to questions, Dr Cass. Thank you for your time.

I call Ruth Maguire.

Ruth Maguire (Cunninghame South) (SNP): Good morning, Dr Cass. Thank you for being with us this morning. Your review is obviously a detailed piece of work that needs careful consideration. We all appreciate that it is based on services in England, but it will have implications for how children are treated in Scotland, too. There is learning for all of us in it. Can you start off by talking about the key conclusions in your work that you would want us in Scotland to draw from to do the best for children in distress?

Dr Hilary Cass (Cass Review): Yes. As will be clear from the report, the main concern for me was the weakness of the evidence base across all aspects of care. The critical issue is the need to work collaboratively as broadly as we can, both nationally and internationally, to try to improve that evidence base.

The second piece of learning from England was that, first of all, children were being bypassed, because they were not getting basic assessments locally; often they were bypassed straight through to the gender identity development service at Tavistock. Crucially—and this point is, I think, transferable—these young people need a very broad multidisciplinary approach to care, because they often have complex presentations, and just seeing them through a gender lens means that they do not get the breadth of care that they need.

I think that those are the two messages that apply, regardless of where in the UK or internationally you are.

Ruth Maguire: Thank you—that was helpful.

Tess White (North East Scotland) (Con): Good morning, Dr Cass. Is there, in the 32 recommendations in what is a very comprehensive report, anything specific in relation to the delivery of services that you believe could apply in a Scottish context?

Dr Cass: I would highlight some of the things that I have just alluded to. In England, in particular, we are embedding these services within a broader children's hospital service setting to ensure that young people with autism, eating disorders and a range of other presentations have access to services, so that they get looked at holistically.

Moreover, with regard to the research and the clinical approach, which is going to be regionalised, there is, should the Scottish Government and the health service feel that it would be helpful, scope to include Scotland within the research infrastructure that we are setting up in England and in the regional network, where there is the ability to share and support clinical practice. Clearly, that is a decision to be made in Scotland; it is certainly something that I think we would welcome in England.

Tess White: I turn to my second question. In your answer to Ruth Maguire's question, you talked about the importance of the evidence base and collaboration. How do you feel about the fact that certain factions of the Scottish Green Party have said that your work is a "social murder charter"?

Dr Cass: I think that it is not for me to comment on any political opinion in Scotland. My job is just to comment on the evidence as I see it, but if those opinions were to be framed into specific questions or concerns about my conclusions or the work, I would be happy to answer them.

The Convener: Dr Cass, what key conclusions in relation to future provision for gender services would you want practitioners in Scotland to draw from the review?

Dr Cass: It is important that young people get a holistic assessment. That includes looking at all aspects of their presentation and trying to understand their gender questioning in the context of other issues that are happening for them. One of the problems in focusing only on gender is that you can end up putting somebody on an endocrine pathway when you have not addressed the fact that they have undiagnosed autism, they are out of school, they are not participating or there is family breakdown—all those other factors.

It is about seeing them as a young person first and understanding the gender distress through that lens, and, I think, accepting that two things are simultaneously true: first, that a small number of these young people will benefit from a medical pathway for their gender distress; and, equally, that for probably a larger number their gender distress will be resolved in myriad other ways—whether that is that it has been a developmental questioning period that spontaneously resolves, whether they resolve uncertainty about their sexuality and then their gender questioning resolves or whether they find that they do not want a very rigid medical pathway but just remain gender fluid or gender non-conforming in the longer term.

It is about being open, exploring and making sure that options are not foreclosed too soon for that young person. That is probably the single most important takeaway.

The Convener: Thank you for that answer.

Ivan McKee (Glasgow Provan) (SNP): Good morning, Dr Cass, and thank you for spending some time with us this morning.

You rightly mention that the evidence base is a hugely important part of the work that you have undertaken, and that has clearly gained traction in the discourse following your report. Will you talk through the approach that was taken in assessing that evidence, including the systematic review methodology, what evidence was included and what was not included as part of that assessment and why?

Dr Cass: The systematic review was carried out by the University of York, which is one of a small number of organisations that are commissioned by the national health service to carry out systematic reviews. It was overseen by the head of that department. It looked at a very wide array of papers—well in excess of 200 across all areas—but the papers that have got most attention are the ones that focus on puberty blockers and masculinising and feminising hormones; 102 papers were included in that search.

There has been significant misinformation about those papers. I hope that that has now been corrected in everyone's minds but, to be clear, incorrect information was being circulated that indicated that 98 per cent of the papers had been disregarded and that only randomised controlled trials were included. Both of those things are wrong. There were no randomised controlled trials. Two high-quality papers and more than 50 moderate-quality papers were used. Overall, 58 per cent of the 102 papers were included in the analysis, because they were of high or moderate quality. Those papers included a variety of different studies, mainly cohort studies, which follow up and compare groups or look longitudinally. Those studies are not randomised controlled trials, but they are still accepted as good evidence if they are conducted well.

The significant weaknesses in most of the literature—I apologise; I have a frog in my throat—was that the follow-up periods were not long enough; that there was significant loss to follow-up, so the studies started off with a larger sample and, because significant numbers dropped out during the course of the study, that made it hard to draw conclusions; and that the comparison groups

were not appropriate. The literature was very poor in comparison to most other literature, including in children's healthcare practice—that was quite striking. The evidence for the efficacy of puberty blockers and masculinising and feminising hormones was weak. We are still unclear about the potential adverse effects of that. I can say a bit more about puberty blockers if the committee would like me to, because that has been a source of contention.

Ivan McKee: We will come on to that in follow-up questions.

You have answered some of my supplementary questions as well. You have said, first, that the supposed statistic that 98 per cent of the evidence should be ignored is wrong and, secondly, that the evidence that was not included—it sounds as though that was a bit less than half of it—was not included because the methodological approach was not robust enough for the University of York's work. I was also going to ask how it compares to methodologies that are applied in other areas of paediatric medicine, but I think that you have answered that by saying that it falls significantly short of the literature that you would see in other areas.

I will move on to ask you about how we fill those gaps. What research is under way at the moment? Is it sufficient, and what else needs to be done? How long will it take for us to build an evidence base that allows us to address these questions more robustly?

Dr Cass: I will address the last point. There has been a question of whether we have set a higher bar for the research and our systematic review—we absolutely have not. These young people should get the same standard of evidence in their care as every other young person; that is the bar that we should set.

In England, a puberty blocker trial is being designed that will obviously involve service users. The lead investigator has been appointed and a group has started to come together to think about it. There will potentially be some international collaboration on that. I feel that we need every young person who walks through the door to, ideally, agree to be part of some kind of study and follow-up process, because it is just as important for us to understand what happens to the young people who do not go on a medical pathway as it is for us to understand what happens to those who do.

We need to understand what aspects of care, both medical and non-medical, have been helpful for the whole group. That would mean following young people into adulthood, including those who go on a medical pathway. Obviously, we cannot compel anybody to be followed up into adulthood and a lot of it is about rebuilding trust with young people so that they wish to be part of a study into adulthood to help the young people who are coming behind them.

09:15

Ivan McKee: That is great, thank you. Just to be clear, what questions would you hope that the research and future evidence would give us the answers to?

Dr Cass: We want to understand whether there is a small group of young people who do benefit from puberty blockers; we also want to understand what potential negative effects there might be on that, particularly for broader brain development and psychosexual and psychosocial development, as well as bone health and other physical health indicators. We want to understand more about which young people may benefit in the longer term from going on to masculinising or feminising hormones.

The real challenge is that young people's sense of self and gender identity continues to evolve into young adulthood and we do not have an accurate way of predicting who will have a long-term stable trans identity. The more we are able to be really clear about who has a successful long-term outcome and who has an outcome that does not meet their aspirations, the better our understanding will be.

We also need to understand what things matter in the longer term to these young people. It is not just about whether someone can successfully achieve a medical transition—we know that we can do that—but about how they are doing in the longer term. Are they participating—do they have a job, do they have a partner, are they happy with their sex life, are they happy, are they psychologically well? All those things are important.

Ivan McKee: So it would be about looking at physical and mental outcomes from a health perspective.

Dr Cass: Yes—and social outcomes.

Ivan McKee: And that research would look at people who chose to detransition at a future stage as well.

Dr Cass: Yes, and there has been anxiety about that. The trans community has been concerned that we are looking at detransitioners to say that we should not be giving gender-affirming care, but the important thing is to understand what factors led people to detransition. Were there earlier signs that it may not have been a successful pathway for them? You can then build those things into the equation and discuss them

with somebody coming through so that they know what the likely risks are for them as an individual.

It is the same as any medical intervention, where you look at somebody who has a less successful outcome and then explain that to people who want to undergo the same procedure to inform them about it. It is not about telling them that they cannot do it; it is about saying that these are the risks that we are aware of.

Ivan McKee: That is great—thank you very much.

Emma Harper (South Scotland) (SNP): Good morning, Dr Cass. Thank you for being here this morning. I am interested in the recommendation that young people should remain within the young people's service from the age of 17 to the age of 25. The recommendation says that NHS England should ensure that each regional centre has

"follow-through services for 17-25-year-olds ... either by extending the range of the regional children and young people's service or through linked services".

I am interested in hearing about how that recommendation means that those young people should stay under the care of the same service from the age of 17 to the age of 25 and how that would work in practice. I think that there has been some misrepresentation of the recommendation as meaning that no one would be able to transition before the age of 25.

Dr Cass: Yes, there has been a lot of misunderstanding about that recommendation as well, as you rightly say. We proposed it because it is in line with other aspirations that NHS England has for longer-term services for young people, including in the areas of mental health and cancer. It is about continuity of care.

The worst possible time to transfer services is when you are at a critical point in your gender transition, at around 17 to 18. We know that that is a high-risk time, when young people get lost between children's and adult services. There are problems in managing their medication through that period, and switching care providers is challenging. We also lose data at that time, which is an important issue if we are trying to get better long-term data.

The idea is to provide continuity for the young people who are already in the service. If you are already over 18 when you are referred, you would still be referred to existing services; you would not come through that follow-through service. At the moment, it is specifically being set up to take people who started when they were younger to give that continuity of clinical care and follow-up data.

