Passage of the
Smoking, Health and Social Care (Scotland) Bill 2004

SPPB 85

Volume 1
Passage of the

Smoking, Health and Social Care (Scotland) Bill 2004

SP Bill 33 (Session 2), subsequently 2005 asp 13

SPPB 85

Volume 2: Stages 1, 2 and 3
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Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill

Volume 1: Report
# Health Committee

6th Report, 2005 (Session 2)

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12 April 2005 (10th Meeting, Session 2 (2005))  
19 April 2005 (11th Meeting, Session 2 (2005))
Remit and membership

Remit:
To consider and report on matters relating to health policy and the National Health Service in Scotland and such other matters as fall within the responsibility of the Minister for Health and Community Care.

Membership:
Roseanna Cunningham (Convener)
Helen Eadie
Janis Hughes (Deputy Convener)
Kate Maclean
Duncan McNeil
Nanette Milne (Committee member from 2 February 2005)
Shona Robison
Mr Mike Rumbles
Dr Jean Turner
David Davidson (Committee member until 1 February 2005)

Committee Clerking Team:

Clerk to the Committee
Simon Watkins

Senior Assistant Clerk
Tracey White

Assistant Clerk
Roz Wheeler

Committee Assistant
Lynn Stewart
Executive Summary

Listed below is the Committee’s overall view on the various provisions contained in Smoking, Health and Social Care (Scotland) Bill.

A number of further conclusions and recommendations, together with the Committee’s reasoning, are included in the body of the report.

Introduction

- The Committee has some concerns that the diverse nature of bills of this type increases the difficulty of carrying out effective scrutiny. The Committee recommends that the Executive bring forward bills that are more discrete in nature to avoid the difficulty of having to deal with very different subject matter. (Paragraph 10, page 6)

Part 1:
Prohibition of Smoking in Certain Wholly Enclosed Places

Committee’s Overall View

- The majority of members of the Committee are of the view that a ban on smoking in enclosed public places would impact positively on public health and that a voluntary approach to tobacco control would not ensure the same outcome. The majority of members, therefore, support the proposal contained in this part of the bill, believing that it will help to save lives. (Paragraph 26, page 9)
Committee's Overall View

- The Committee\(^1\) supports the Executive’s proposals to introduce free oral health assessments and eye examinations and believes that, if properly implemented, they have the potential to improve standards of oral health and reduce the number of long term sight problems in Scotland. (Paragraph 77, page 18)

PART 2, SECTIONS 11, 12, 13, AND 14:
GENERAL DENTAL SERVICES

Committee’s Overall View

- The Committee supports the proposals in sections 11 to 14 on general dental services and the wider policy intention stemming from 'Modernising NHS Dental Services in Scotland' of enabling health boards to take a more active role in securing and providing general dental services. The Committee believes that, if properly funded and implemented, the policy will provide for better access to a wider range of general dental services at a local level. (Paragraph 103, page 23)

PART 2, SECTIONS 15, 16 AND 17:
LISTING ADDITIONAL CATEGORIES OF DENTAL PRACTITIONERS,
OPTOMETRISTS AND OPHTHALMIC PRACTITIONERS

Committee’s Overall View

- The Committee supports the Executive’s proposals to extend health board lists to include all dentists and ophthalmic medical practitioners and believes they will allow health boards to ensure all practitioners are regulated and can be held directly accountable for their actions. (Paragraph 117, page 25)

PART 3:
PHARMACEUTICAL CARE SERVICES

Committee's Overall View

- The Committee supports the Executive’s proposals for the provision of planned pharmaceutical care services. The Committee believes that, if properly implemented the proposals could ensure the provision of a wider range of pharmaceutical services throughout Scotland on the basis of the needs of individual communities. (Paragraph 130, page 28)

\(^1\) One member of the Committee dissented from this position
PART 4: DISCIPLINE

Committee’s Overall View

- The Committee supports the Executive’s proposals to strengthen the disciplinary procedures contained within part 4 of the bill. (Paragraph 139, page 29)

PART 5, SECTION 24: HEPATITIS C PAYMENTS

Committee’s Overall View

- The Committee supports the Executive’s proposal to provide a firm legal basis under Scots law for the making of payments to Hepatitis C sufferers. (Paragraph 150, page 31)

PART 5, SECTIONS 25, 26 AND 27: AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001

Committee’s Overall View

- The Committee supports the Executive’s proposal under sections 25-27 of the bill. (Paragraph 180, page 35)

PART 5, SECTIONS 28 AND 29: DE-REGISTRATION WITH THE CARE COMMISSION

Committee’s Overall View

- The Committee recognises the case for making this legislative arrangement, but regrets the need to do so due to the oversight in implementing the previous legislation. (Paragraph 184, page 35)