Emma Harper: I want to pick up on what you said about the misrepresentation of that recommendation or other parts of the report. You talked about a holistic assessment for young people for the whole process. One of the comments that have been made is that the recommendation is based on "dubious science". Can you solidify for us your advice or your recommendation around having a whole process for young people right up until the age of 25?

Dr Cass: Sorry, but is the bit that you think has been said to be based on dubious science about having a holistic assessment?

Emma Harper: It is really about the wider recommendation on supporting young people right through the process. The information that we have says that it has been said to be based on dubious science. I would be interested to hear how that is one of the misrepresentations of the report.

Dr Cass: The misrepresentation was that, when we said that young people would not have to transition at that vulnerable time, we meant transition between services, and that was taken to mean that they would not have to make a gender transition at that vulnerable time. That was a misreading, because the term "transition" is used to describe the move from children's to adult care, as well as gender transition. It was taken to mean that we were saying that children should not go through a gender transition at that time, but that was not what we were saying. I think that the point came in a section headed "Service Transition", so that was a misreading.

I do not know whether that helps.

Emma Harper: It does help, actually—it shows the power of correct words. Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS general practitioner.

Thank you for joining us, Dr Cass. I have grave concerns about the use of puberty blockers for children, given the paucity of evidence and given that the early intervention study did not demonstrate benefit. I feel that ideology and dogma have no place in medical treatment. Given that you have stated that young people's gender identity is "fluid" and that there is "no hierarchy", do you feel that there is an age where it becomes more fixed?

Dr Cass: A study was released around the time that the report was in press that showed that gender discontentedness was relatively high from age 11 and continued to drop sequentially into the early 20s. It is really difficult to know the exact sweet spot when somebody's gender identity is not going to continue to change and the best time to commence an irreversible treatment.

We were quite struck by young adults whom we spoke to as part of the engagement process and

also through our qualitative research saying that they wished they had known that there were more ways to be trans than just via a binary medical transition and that one could be more fluid without necessarily having to go down a medical pathway, although some people will do that. They said that their main advice to their younger selves would be that this is not urgent and you do not have to rush, although they acknowledged that it feels urgent and that their younger selves probably would not have taken too much notice of their older selves. It is the dilemma that we all face.

Sandesh Gulhane: Certainly, the things that I believed when I was a child are very different from the things that I believe now, as are the things that I feel are or are not important.

In your report, recommendation 8 states that we should be looking to prescribe medication at 18, and recommendation 6 states that we need a trial. If medication were to be given below the age of 18, would it be appropriate for that to happen without parents' knowledge, or do you feel that 18 is the right point? Also, given your previous statement, why did recommendation 8 state 18 as the age?

Dr Cass: My remit does not extend beyond 18, and, as you know, a young person is considered to have capacity at 16, unless we have good reason to think that they do not. Therefore, as far as capacity is concerned, it is hard to make a legal distinction between a 16-year-old and an 18-year-old.

When I thought about consent, I considered that the challenge is not so much about capacity but about other elements, one of which is clinical judgment with regard to offering a treatment. As you know, we all bear responsibility for the treatments that we offer and for knowing whether a treatment is the right one for an individual. Another element is the information about risks and benefits that we give to inform consent; again, that is weak. Legal cases have obviously focused on competence and capacity, but those are the other challenges—the two pillars of knowing whether we are giving the right treatment to the right people.

Sandesh Gulhane: Gillick competence can mean from the age of 13 onwards, which is why I asked about parents, too. Can we use Gillick competence in this treatment pathway, and, if we can, should the parents be aware?

Dr Cass: The Tavistock avoided treating without parental consent and engagement, and everything that we know about outcomes in young people is that they thrive better with family support. I would have severe reservations about any child being put on this kind of pathway without a competent adult supporting the decision. The Dutch protocol, which the Tavistock was supposed to be adhering to in its service specification, specified parental support for such decisions, and I think that that should stand.

Sandesh Gulhane: I have major concerns about private treatment. Throughout your report, you talk about a multidisciplinary team approach; it is, in fact, mentioned in recommendation 9. In that case, should a single private practitioner be prescribing medication? Is it appropriate for that to occur?

Dr Cass: Like you, I have really deep concerns about private provision de facto; based on the recommendations that we have made, it will not meet the standard. I feel that it would put young people at considerable risk not to have the level of assessment that we are describing.

09:30

Sandesh Gulhane: I have a final question, Dr Cass, if I may. An important area is regret and detransitioning. What does your research show about the number of children who experience regret? Indeed, has it been able to show that? You have said that puberty blockers are irreversible, so what do we then do with children who face that issue?

Dr Cass: What we know to be irreversible are some of the effects of the masculinising and feminising hormones. We do not know the percentage of people who detransition or feel regret, largely because the follow-up has not been long enough and also because those who detransition or regret do not necessarily come back to the NHS and—[*Interruption*.] Excuse me—I think that I have a frog in my throat this morning. Often they do not come back to the clinic from which they originated, and it is a significant problem.

That said, I think that it is more subtle than that; for example, I spoke to a young adult who started transition very early from male to female. She is doing well—she had puberty blockers and feminising hormones at the earliest stage, and she passes very well as a woman—but with hindsight, she knows that she was a boy with intense internalised homophobia and was gay. At this point in her life, she is clearly not going to detransition, so she would not show up in regret or detransition data, but she thinks that it was maybe not the right decision to have made.

There will be people living a good life but who might, with hindsight, have made a different decision—that sort of thing is much more subtle. There are also people who are living their best life having gone through a medical transition, and for them, the costs and side effects of treatment are worth while compared to what it would have been like to have had to live their lives within their birth-

registered gender. It is really difficult for us to get under the skin of those sorts of subtleties.

Gillian Mackay (Central Scotland) (Green): Good morning, Dr Cass. Do you believe, and does your research show, that puberty blockers or gender-affirming hormones could be the right intervention for some children or young people?

Dr Cass: We think that masculinising and feminising hormones could certainly be the right treatment for some young people, but we do not know which young people those would be. In the case of puberty blockers, it is much less clear what the indication is. Would the convener like me to say something about what we do and do not know about puberty blockers and the various indications?

The Convener: Yes, please.

Dr Cass: To start with, we need to look at why puberty blockers were introduced. Previously, you would not start on a medical pathway until you were 16-plus. The consultant who moved into the Dutch clinic had seen poor outcomes in adult patients and felt that one of the reasons for that was that they were not passing, and that was having adverse psychological effects. Therefore, she reasoned that if you blocked puberty early on, you would not get the irreversible pubertal changes that birth-registered males get—that is, the facial hair, the voice dropping and so on—and which will always make it hard for you to pass. Secondly, she reasoned that it would buy time for people to think.

Going through those indications, I see no evidence that it does buy time to think, in that the vast majority of those who take puberty blockers then go on to masculinising and feminising hormones. It might be that it alters the trajectory and makes it less likely that, once you start, you will reconsider the options, because you have not gone through your own puberty or through that psychosexual development pathway.

The other aspects that have been looked at are whether they improve your body image and whether they make you less dysphoric. Nobody—not even the original Dutch study—has shown those things to be the case. The other question is: do they improve your psychological wellbeing? Although the original Dutch study found some weak evidence of that, the English study did not replicate that. Indeed, no other study really has, either.

That leaves us with one specific indication, which is that they might be helpful, particularly for birth-registered males in preventing those irreversible changes. However, one of the downsides of the focus on puberty blockers, which have become almost totemic as the way to get on to a treatment pathway, is that it has stopped us looking at other ways of managing young people's distress when they are working out the right pathway for them. As a result, we have not looked at known evidence-based treatments for anxiety and depression such as psychological support or medications for anxiety and depression that might be just as or more effective than puberty blockers. It is all about being really clear about what they are for and for whom.

Gillian Mackay: A range of trans organisations and people have said that the report's recommendations and the narrative surrounding it give the impression that transition would be the worst outcome for a young person. How would you respond to people who get that impression from the report?

Dr Cass: For somebody who is going to have an enduring long-term trans identity, medical transition is an important option and one from which many people benefit. The risk of starting that transition at a time when somebody is still developmentally labile—that is, still in the process of development—is that you give the treatment to the wrong group of people. That is a negative outcome, because medical transition does not come without costs to effect on sexual function and fertility, and there are knowns and unknowns in relation to long-term bone-health risk and the limitations of surgery.

All of those costs are well worth while if you have a long-term stable trans identity, but it is a high cost to pay if, in the longer term, you do not, and it is, as I have said, very important to find that sweet point where you have a high level of certainty that you are giving the treatment to the right people. The group that we have least understanding of is the group that we are most commonly seeing now in clinic, which is birth-registered females presenting in adolescence, for whom a range of other factors might be driving their gender-related distress.

Gillian Mackay: Thank you. I have a final question. You have mentioned research in your other answers. What, in your view, does good research look like in this area, and do you think that it is important that trans and non-binary people are involved in all stages in co-producing it?

Dr Cass: The answer to the second question is a straightforward yes. That is clearly built into any good research, and it will be built into this. However, we need well-designed studies with adequate follow-up and clear comparisons with other kinds of treatment options. That is what has been lacking from previous research. The team is already thinking about the most ethical and acceptable ways of doing that, and there will be very careful engagement with service users.

Paul Sweeney (Glasgow) (Lab): Thank you, Dr Cass, for your contribution so far. I want to look at the wider balance of harms. We have noted that the average wait from referral to being seen at a gender dysphoria clinic can often be more than four years. During that time, people may experience significant distress—physical, psychological and social—and they may self-medicate with hormone replacement drugs, although I am not sure how accessible puberty blockers are. Obviously, that can introduce unregulated harms beyond, say, the practice of bridging prescriptions. What observations do you have and what evidence have you seen about that broader behaviour of self-medication?

Dr Cass: We have not had any way of systematically understanding how much of that goes on but, clearly, it happens way more than we would wish.

As we all understand, that is driven by major shortfalls in children's mental health services. Young people are in a state of distress and anxiety. Often, they get no support for that or for any other aspect of their presenting problem, and advice is available only from the internet or from peer support groups. It is therefore inevitable that they will take actions that we would deem to be of higher risk. I can understand that, because, often, the care that is provided by the health system is failing them. That system failure is related to workforce and all sorts of other things.

Another big problem is fearfulness among healthcare practitioners. Those young people are more disadvantaged than other similarly distressed young people—certainly in England—because people have been bypassing them. When somebody says that they are gender questioning, health professionals feel nervous, because they do not think that they have the necessary skills, and they are worried about the toxicity of the debate and about doing or saying the wrong thing, so they pass them straight through to the GIDS waiting list. Consequently, those aspects that they would have been able to manage, because they have all the skills to do so, are not treated.

Paul Sweeney: Do you have any thoughts about how best to remedy that?

Dr Cass: That is starting already, in the new centres in England. There has been concern about starting that new service, but now that practitioners have started seeing young people, they are clear that those are the same young people that they see in other clinics.

It is about building confidence. When I was the registrar for the Royal College of Paediatrics and Child Health, some 15-plus years ago, we were really worried that we would not be able to recruit paediatricians, because people were so scared about safeguarding. It was catastrophic if you made an error in either direction—overdiagnosis or underdiagnosis—the research was poor, there were no guidelines and there was little training. We remedied that with much better research, much better guidance and really clear training and supervision. That turned things around and it became an interesting area of practice. That is what we want to achieve.

As I said, a lot of it is about building confidence, because professionals have the transferable skills and they just need to know that those are the same young people, with the same hopes, aspirations and anxieties as most of the rest of the people in their clinics.

The Convener: Dr Cass, in your response to Paul Sweeney when he asked about unregulated access to hormonal treatment or to puberty blockers, have I picked up correctly that you were saying that it is happening way more than we would wish that children and young people are accessing those medications in an unregulated way?

09:45

Dr Cass: Yes.

The Convener: Thank you. I was just seeking clarity on that point. I call Ivan McKee.

Ivan McKee: I have covered all the issues on research follow-up when I asked questions earlier.

The Convener: We move to Carol Mochan.

Carol Mochan (South Scotland) (Lab): Dr Cass, I want to explore the approaches to gender care for young people and the move to what you have described as the gender-affirmative model, which is the dominant model of care. You have talked about clinicians feeling pressure to simply affirm children and that that could lead to diagnostic overshadowing; for example, you have spoken about mental health issues that have been missed. How would a conversion therapy ban affect that situation? Could you advise how we might go forward with a ban to ensure that we give children protected time to consider things?

Dr Cass: That is a big challenge. All that I can say is that I am glad that I am a doctor and not a litigator, because it is a really difficult problem.

Everyone should be protected from conversion therapy. It is a completely unacceptable practice. In thinking about legislation, however, the issue has been intent. If a therapist engages with a young person and that young person changes their views about their gender identity during that therapeutic relationship and they subsequently say that that was because the therapist had an intent to change their gender identity, that puts the

therapist in a difficult position, because how can someone legally determine intent? The anxiety that they might become the test case for that is making clinicians even more anxious about working in this area, and we do not want to do anything to frighten off professionals from working in it. Walking that path is very difficult.

The only thing that I would say is that no credible professional body would support conversion therapy so if any practitioner is deemed to be practising conversion therapy, that should, in the first instance, be a matter for their professional regulator before it would be a legislative issue.

However, I do not know how we get that balance right of protecting people from conversion therapy and not frightening therapists who are just doing their job by having an appropriate exploratory conversation with a young person.

Carol Mochan: Thank you. That is one of the issues that we need to get right for both clinicians and young people.

I wonder if you could you give us a little information. One thing that has interested us is people presenting at the clinics who are same-sex attracted and how we make sure that there is that space for those young people. You mentioned a case earlier in which a person reflected on what had happened to them in that regard. If I put that issue in the context of a conversion therapy bill, do you think that we need to take that apart and look at having a bill that deals with conversion therapy in relation to same-sex attraction and trans identity? Should we consider doing that?

Dr Cass: I think that we need to. A very high percentage of these young people are same-sex attracted, so you can see how the two things could get conflated.

It might have been naive, but one aspect that I was surprised about when I was conducting the review was how much homophobia and transphobia still exist. We have to support people to enable them to express and understand their sexuality as well as their gender identity.

Carol Mochan: My final question is on a point that was raised with the committee, which was about including someone with trans identity in the review team. Did you consider doing that?

Dr Cass: I am sorry; could you say that again?

Carol Mochan: Why were no trans people included in the review team?

Dr Cass: The review team was very small—there were only four or five people in it. We did not specifically exclude trans people from the team, but none applied. It is hard for a person on a team to be what might be seen as a tokenistic representative of the whole community.

However, we ensured that we had wide engagement. Every four to six weeks, we spoke to the main trans advocacy groups. We also had listening sessions with service users, 18 focus groups with young people, round-table meetings with support and advocacy groups, and qualitative research that took account of both young people's and young adults' experiences. Further, we consulted internationally. Therefore, we made every effort to incorporate service users' voices as broadly as we could.

Carol Mochan: That is really helpful. Thank you very much.

Ruth Maguire: Dr Cass, I wonder if I could go back a little. You spoke about professionals' fearfulness of discussing this area. In answer to my colleague Carol Mochan's questions on conversion and on professionals having space to explore options with children and young people, you said that research, guidance, training and supervision were the answers. Do you want to add anything further? I know that you will have had personal experience of the heat and noise that surround this topic.

Dr Cass: One of the challenging aspects for the Tavistock and the GIDS is that they were a single provider. It is difficult whenever there is a single provider that is not peer reviewed, and which does not have the ability to share practice with other centres. That is why we are setting things up in England so that there is a single national provider collaborative, in which such centres can come together, as an overarching structure, to support all the regional centres. The idea is that it does not matter whether someone walks into a service in Birmingham, London, Newcastle or wherever else; they will get the same standards of care and the same decision making. That also means that clinical guidance and training can be shared, the research works across the sector and, importantly, those centres can share data, through a shared data set that works across them all. That was why I said that if there were to be interest from Scotland in a centre here becoming a regional one, that might work, although it might not be physically close. I cannot speak for NHS England or about the formal governance of such an arrangement, but I am sure that the prospect of being able to share practice would be welcomed on both sides.

Sandesh Gulhane: Dr Cass, I know that adult services were outside the scope of your review, but you mentioned them in your report. At paragraph 19.31, you stated:

"There was an expectation that patients would be started on masculinising/feminising hormones by their second

appointment, which was a cause of concern given the complexity of presentations."

Did your research show anything similar for children's services?

Dr Cass: I know that, in the past, some children and young people have started on treatment relatively quickly. There was variability across the various teams within the GIDS, but that was certainly not supposed to be the way that things operated. Certainly at the latter stage, there was more careful control to make sure that it did not happen.

A number of people from adult services spoke to me about their concerns, and that comment was part of their feedback to me. Given that they were seeing the same sorts of young people moving through, with the same complexities of presentation, they had clinical concerns about having to make such decisions so quickly.

Ash Regan (Edinburgh Eastern) (Alba): Good morning, Dr Cass. I want to pick up on a couple of areas that have already been discussed. The first is about the cohort of patients. The data shows a huge and quick increase in birth-registered females, the majority of whom are same-sex attracted. That is a very different cohort from the one that was considered in the earlier studies. Also, the new cohort's presentation is much more complex. You have suggested that care should routinely include, for instance, screening for neurodevelopmental conditions. Will you tell us a little bit more about the change in the cohort, the extent to which treatments had been based on the previous one, and the potential risks around that?

Dr Cass: You have summarised it exactly. As I said, the existing research on the previous cohort is weak, and that on the current cohort is even more limited, so we cannot make any assumptions that the original puberty blocker studies can be read across to this group.

It is important that we consider the newer presenting group in the context of what is happening to adolescents in gen Z more widely. We know that there are high rates of depression and anxiety among them. They have stresses that previous generations did not have when they were growing up, in the form of social media and the expectations on young people that arise from early exposure to pornography. We do not understand what any of those factors might do to how their distress might be presented. For some young people, such distress, or the feeling that they do not fit what they perceive to be the expected gender norms, might manifest itself through questioning their gender identity. That is why we really have to take this as a new cohort, not rely on the previous research, and work with young people to help them to unpick all the factors that might have led to such gender distress.

One aspect that has been somewhat lost in the debate is that there is a really close mind-body interaction—in the relationship between mental health and how people physically manifest it. Unpacking that is really complex and difficult, and it has to be done very carefully.

Ash Regan: Thank you. I have a question on detransitioners, if I may.

The Convener: We must close, I am afraid. We need to finish this part of the meeting by 10 o'clock.

Thank you for your attendance, Dr Cass, and for the information that you have given to the committee. I am sure that it will help us in our further inquiries when we have other interested parties along to speak to us in the coming weeks. Thank you for your time.

09:59

Meeting suspended.

10:06

On resuming—

Food Standards Scotland

The Convener: The third item on our agenda is an evidence session with Food Standards Scotland. I welcome to the committee Heather Kelman, chair; Geoff Ogle, chief executive officer; and Dr Gillian Purdon, chief nutritionist—all from Food Standards Scotland. I invite you to make a brief opening statement.

Heather Kelman (Food Standards Scotland): Good morning, convener, and members of the committee. I know some of you quite well, but I recognise that the committee membership has been refreshed since our attendance in January last year, so I will take a couple of minutes to introduce us and the work of FSS.

In addition to Geoff Ogle and me, and recognising that the committee is very interested in diet and health, we are joined by our chief nutritionist and head of our public health nutrition department, Gillian Purdon, who some of you might already know.

Food Standards Scotland was established in April 2015, under the Food (Scotland) Act 2015, as the new public sector food body for Scotland. We are a non-ministerial office of the Scottish Administration, independent from Scottish Government ministers and from industry, and accountable to the Scottish Parliament.

Our three key objectives are: to protect the public from risks to health, which may arise in connection with the consumption of food; to improve the extent to which members of the public have diets that are conducive to good health; and to protect the other interests of consumers in relation to food.

FSS is Scotland's independent public sector food body, and we collaborate closely with the Scottish Government, Public Health Scotland, the Food Standards Agency, the Department for Environment, Food and Rural Affairs, the UK Health Security Agency and food businesses in Scotland to represent Scotland's interests in food-related issues at home, at UK level and abroad. Our purpose is public health protection.

We have an annual budget of £22.7 million which, apart from an injection of £7 million to deal with the consequences of leaving the European Union, has remained unchanged from our original allocation in 2015 of £15.7 million. Seventy-six per cent of our budget relates directly to staff costs. We employ around 290 staff, which is a decrease of approximately 26 staff since our report last year.

Approximately half of our staff work in operational settings, such as abattoirs, where they give direct oversight to food production and ensure that food and animal feed are safe and compliant with food legislation. Our other staff work to develop—and help others develop—policies on food and animal feed. They advise the Scottish Government, other authorities and the public on food, feed and public health nutrition; they provide guidance to the Scottish public and users of animal feed to help them make informed decisions about food and feedstuffs; they investigate and disrupt criminal activity in the food supply chain; and they monitor the performance of food enforcement authorities.

Our annual report and accounts were laid before Parliament last November and summarised our performance for 2022-23. It was a period of challenge, in which we continued to address the knock-on effects of the UK's exit from the EU and to reset our priorities, as inflation, increasing demand and a fixed budget made it essential for us to focus on the key areas of work for FSS.

I commend the involvement of our staff in developing clarity and a vision of the way forward for the organisation. That work will continue, as we recognise the need for the public sector to be as efficient as possible and to seek further opportunities to modernise and make best use of emerging technology.

Last year, we also published our second joint report on food standards, "Our Food 2022", in conjunction with the Food Standards Agency. I am pleased to inform the committee that the third report will be available next month. It is a data and evidence-based annual status report, which tracks the safety and standards of food in the UK and aims to ensure that consumers and parliamentarians remain sighted on the main changes and threats to our food system.

Since we last met, the FSS board has approved a new public health nutrition strategy, which is designed to deliver our statutory duty to improve the extent to which the public have diets that are conducive to good health in Scotland. We have engaged with a wide range of stakeholders to develop the strategy and encourage collaboration and a drive towards improved nutritional health in Scotland.

As part of our work to protect consumers from food safety risks, we also created a new online allergen training tool to support food businesses and give their staff a better understanding of food hypersensitivities. We delivered a number of risk assessments on various food products, on issues such as listeria in smoked fish and blue cheese, and updated our advice to the public on safe consumption of those foods.

In response to a request from the minister for advice on the diet-associated recommendations from the Climate Change Committee, FSS commissioned research from the University of Edinburgh. That research has been widely acclaimed, and I believe that we might discuss it a little further during today's session.

Other consumer-facing campaigns included: the promotion of the risks of campylobacter to vulnerable groups; the campaign to promote the consumption of vitamin D supplements; and a farm incident prevention campaign, to protect livestock from the deadly consequences of lead poisoning.

The year ahead presents both challenges and opportunities for FSS. The shortage of vets across the nation continues to challenge us. We are working closely with all relevant bodies to find longer-term solutions, but the short-term measures to fill the gap are not only financially costly; more importantly, they cause stress for our existing staff.

The capacity and resilience of the food law enforcement regime remains compromised. Local authorities continue to have difficulty filling vacancies. An increasing workload, when councils have significant budget challenges, has placed local authority environment health teams in a precarious position.

The need to modernise our food law enforcement system continues to be a priority, and we have been working hard to find a source of funding to finance a transformation in food law enforcement. In the meantime, to minimise the risks, we remain in close contact with our local authority partners.

I think that I have said enough by way of an introduction, and do not wish to take up any more of the committee's time. I look forward to our discussion this morning.

The Convener: Thank you, Ms Kelman. We move straight to questions.

Emma Harper: Good morning to the witnesses. From what you have just described, Food Standards Scotland's remit is pretty huge and broad-ranging, and I am really interested in the work that Food Standards Scotland does on a range of issues, as you know.

I will come on to issues around ultra-processed foods in a wee minute but, first, I will talk about the University of Edinburgh's research and recommendations on red meat consumption. We keep hearing about beef being really bad for the climate, and I worry that our farmers in Scotland are condemned for beef production, although they do it really well. Scotland is just a wee country that, compared with China, the USA and Russia, has really low carbon emissions.

I am interested in hearing about the recommendations for a reduction in red meat consumption. To achieve a 20 per cent reduction in the average intake, the previous recommendation of no more than 70g a day has been reduced to no more than 60g a day. There are a lot of figures around that, so I am interested to hear what consideration Food Standards Scotland has given to the findings from the University of Edinburgh's research into recommendations for reduction in red meat consumption.

10:15

Geoff Ogle (Food Standards Scotland): That is an interesting and complicated subject. To be clear, we focused on risk assessment and were asked by ministers to look at the dietary implications of the Climate Change Committee's recommendations. Risk management decisions about where to go with that and what should happen will rest with ministers, who will want to consider a range of other factors and will take the economy and societal attitudes into account.

We primarily looked at the health and dietary implications of the Climate Change Committee's recommendations. Meat and dairy are important sources of protein, so the issue was the effect that any reduction in current intake would have on people's diets. The intakes are based on the "Eatwell Guide" and the 70g figure comes from that guide. Our general observation was that there is no doubt that the committee's objectives could be described as stretching or challenging. We are currently some way off hitting the Scottish dietary goals and if we are not hitting those current targets, it seems unlikely that we will hit more stretching targets in the future.

You also have to understand the social and behavioural science around that. It is all right to say that we must reduce our intake at population level but, within that, there are different behaviours from different parts of the population.

It is not for us to say what the impact might be, but I have already mentioned behaviour. If Scotland unilaterally reduces the target figure but does not do anything to change behaviour, so that people are still consuming, we will import more than we are producing and we will not actually solve the problem. Those are the sorts of things that ministers would have to consider as part of a wider process of making conclusions based on our risk assessment.

Dr Gillian Purdon (Food Standards Scotland): I can talk about the existing recommendations. As Geoff Ogle said, Scotland

has a set of dietary goals, one of which is about red meat and processed red meat. The goal is for high consumers to reduce from 90g to 70g. The modelling focused on high consumers. If we brought people with high consumption of red meat and processed red meat down from 90g to 70g that would lead to a 16 per cent reduction in meat consumption, which would go quite far towards meeting the Climate Change Committee recommendations. That is what the modelling showed.

As Geoff said, because our overall diet is very poor, any reduction in really rich sources not only of protein but of vitamins and minerals, such as red meat, would have to be replaced with the right type of protein or we will become micronutrient deficient. There is quite a lot of risk to the population if we do that across the board, so we have focused on looking at existing recommendations and bringing everyone into the 70g limit.

The reason for the recommendations is to do with colorectal cancer risk, which we were able to look at when we did the modelling. That is much more difficult to do for dairy, so we do not have any recommendations for reductions in dairy consumption. Dairy is important within the diet—in fact, it is quite protective—and there are no health benefits to reducing dairy consumption, so we did not make any recommendations to reduce dairy.

We looked at the existing recommendations for meat, which is one of the only dietary goals that we are actually meeting. We do not meet most of the others but, at population level, we are under that 70g level, although there are obviously sub-parts of the population where consumption is above that.

Emma Harper: There are alternatives to meat. I looked up what 70g means. A plate of spaghetti bolognese has about 100g of meat; a quarter pounder beef burger has 90g. I was trying to work out what that all means. A full Scottish breakfast can also have about 90g, so you get your whole daily recommendation in one meal. However, if you were vegetarian for the rest of the week, that might be acceptable.

I am interested in how we support people to replace red meat with things such as eggs, legumes and other vegetable options to give them the nutrients that you talked about. What could Food Standards Scotland do to recommend alternatives to people?

Dr Purdon: As has been mentioned, we provide advice through the “Eatwell Guide”. We have a model diet for a week, and the amount of meat in that is well below 70g a day. As you said, people can have more meat on some days and no meat on other days—it balances out across the piece.

As far as replacements are concerned, things such as beans and pulses are cheap and readily available in the shops. Over time, consumers have been purchasing less meat, but we think that that is more to do with the cost of meat rather than anything relating to health. When it comes to alternatives, rather than going for ultra-processed meat replacements, it is a case of opting for alternatives such as beans, pulses, fish and eggs, which are widely available in Scotland.

Heather Kelman: I will add a little to that. On our website, we have a tool called “Eat Well, Your Way”, which gives advice to individual consumers on how to nudge their diet closer to the “Eatwell Guide”. That gives people practical advice on how to change their diet and move it towards what is set out in the “Eatwell Guide”.

The Convener: I point out to our witnesses that they do not need to do anything to make the microphones work—broadcasting staff do that.

Emma Harper: I am conscious that there is loads to cover, but I want to focus on ultra-processed foods.

Henry Dimbleby and Jemima Lewis were co-authors of a book called “Ravenous”. Recently, Henry Dimbleby gave a presentation at the shaping the science for the Scotland’s food future event at Dynamic Earth. It was really interesting to hear him talk about his research and his work on a proposed food strategy.

We know that the food system is really complicated, but is it a good idea to replace Scottish lamb and Scottish beef that are produced to high welfare standards with meat replacements containing chemicals such as stabilisers, emulsifiers, xanthan gum, guar gum, colours, flavourings and stuff that has been labelled as “industrially created enteric substances”? Is that really food? Given that we produce meat to the best welfare standards, I would be interested to hear your thoughts on replacing that with ultra-processed food that has unpronounceable chemicals in it, and how that links with, for example, the issue of the high levels of fat, sugar and salt in food.

Heather Kelman: Gillian, do you want to take that to start with, or will I?

Dr Purdon: Go on, Geoff.

Geoff Ogle: There is a lot of debate and discussion about ultra-processed foods at the moment, and the board discussed the issue in March. It is a nuanced and complicated subject. I think that it is important to separate the issue of quality from the issue of safety. Anything that is used in food, whether it is an additive, an emulsifier or whatever, must go through a pretty rigorous risk assessment and must be approved—

it must be shown to be safe before it can be used. That is a separate issue from your point about the quality of food that is being consumed.

As the board paper said, a lot of high fat, salt and sugar foods are ultra-processed foods. Therefore, if someone is concerned about ultra-processed food, by eating less high fat, salt and sugar food, they will, by definition, be eating a lot less ultra-processed food. However, it is a bit more nuanced, because of the way in which the definitions work. For example, steak is not an ultra-processed food, but having it every single day presents some health risks, such as colorectal cancer and everything else that Gillian Purdon has just mentioned. Also, certain types of food, such as vegan foods, require a degree of processing.

Heather Kelman can speak on behalf of the board but, for us, it is about the focus on high fat, salt and sugar, because that is where most of the ultra-processed food does not support a healthy diet and, in fact, does the reverse. That is the issue with UPFs. However, if you focus on high fat, salt and sugar, you will reduce your UPF intake.

Dr Purdon: The classification of ultra-processed food comes from the Nova classification, in which there are four different groups. The first group is unprocessed—your red meat, for example, would be one of those. Then, you have processed culinary ingredients, such as oils. You then have processed foods, such as plain tins of beans. Baked beans fall into the ultra-processed group, because you look at the label and see lots of different ingredients, which tends to be one of the elements.

When that system was developed, however, it was not based on nutrients but primarily on processing. Evidence is emerging that those ultra-processed foods might be detrimental to health, but we are not able to ascertain where that could come from. Is it an element to do with the processing? Is it an ingredient? That is not clear at the moment.

We will look at the evidence base. We asked the Scientific Advisory Committee on Nutrition to review the evidence base, which it did, and it will keep it on its horizon scan. However, at the moment, there is not enough evidence to support a change in policy around ultra-processed foods—that is not to say, however, that that could not come in the future. We will certainly ensure that we keep our eye on that emerging evidence base.

As Geoff Ogle has said, where we have sufficient evidence is around high fat, salt and sugar food—we know that it is bad for us and we know the different mechanisms. Reducing consumption of that type of food in the population would be a really big effort. We know that about 15 per cent of our calories come from those types of food. They are pervasive in everybody's diet and we know that a lot of them have little benefit but do a lot of harm. Instead of being distracted—if that is the right term—by the UPF debate, it is important that we keep focused on the evidence base.

Gillian Mackay: I think that Emma has covered most of what I was going to ask. Given the sort of issues that we have just covered around nutrients and reducing recommended amounts of meat by 20g or other amounts, and that a lot of evidence is coming out about how diet could change with climate recommendations and so on, how does Food Standards Scotland approach communication around some of that? There is the "Eatwell Guide", but there is no guarantee that some of the evidence that comes out over the next period will not impact some of its recommendations.

The matter is quite nuanced. It might be for higher consumers, rather than for everybody, to reduce. There are potential knock-on impacts for groups that could be more affected by some of those changes than others, such as those in the lower ranges of meat consumption—there is a lot in that question, too. How do we approach that information environment as a whole? How do we ensure that we take in some of those underrepresented and potentially vulnerable groups in doing all of that?

Heather Kelman: One of the things that Food Standards Scotland has become very aware of is that we must understand the targeting of messages. Our corporate communications department has been looking closely at how we use social media to get certain messages to particular target groups. We have just talked about the food safety issues and, for example, certain groups really should avoid eating raw smoked fish. We have become much better at understanding the groups that we need to target and addressing the messages directly to them as much as we can.

At the board, we addressed the fact that that message would be very complicated to get out—obviously, for young females to reduce their meat intake further if they are already at 50g or 60g could be quite detrimental to their health. We have to be very careful, therefore, about how we nuance that message. We do not yet have all that detail, but it is clearly stated that we have to think carefully about messaging, targeting and focusing on the right groups.

10:30

Our team analysed lots of data on food eating patterns. The research that was done by the University of Edinburgh drew to a great extent on our Intake24 survey data, which let us know

exactly where those groups were. We are using evidence to focus and target for future messaging but, yes, it will be a challenge. We await the final recommendations.

Geoff Ogle: We have also looked at the design of our website. We have done quite a lot of research on how it is currently structured and what changes we can make to it—partly to get a better differentiation between consumer needs and business needs, both of which we support. That is one of the challenges.

Another thing that we need to work on, and which works in our favour, is that, in our biannual consumer tracker, levels of trust in FSS are pretty high, at about 78 per cent. In Government terms, that is pretty good—I just thought I would get that in. [*Laughter.*] Particularly over health and diet, there is so much coverage that it is easy for people to take up mixed messages or get the wrong message. Given that we are a trusted source, we need to make it easy to find the information. That is some of what we are doing on our website. Another thing, which is part of our communications strategy, is how we can work with other organisations and use them to get our messages across.

It is one of those things: there is no right answer, and you just have to keep developing it as attitudes and means of communication change and develop.

Dr Purdon: Particularly when it comes to diet, there is a big say-do gap. For example, although a lot of people know the message around five a day—the number of portions of fruit and veg that we should eat—people do not do it; and the question is, why? That can be about resources but it is also about looking at the food environment where we live, and making it easier for people to get and eat a healthier diet. There are a lot of big challenges in that. It is about not just communicating directly to the consumers but doing things in the background that facilitate those changes as well.

As Heather Kelman said, our Intake24 dietary assessment tool is integrated into the health survey, every three years, which is fantastic. That now gives us the ability to track over time, which we have not had before, and to look at different population subgroups.

We also have a survey of children going on at the moment, which I can talk to in a bit more detail if that would be helpful, so we will be able to look at what children are eating, which has been a big gap for us for quite a long time.

Sandesh Gulhane: I declare an interest, in that I am a practising NHS GP. I am a bit disappointed to hear that the issue of a reduction in red meat is due to the climate report, not simply to a discussion about healthy eating. I was glad that Dr Purdon eventually spoke about the risk of colorectal cancer. Ultimately, we need to eat a wide and varied diet, with a rainbow plate; one portion of red meat a week; far more fish; and far more vegetables.

I am also glad that Dr Purdon mentioned the food environment, because that is what I want to speak about. I have heard that all branches of Greggs are approximately 200m from a school. Is that accurate?

Heather Kelman: We have not looked specifically at Greggs. We have raised concerns about the proximity of high fat, salt and sugar food outlets close to schools, and the need to look at planning legislation to ensure some control over that, but we have not looked at Greggs per se.

Because you have brought up Greggs on its own, I will say that what is challenging for me is that, according to evidence that I have seen about a branch of Greggs that is based in a hospital—Greggs won a contract to be one of the shops in the mall of a hospital in the north of England—the company is capable of producing a very healthy range of foods when that is in the contract.

It is possible for such outlets to offer a broader range—a rainbow of foods, as you so rightly described—and to encourage people not just to go for the pastries and other foods high in salt, sugar and fat. I would like to see the food environment change and food businesses taking more responsibility for offering the public the range of healthy foods that we require.

There is a real cultural issue with how we in the UK and Scotland view food. We have become more focused on refuelling rather than on the social and mental health benefits of eating a proper varied diet. It is not just physical health that can gain from this, but emotional and mental health.

The areas around schools are particularly vulnerable. We should make sure that a full range of food outlets is available around schools.

Sandesh Gulhane: I will come back to schools. I do not particularly want to start banning things, but let us look at a meal deal from a supermarket. You get a sandwich, a drink and something else for a set price. I do not know many people who would choose a single banana over that massive chocolate bar. If we just look at value, a single banana in Aldi is 16 pence but the chocolate bar is £1-something, so people will go for the thing with value. Should we not be encouraging the supermarket to give that single piece of fruit, which has a very low value to the supermarket, free with that meal deal, regardless of what else someone is choosing? Maybe the person would choose to

eat the fruit instead of the chocolate and save that for later and maybe not even eat it.

Dr Purdon: I am happy to come in on that. At the moment, the Scottish Government is consulting on restricting promotions of foods high in fat, salt and sugar. The consultation closes later in May so there is still time to respond to it and I encourage everybody to do so.

Part of that consultation is looking at meal deals—that is not incorporated within the English legislation—and, as Dr Gulhane mentioned, whether unhealthy foods that are high in fat, salt and sugar should be allowed to be sold as a meal deal. That is part of what the Government wants to look at.

There are also things such as unlimited free refills and other things that encourage us to have more food that is high in fat, salt and sugar than we might have otherwise. Dr Gulhane absolutely right. When it is a meal deal, it is tempting. You are on a budget and you want to get the best value, potentially. That is something that the Government wants to address.

From our evidence, we know that those types of foods—what we would call the discretionary foods—contribute significantly to our diets and we really need to rebalance that. We need to make healthier foods more appealing and economically viable, so that people who are on lower incomes are more able to purchase the healthier types of food and are not tempted towards unhealthy foods.

Sandesh Gulhane: On that point, the supermarket knows everything about me through all my cards. I do not know, but they might even track the way that I walk through the supermarket. What we do know is that the most valuable spaces are the shelves that are at eye level, the end-of-aisle shelves and what you see when you walk in. Again, if you look at a Lidl or Aldi, it is fruit that you come to first, which is not always the case. In a lot of other supermarkets, you come first to that high-sugar content. Should we be looking at legislation or other ways of making sure that healthy foods are in the premium places rather than unhealthy foods, which I think is the case right now?

Dr Purdon: Yes, that is a good point. The legislation is looking at restricting putting unhealthy foods in position points such as checkouts, the ends of aisles and other key points. I would favour going further and saying that that is where we need to position the stuff that we need to rebalance. I do not think that the consultation is going that far at the moment, but we have spoken to Ms Minto about having a piece of legislation that can be built on to encourage things to go further. This is the first step towards restricting where unhealthy things are.

Geoff Ogle: I would just add that there is a broader question around the food environment. You are absolutely right about the placing of product; there is no doubt that it is influential. We have now got some pretty good evidence, for example, around the introduction of the sugar levy, which the UK Government introduced not as a revenue generator but in order to encourage and speed up reformulation.

There is evidence that says that introducing policies around reformulation and backing them up with a fiscal measure works. Coca-Cola now sells more of its Diet and Zero versions than it does of its full-sugar version. People can get cans of soft drink with no calories or very little sugar, but then they buy a pasta sauce with five, six or seven teaspoons of sugar in it. Why is there a sugar levy on soft drinks but not on other food products?

There is a broader reformulation question. In a way, the placement of the product takes advantage of the fact that those products can be produced in the first place. If you introduce policies around reformulation—so that producers reduce the calorie content and the high levels of fat, salt and sugar—and tackle product placement, there will be a much healthier food environment in the first place.

Sandesh Gulhane: Certainly, a lot of people who speak to me say that Irn Bru has been ruined by reformulation. [*Laughter.*]

This is a big topic and it is not fair to give you just one question on it, but I want to ask you about school meals. We need to see big healthy choices for school meals, and they should be encouraged over other types of food. Do you feel that the best place to start is with very young children in nurseries, where teachers possibly have the time to introduce different flavours and tastes to children who might never have experienced that type of food? Teachers could help them to make those choices as they go through the school environment, so that the children actively make the choices.

Dr Purdon: Recently, the scientific advisory committee on nutrition has put out new recommendations for one to five-year-olds, and we are currently working on that with Public Health Scotland and the Scottish Government. That Scottish Government-led piece of work on guidance for one to five-year-olds, which covers nursery provision, will incorporate the new scientific evidence and make sure that that plays through. We hope that that will be published later this year, and it will be incorporated within the guidance for nurseries. Those types of things are all being considered as part of that review.

School food has requirements for fruit and veg and, in the primary school setting, it works really

well. As Dr Gulhane alluded to earlier, at secondary school, there are more challenges because there can be a proliferation of outlets around the school. That is where the national planning framework 4 comes in, because that can help stop the opening of new outlets. However, existing outlets will remain. To tackle that issue, we are working with the Scottish Government and Public Health Scotland on an out-of-home action plan, and part of that is an eating out, eating well framework. At the moment, about 50 businesses are in a pilot scheme that is looking at implementing a number of different aspects, so that the food that they provide is healthier and more sustainable. We are looking at improving provision within existing outlets, and the framework is there to consider the proliferation of new outlets and make sure that they are not all unhealthy. Not all outlets are unhealthy but, when children are at the age when they can leave the school site, we need to create that healthy food environment, not just in the retail environment but in the out-of-home environment.

Emma Harper: I have a wee supplementary question. One of the questions in the Scottish Government's consultation was about restricting the sale of foods with high levels of fat, sugar and salt within 2m of the checkout. What Sandesh Gulhane said about product placement in supermarkets is valid. There are challenges for us in Scotland when it comes to marketing and advertising; we cannot control what Ofcom does about advertising on television, because that is a reserved matter. However, with regard to supermarkets, we can certainly advocate for restrictions on product placement at the end of the aisle or within 2m of a checkout. Is that something that we could support?

Dr Purdon: As far as I am aware—yes—we can absolutely support that.

Geoff Ogle: However, we also need to look at the overall retail sector, not just the big supermarkets. If we look at the proportion of food that is bought in local, smaller shops, there is a general issue around the food environment that we need to consider. That does not mean that those smaller businesses should not be included or looked at, but we might need a slightly different answer—giving them more time to comply, for instance. When we are talking about the food environment, that should not just concern big retail; we need to ensure that we cover the whole area.

10:45

The Convener: We have a lot to get through in the next 45 minutes, so I ask members to keep their questions short and to the point. I ask the witnesses, please, to be a bit more concise with answers.

Paul Sweeney: The supermarket distribution and wholesale system is a huge influence on food consumption behaviours. A large part of that is not necessarily to do with poverty in the financial sense but is about time poverty. People are increasingly thinking at the margins, and single-occupancy households pick things that are convenient to make late in the evening or whatever.

Would you be able to provide retailers with guidance on product bundling, which could help them to package or offer more healthy options for people. There has been significant progress in improving the density of Scottish supply-chain products in supermarkets. Aldi is currently the leader, with 25 per cent Scotland-sourced products. It would be interesting to know more about that.

Companies such as HelloFresh are providing people with immediately ready kit for making nutritional meals, but are quite expensive: it is a high-end offer. How can we make that a more normal choice and use it as a way to seed supply-chain density in Scotland?

Dr Purdon: That has been considered in the Scottish Grocers Federation healthy living programme. We have recipe cards that assume that people will shop at smaller local shops, perhaps in more deprived areas. There could be provision of such recipe cards with, potentially, savings on bundles of ingredients. I do not know how easy it would be to do that with bigger retailers, but we could consider it for the future.

Geoff Ogle: There has been a bit of a market shift. Demographics come in, too.

Greggs was mentioned earlier. We can think about lunchtime offers, for instance, with meal deals that contain fewer than 600 calories. There is something about how retail taps into social demand; there is a question whether retail or consumers create social demand, which can get a bit murky and complicated.

It is demonstrated that such things can be done; the question is whether they are being done enough and in an affordable way. That is where the challenge is. There is definitely a perception that eating more healthily costs more. To a degree, it does. There is a question to be asked about how we can tap into calorie consciousness in a way that is affordable for the full range of the population, and not just for those who have sufficient income.

Paul Sweeney: We have seen the development of food pantries, particularly in urban areas, which have been a really positive thing in recent years. I

declare an interest as a trustee of the Courtyard Pantry Enterprise in Glasgow.

I am interested to know more about efforts to co-operate with local authorities on turning more parkland over to cultivation. One of the big challenges that has arisen from local government budget cuts in recent years is the collapse in finance for urban parks. In Glasgow, the budget for parks has gone down by, I think, 80 per cent over the past decade. Is there an opportunity to promote greater agricultural use of urban parkland, which could allow councils to reduce budget pressure from maintaining what have traditionally been manicured landscapes?

Heather Kelman: That is a little bit outside our remit, but that does not mean that we are not highly motivated to contribute to good food nation planning. It sits very much within the good food nation plan to ask councils to consider what opportunities they will have in the future to re-engage the public with growing food and producing food for themselves. In considering what a good food nation looks like, that is part of the vision of what we want to create for Scotland. Will we have more opportunities for community gardens and community production?

Paul Sweeney: I will touch on public procurement. It has been mentioned in relation to school meals and so on, but how engaged are you in decision making around public procurement of food, its quality and supply-chain design? Is that something that you take an active role in, or is it more the case that you provide guidance? I am curious about how you operate in that space.

Geoff Ogle: Public procurement is not generally an area in which we lead, but we provide support and evidence. Gillian Purdon spoke about work that is being done in relation to school meals. We contributed to a review of school meals, which is a fairly big area of public procurement.

However, we would not lead on hospital food procurement, for example. One hopes that the NHS has in it the nutritionists it needs to provide necessary advice about healthy diet. We are here to advise ministers; they can request advice from us. We have done that in the past, but it is not a regular and on-going activity for us.

Paul Sweeney: In relation to supermarkets, we can see the range of products and where supply chain densities are in terms of geography. Forgive me if it is already visible, but is that visible the public sector? Can we see supply chain density for the NHS, for example, including on whether products are procured from certain farms or locations in Scotland? There are large industrial catering companies, such as Bidfood Ltd and Brake Bros Ltd, that supply NHS organisations. Is there visibility in those processes? If there is not, should we design it in so that we have greater capacity to make rational adjustments?

Heather Kelman: That does not fall directly within our remit, but I think that, as health boards and local authorities go through developing and writing their good food nation plans, one of the areas that they will look at closely is procurement and best practice in it. I am not sure whether that is an area that the incoming Scottish food commission might look at.

Carol Mochan: You have covered a lot of what I was going to ask about. I am interested in the notion that, if we want to meet more targets, particularly on childhood obesity, we need to move away from talking about things to taking action. I believe that Governments must take responsibility for their part of the picture: it is not all about individual choice, because we know that communities are not set up that way, especially in areas that have high levels of health inequality. If you were going to give us homework, on what three areas could the committee achievably push the Government to take action?

Heather Kelman: First, I would love to see the work on restricting promotions of some foods progressing—preferably, with cross-party support. The food industry needs confidence so that it can reformulate for the future. If the industry thinks that things will change in the future, that will not provide food producers with the long-term horizon that will force or encourage them to look more closely at reformulation and changing the range of available products. We need to look closely look at how we tackle promotion of products that are high in fat, salt and sugar.

We have just written to number of health spokespeople in Westminster about advertising and marketing of food. A four-nations approach will be required in order to get movement on that and to address marketing issues. It is unacceptable that we allow products that are high in fat, salt and sugar to be promoted during the times when children watch television programmes. I have a long list, but I will let Gillian Purdon, as the head of nutrition, talk about the third thing.

Dr Purdon: I agree about promotions and the bigger picture. The question is good, but it is quite difficult to answer because we are talking about preventative measures. A lot of the time, we want to prevent things from happening; therefore, the measures are upstream. We are talking about areas such as reformulation and making sure that healthy, rather than unhealthy, products are promoted.

Action on universal free school meals, for example, is beneficial and is within the gift of the Scottish Government. Existing work on promotions legislation, which is important, needs to be

progressed. The early years is another area to put resource into; I know that the Scottish Government is doing that.

We are all in the same position of having limited resources, so there has to be partnership working. The Scottish Government and Public Health Scotland can do a lot more at community level. That touches on Paul Sweeney's questions about what is happening in communities.

The good news is that we are all working together on those aspects so that we can have synergy and are greater than the sum of our individual parts, in our approach.

Carol Mochan: There is talk about labelling or not labelling foods, particularly on menus when people eat out. I am interested in that, as well. Where are you on that?

Dr Purdon: We previously recommended mandatory calorie labelling to ministers. The Government is very aware of an emerging evidence base on the impact of menu calorie labelling on people with eating disorders. It commissioned research from Public Health Scotland that was published quite recently.

There is currently a big evaluation being done of the scheme in England. Members might be aware that big businesses in England—businesses with more than 250 employees—must have menu calorie labelling. That is something that we, too, are considering. We will speak to our board in a closed seminar to update it on the evidence base, then we will return to the minister with an updated position on that. Basically, we have to be a science-based and evidence-based organisation, so we need to ensure that we are alive to existing and emerging evidence.

We are tasked with monitoring the out-of-home food environment provisions, which is extremely difficult because of the lack of calorie information. In a way, regardless of whether consumers see that, it is important that businesses are aware of it, because a lot of businesses are not currently aware of what they provide to the consumer.

There are various elements, and we are looking at all of them and mitigating potential harm.

Geoff Ogle: I would add the case for transparency to the list of asks. Henry Dimbleby talked about the food data transparency partnership, which required industry to be more open about things such as sugar content. It seems to have gone very quiet.

On making things more visible so that consumers have more information, the issue is how information is made available. Once consumers get that information, they have the opportunity to change. If they have no information at all, it is difficult for them to know what to do.

Carol Mochan: That is really helpful. Thank you.

The Convener: I have a follow-up question about reformulation, which was mentioned earlier—in particular, reformulation of drinks in anticipation of introduction of the sugar tax. We know that sweeteners can have adverse effects and that they do not make drinks any less sweet. I take on board what Mr Gulhane said: they might change the taste, but they do not make the drinks less sweet, so they do not retrain the taste buds. To what extent, do you believe, is replacing sugar with artificial sweeteners the correct approach?

Dr Purdon: There is, for example, evidence that a reduction in sugar-sweetened beverages can help people with type 2 diabetes to lose weight. We also know that the introduction of the soft drinks industry levy has resulted in beneficial effects in terms of reducing obesity rates among teenage girls. We know that there are some positive impacts from that.

Having said that, I take your point on board entirely. Use of artificial sweeteners does not help with people's sweet tooth, with the pervasiveness of high-fat, high-salt and high-sugar foods and drinks in our food environment, or with trying to get away from that taste. That is something that we need to look at.

I do not know how easy reformulation is—I am not an expert. However, the industry was well placed to reduce salt levels gradually. That was the way in which consumers' palates became familiar with flavours and did not reject them. I do not know whether the same thing has happened with sweeteners, which are so intensely sweet. There is a question around that; we do not have the answer on how easy it would be to dial their use down a little bit.

11:00

Paul Sweeney: I have a question on calorie publication. Have you noticed a change in the behaviour of food providers in reducing calorie density in things that are excessively calorie dense? If there are 1,500 calories in a meal, for example, they might consider that that is quite alarming to the consumer and try to reduce it to 800 calories or whatever.

Dr Purdon: The answer to that is yes and no. There is some evidence that one of the key things that happens when a business works out calories is that it makes menu changes. They basically reformulate what is on their menu so that it is not so high in calories. We have some evidence on that, but that evidence base is not as robust as we would like it to be. However, that is one of the biggest impacts that we have seen.

We have on our website a tool called menucal, which can assist smaller businesses, or any business, to put calorie values on menus. We did a pilot survey quite a long time ago, which found that using that tool made businesses realise how many calories were in the stuff that they were providing. They made quite significant changes. They thought, "Wow! Two thousand calories in mac and cheese!"—they had not realised that it was so high—and reformulated as a result. Such knowledge can, whether the consumer knows it or not, impact on business practice, which is a really big important part that is often missed.

David Torrance (Kirkcaldy) (SNP): Good morning.

Food Standards Scotland's website is a source of evidence-based nutrition-related information, but it has to compete with the misinformation that consumers might access from other digital sources. How can Food Standards Scotland ensure that its evidence-based message and advice are heard?

Geoff Ogle: That is a good question, which relates to the point that I made earlier about the amount of information that is out there. Misinformation is certainly a risk for us, and we continually monitor it. This goes back to the point about us being a trusted source.

Another thing that we do is called—I think—social media listening. I do not profess to be an expert on it. It basically means looking at what people are talking about, interrogating what is happening on social media and thinking about how to use that information. The reality is that we do not have the resource to address every story and every piece of misinformation, so the issue is where we concentrate our effort. A good example is ultra-processed foods, on which we noticed a surge in interest in the media. We had a board discussion on it and then—rather than getting involved in the debate and commentary—we put the board paper on the website to let people look at it.

We need to ensure that our evidence is there and that it stands up so that people have a source of truth. The main thing is that we listen to what is going on and are then quite specific and focused in respect of whether we interject in a debate. An example from last year, or the year before, is that there was quite a lot of debate about use-by dates and best-before dates and whether we should get rid of them. Again, we decided to just cut through the debate, take a paper to the board, get the factual position and make that available. For us, consumer trust is the bedrock of ensuring that we handle misinformation in the right way.

David Torrance: Has Food Standards Scotland undertaken any work to influence the school curriculum—in particular, relating to educating children on online nutrition-related misinformation on popular apps such as Instagram and TikTok?

Dr Purdon: That is interesting and it is a good question. We debated the matter with the board in a closed seminar. The curriculum includes a lot on diet, including on the Scottish dietary goals, but perhaps it needs a refresh to reflect the current situation with social media—with the fact that the food environment is not just the physical environment but includes the virtual environment. Advertising, promotions and so on are pervasive throughout all social media platforms. We have not yet made any inroads on that, but how the curriculum can be updated is certainly on our radar. As I said, there is quite a lot in there, and it might not go far enough yet.

David Torrance: That leads me to ask whether Food Standards Scotland has a strong social media presence. If you are trying to influence a certain age group, especially the younger generation, you need a strong social media presence. How do you measure that? You could measure how many hits your website gets or how many people look at your social media stuff. Do you do that?

Geoff Ogle: Yes—we have quite a few stats. It might be easier to send the committee that, because we collect quite a lot of information on the whole range of communications, including social media and press coverage. We could make some of that information available to the committee.

When it comes to website hits, we are in the same position as a lot of organisations, in that we are competing in a very cluttered landscape. I go back to the analysis that I talked about earlier. In research on who uses our website, we have found that it depends on what they are going to the website for and what they are trying to find there. The question is how we make information on the website more visible and easier to access.

To be honest, I say that one of the issues for us at the moment is that we need to make information on things such as diet more accessible. Our search engine is really out of date and clunky, so that needs to change. We know what we need to do, and we are in the process of doing it now.

Tess White: Thank you for coming. I have two questions, which build on those that David Torrance asked. Has Food Standards Scotland undertaken any work to influence the school curriculum? As David said, children are more likely to go on social media and apps such as TikTok and Instagram, in particular. Is your work having an impact on the school curriculum?

Dr Purdon: As I said, elements of our recommendations—I mentioned the Scottish dietary goals and the "Eatwell Guide"—are part of

the curriculum. You make a good point about the social media element, which we can take away, but we have not been actively involved in that area in relation to the school curriculum.

There are other organisations that do a lot of work in this area, such as Bite Back, which runs good campaigns that help to empower young people by enabling them to understand what is happening and the manipulations around them. We can take that point away and see whether there is anything that we can do there. I do not have a detailed enough knowledge of the curriculum to know to what extent that is covered, but we could certainly look at that.

Tess White: That is good, thank you. Are you looking at search engines when updating your website, so that it becomes a go-to site?

Dr Purdon: That will all be part of the website overhaul. When it comes to our nutrition pages, there is the stuff that we want to provide for consumers—the advice and information—but we also want to provide access to the research. We have a nutrition hub where all our research is. Those different elements have totally different audiences. We need to make sure that those pages are nice and easy to navigate, and clear, so that anyone who is interested in the detail of why we have made a recommendation can find that information in the same way that people can find information about diet.

Tess White: At the moment, there is a craze for the carnivore, paleo and keto diets. A particularly successful group sticks in my mind. It sprang up during Covid and took hold of social media post-Covid. There is evidence on those diets from doctors in the States, who quote a Harvard University study. In social media questionnaires on the keto and paleo diets, people say that they are taking control and getting their nutrients from red meat and eggs. That flies in the face of what you say in your report, which is that people should eat less red meat.

Do you have a view on that yet, or will you take it to your board, which is listening to what is going on? As I said, that type of diet is taking a huge hold right now.

Dr Purdon: Geoff Ogle talked about the tracker survey earlier. We usually ask questions in that about whether somebody is on a particular diet, so—

Tess White: Sorry—are you aware that that is going on?

Dr Purdon: Yes. Those types of diets have been around for a long time. We are aware, which is why we ask questions to identify whether people are following a specific diet, for whatever reasons, which may be quite broad and include religious or ethical reasons. We are aware of those types of diet. However, we work at population level. We can include some of those types of diet in our search terms but they would not routinely be picked up in the monitoring that we talked about. Tracking that has not been at the top of our list, but we could include it.

Tess White: Getting your nutrients from red meat flies in the face of evidence that says, “eat less red meat”, and counteracts the point about heavily processed food.

Dr Purdon: We would need to work out what the numbers are as a proportion of the population. Even the proportion of vegan consumers in Scotland is very, very small. We look at the majority rather than those who are more niche, if you like.

I reiterate that our advice is only for high consumers to cut back. It is not necessarily for everyone to cut down. People who follow those sorts of diets are not necessarily following a healthy balanced diet, as you alluded to. We need to make sure that we get that message across, rather than just look at those very niche and specific pieces. However, if those become more predominant, we will certainly make sure that they are on our radar.

Ivan McKee: Good morning—it is still morning. I have just a couple of brief points. What is your perspective on the effectiveness of the good food nation plan, and the targets in it, in tackling both dietary challenges and climate targets?

Heather Kelman: We welcome the good food nation plan. Anything that makes it clear that we have ambitions for Scotland to eat more healthfully and in line with the “Eatwell Guide” is strongly welcomed. Scotland has a very good food history to be proud of and to promote.

In particular, when it comes to the plan, it is good to have a baseline, to see what we have in progress and what we need to follow through on. There is room for a clearer connection between the outcomes that we seek for the objectives in the plan, and the actions that we will take. At the moment, some of the linkages between the actions and the intended outcomes are a bit loose, so we may need to tighten up a little on where results will come from. Although we strongly welcome a lot of the on-going actions, will they lead to the desired outcomes in the long term? That needs to be tightened up quite a bit.

It is the first iteration of the plan that has been consulted on and we will continue to work with the Government and other partners to make that linkage a little bit closer. For example, the Scottish child payment is in there as an action. That is excellent. Everybody welcomes the approach of tackling child poverty. However, I would like

something more, which says how that money gets directed to improving childhood health through improved public health nutrition.

Ivan McKee: That is helpful. Thank you.

My second question is about the roles and responsibilities of yourselves—Food Standards Scotland—and the Scottish Food Commission. The issue has been raised before. What is your perspective on the discussions to clarify that?

Heather Kelman: Now that the post of commission chair has been advertised, it is a good time for us to sit down to clarify that, so we have made approaches to various parties in Government to ask for that clarity on where our role stops and that of the Scottish Food Commission starts.

There is a paragraph in the good food nation plan about the commission being focused on the plans from local authorities and health boards. Gillian Purdon talked about how we need to make sure that all the contributions add up, to get the kind of influence that we need. We need to sit down together and work out where those lines are—who is responsible for what. At the moment, we have a huge focus on industry, retail and so on, to ensure that the food environment improves. The plans that the Scottish Food Commission is looking at, however, are more in the public sector domain. That interface between our role with industry and the public sector role that is looking at the good food nation might be where we could meet and overlap. However, we need to have those conversations—and sooner rather than later—given that the job of chair to the commission is being advertised.

11:15

Ivan McKee: That is good, thank you.

The Convener: We have already touched on the "eatwell everyday" meal plan. I am keen to know how FSS is measuring people's engagement with that resource and what tools you are using for that.

Dr Purdon: I am happy to come in on that. There are two separate things, which sound very similar. There is the "eatwell everyday" resource, which provides a menu over a week. We use that for a lot of things, including to look at the amount of meat in a diet. I do not think that a huge number of consumers are engaging with that resource at the moment but, when we overhaul our website, we will certainly look at that. We also have a healthy eating tutorial, which is helpful for those who want to upskill and know a bit more about nutrition. Again, that resource is underutilised, so there are some opportunities there.

As Heather Kelman mentioned, we also have the "Eat Well, Your Way" resource, which helps consumers when they want to make some changes to their diet. It looks at motivations, actions and prompts, so it has some behavioural techniques behind it, which can include smaller actions that are more sustainable over time. Those are the main consumer-facing tools.

We had a campaign—we do not have the money for it any more—and there was a lot of traffic to the website at that point. That has not been sustained but we are keeping track of it. Following the overhaul of the website, the position of that resource will be changed; we hope that it will be integrated and that we will drive more traffic there. The pages on nutrition and the five food groups are well visited, so we want to utilise some of the traffic to those pages. We analyse that, and the resulting traffic beyond those pages tends to stay. The information that we have is quite good but we need to get more people visiting it. We have done work with health professionals to see whether that is something that they would be keen to work with when they are working with community groups and others. So, we are looking at ways to address that issue but, as you point out, there are underutilised bits of the website.

We have looked at the "eatwell everyday" menu in order to cost a healthy balanced diet and compare that with what people spend. The average figures are actually similar, so, on what people spend, they could, in theory, have a healthy diet. However, the figures are average, so there are lot of people who are spending a lot more and a lot of people who are spending a lot, lot less. It is also not just about how much money you have but the social environment and facilitating and making it easier for people to purchase what they need in order to have a healthy diet. There are so many more social factors that need to be looked at, which often sit outwith our remit, to be honest. However, we would like to work with others to move those agendas on.

The Convener: It would be helpful to see the figures for visits to the website pages, if you are able to write to the committee with those.

Dr Purdon: Yes, we can do that.

The Convener: That will give us a baseline so that we can see whether traffic increases after you have refreshed the website.

Emma Harper: I am looking at the Food Standards Scotland website. The "Eatwell Guide" is available in British Sign Language—there is a wee video—so it is probably worth us sharing that on our social media.

I have a question on food crime. That is another area where people seem to be unaware of the

work of Food Standards Scotland. I know that time is tight—we might need to get more information by writing to you—but that work is really important and I am interested to hear a quick word on the food crime prevention strategy and what that means.

We have also not really talked about food for cattle and the role of Food Standards Scotland in the regulation and monitoring of feed for animals that end up in our food supply chain. However, food crime is something that you were probably expecting to be asked about, so I am happy to hear about that.

Geoff Ogle: I will try to be brief. Our food crime team also deals with incident management, intelligence and investigation, which are all part of one unit. When we were setting up in 2015, we made food crime one of our priorities, in light of the horsemeat incident in 2013.

One current challenge is that food law does not really tackle crime very well, so we have to use common law. We are working with the Crown Office and other authorities and sit in an organisation of about 18 enforcement authorities.

We use the national intelligence model as the basis of our prevention operation because all enforcement communities understand that. Deterrence and prevention are important, with the criminal sanction of taking people to court as the end of the process. If we can stop or disrupt food crime in the first place, that is what we will do.

We have recently introduced a food crime risk assessment tool that businesses can use. They do a self-assessment to find the threats to their supply chains and production, again in order to focus on prevention. Yesterday, we did an exercise that we have been running for a number of years now, which is about lead poisoning of cattle on farms. We run that regularly because of the risks to human health and farmers' livelihoods.

We do not talk about food crime much, but it is worth stating that the vast majority of people who are in the food sector as there for the right reasons, not the wrong ones. At one extreme, there is serious organised crime; regulatory crime is at the other end and there is a more complicated fuzzy bit in the middle about food fraud, authenticity and substitution.

We can provide more information and if you want something more private, we can share more information than we would in public. Food crime is an important area of focus for us because it is about protecting Scotland's reputation. At an international level, we currently chair something called the Global Alliance—we did not call it that—which includes Australia, New Zealand, the United States, Canada and the UK and shares approaches, techniques and information. We also do a lot of horizon scanning and surveillance to look at where the threats are. That can include climate factors. For example, a bad olive harvest will escalate the risk of the adulteration of olive oil.

That was a very quick canter through food crime.

You asked about feed. To be brief, feed control is split. We have responsibility for it and do some of the direct delivery ourselves while also using local authorities to do that. It is a risk-based process with farm inspections and third-party audits of feed premises. That is part of the end-to-end risk-based approach to the food chain.

Emma Harper: That is great; thank you. I know we might have to get some further information from you.

Sandesh Gulhane: I believe that meal replacement shakes are part of a diet culture. A huge proportion of people—I suspect, most people—have been on diets, on and off, for their whole lives. Do consumers feel that things such as meal replacement shakes are healthy alternatives to eating well? If you do think that, what have you done about it?

Dr Purdon: That is a very good question. The answer is that we do not know whether consumers think that they are a healthy alternative. We have not asked that question. Where we are aware of meal replacement shakes, we know that they are for weight loss, and they are specifically designed for that. There are programmes for using very-low-calorie meal replacements in the treatment of type 2 diabetes and for weight reduction. Those types of meal replacement shakes are more designed for the general public, however, and they are certainly not something that we would recommend. We recommend a healthy, balanced diet. Consumers may want to have those things, and they sit within the existing food regulations for labelling and safety, so we do not have concerns there.

We would not necessarily advocate those products. That is not something that we have asked a lot of questions about, and we do not have a lot of information about it regarding the general population. I know that sales are expected to increase, and that is possibly something that we need to have more of an eye to. There is an inequalities aspect, as such products are more marketed towards those with higher incomes, rather than those on lower incomes. We have to be careful to keep that in our sights, too.

Sandesh Gulhane: On the perception of healthy foods versus what is actually healthy, a lot of people think that cereal bars are a very healthy alternative to having breakfast, whereas they are in fact full of sugar, salt and other things. A lot of foods are perceived to be healthy but are patently

not. What research have you done on that and on the public's perception of what is healthy?

Dr Purdon: We tend to ask quite general questions, rather than questions on specifics. We would have advice around front-of-pack labelling and so on. Cereal bars and breakfast cereal almost come into the same category, in that we can have extremes, with good ones and bad ones. We really need to look at the label: if it is on the front of the pack, that is the best way to determine it. People do not necessarily have time to do that, however. We know that it is complicated for people. That is why rebalancing promotions is important. If it is not possible to promote the products, they are less in the consumer's psyche. Promoting products at the healthier range of the spectrum is one approach.

We have not specifically looked at those questions; we have considered more general questions around healthy diet. When we model our healthy diet every day, it is quite hard to fit any of those things in. We have to have very-low-sugar cereals and plain porridge; that is how people can have a healthy breakfast. There is not a lot of scope for sugar, particularly in a healthy diet. That gives us a good idea of how difficult it is to fit some things in—we can fit some in, but only a small amount. A sugary cereal bar will contribute quite a lot to people's sugar intake.

Geoff Ogle: There are lots of people looking for a quick fix to dietary challenges, and that is part of the issue. How can I lose X calories in the next three weeks? It is about that sort of philosophy.

At the most strategic level, there is the basic question of energy in and energy out, with issues about micronutrients and diet, too. That goes back to the broader question of consumer education and understanding about diet, how the body works and metabolism. All those things are part and parcel of how we move towards being a healthier nation. About 67 per cent of the population are overweight or obese, and at some point we have to be serious about reversing that trend. If we keep going as we are, the situation will just get worse and worse.

There is a broader contextual aspect of our basic understanding of how we consume, what we consume and the way the body uses the energy that it is provided with. That comes down to personal responsibility, but the answer is not solely to exercise more and eat less; it goes back to the other points that have been made about the overall food environment. How do we make it easier for people to make the right choices? That is a critical question, too.

11:30

Sandesh Gulhane: We had a long discussion about that earlier.

I know that time is against us, but I have a final question. I have been on your website and I looked at your X account. You have 6,000 followers, or maybe fewer than that, so that is certainly something that can be improved. I did not see anything about portions on your website or X account. The size of our plates has gone from a side plate to what used to be a serving plate. Portion control is possibly one of the most important ways to have a healthy, balanced diet that allows calorie control and allows us to think about what we are doing. Using hands is a great way of doing that. Do you have any thoughts on that and how to promote it?

Geoff Ogle: It is interesting, because some of the answers to the issue have been around for a long time. A report by McKinsey & Company in either 2006 or 2009 came up with five answers to diet. Reformulation was in there, as were portion size and taxation. It is not that the answers are not around—they have been around for quite a while. The difficulty with diet is that there is not any one simple answer to the problem.

You are absolutely right that portion size is an issue. Are portions too big? Yes, generally they are. A couple of years ago, we did a campaign around the upgrades in fast food restaurants, such as paying an extra 50p for the large portion of fries. We did some evaluation of that and it showed that with the right focus, you could change behaviours, such that people moved away from larger portion sizes.

Portion control is key, but reformulation is also key, and our view is that taxation and levies are key. You need all of those levers.

Dr Purdon: That is absolutely right—there is no one thing that will do it. To emphasise what Geoff Ogle said, we know that in the out-of-home food environment, the portions are significantly greater than they are in the retail environment. It is harder to know what is happening in the house. Our Intake24 survey will help to shed some light on that. We know that 25 per cent of calories come from the out-of-home food industry, where there tends to be larger portions that are more energy dense. We need to make sure that we look to address that in the future.

Sandesh Gulhane: Thank you.

The Convener: I thank the witnesses for their attendance this morning. Next week, the committee will not be meeting, as we will be undertaking external engagement in Skye as part of the committee's inquiry into healthcare in remote and rural areas. That concludes the public part of our meeting.

11:32

Meeting continued in private until 12:03.

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