PART 5, SECTION 30: AUTHORISATION OF MEDICAL TREATMENT

Committee’s Overall View

- The Committee supports the Executive’s proposal to extend the types of professionals who can issue an incapacity certificate. (Paragraph 188, page 36)

- The Committee does not support the extension of the maximum duration of a certificate from 1 year to 3 years. (Paragraph 189, page 36)
PART 5, SECTION 31: JOINT VENTURES

Committee’s Overall View

- The Executive intends to provide for new powers to form and participate in joint ventures in the health service by introducing potentially wide-ranging enabling legislation. (Paragraph 225, page 40)

- Much of the evidence available to the Committee related to the experience of NHS LIFT projects in England. While a number of these projects are now underway, the Committee is of the view that it is too soon to make an objective judgement about the performance of this model. The Committee is also aware that other joint venture models are possible under the Executive’s proposals; however, it appears that a limited amount of consideration has been given to alternative models by the relevant public sector agencies. The Committee considers it important that a range of alternative joint venture models are considered, including the mutual model. (Paragraph 226, page 40)

PART 5, SECTION 32: SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST

Committee’s Overall View

- The Committee supports the Executive’s proposal to convert the Scottish Hospitals Endowments Research Trust from a Non-Departmental Public Body to a charitable trust. (Paragraph 246, page 44)
INTRODUCTION

1. The Smoking, Health and Social Care (Scotland) Bill was introduced by the Scottish Executive on 17 December 2004. The Health Committee immediately issued an open call for evidence on the bill with a deadline of 11 February 2005. The Committee received 46 written submissions on the various elements of the bill, the majority relating to the smoking proposals in part 1.

2. The Committee had previously considered the Prohibition of Smoking in Regulated Areas (Scotland) Bill, introduced by Stewart Maxwell MSP. The Committee gathered a considerable amount of evidence on this bill at stage 1 and published a report of its deliberations and conclusions in January 2005. It agreed to take on board the evidence received as part of its consideration for this bill in examining the Smoking, Health and Social Care (Scotland) Bill.

3. The Committee heard oral evidence on the Smoking, Health and Social Care (Scotland) Bill on 11 January 2005 from Executive officials and agreed to focus its subsequent evidence-taking on the most potentially contentious sections of the bill.

4. The Committee heard oral evidence on different sections of the bill on 22 February and 1, 8 and 15 March. Some of these evidence sessions were undertaken in the form of a ‘round table’ with a number of groups interacting at the table at the same time. Other sessions were undertaken in a more formal format. The Committee took evidence from 38 organisations in total. A number of those organisations were represented on more than one occasion.

5. The Committee received oral evidence on all parts of the bill from the Minister for Health and Community Care, Andy Kerr MSP, on 22 March.
6. The Committee was very keen to receive the patients' perspective through the evidence. Unfortunately the abolition of local health councils on 1 April meant that it was not possible to involve all those bodies who had contributed to the original Executive consultations.

7. In order to better understand the smoking provisions of the bill, the whole Committee visited Ireland in early February to examine the implementation of the smoking ban there. The Committee visited both urban and rural areas and spoke to opponents of the ban as well as those who had introduced it or were responsible for its implementation.

8. The Committee received reports from both the Finance and Subordinate Legislation Committees (attached at Annex A). Where relevant these reports are referred to in the text on the various sections on the bill.

9. The Smoking, Health and Social Care (Scotland) Bill is very varied in its provisions. It includes not only the smoking proposals but major changes to dental, ophthalmic and pharmacy services, the tightening of disciplinary procedures for professional health staff, changes to the law regarding the issue of certificates of mental incapacity, a legal basis for the making of payments to Hepatitis C sufferers, and the introduction of significant powers to create joint ventures.

10. The Committee has some concerns that the diverse nature of bills of this type increases the difficulty of carrying out effective scrutiny. The Committee recommends that the Executive bring forward bills that are more discrete in nature to avoid the difficulty of having to deal with very different subject matter.

11. Because of the complexity and wide-ranging nature of the bill, in this stage 1 report each of the main components of the bill is dealt with in turn. For each component, the following is considered:

- the purpose of that part of the bill – what it does
- the overall views of those submitting evidence – in favour or not
- the Committee’s overall view – in favour of the proposal or not
- specific issues raised by those submitting evidence (together with the Committee’s view on each of them, where appropriate, in bold).
PART 1:
PROHIBITION OF SMOKING IN CERTAIN
WHOLLY ENCLOSED PLACES

Purpose of This Part of the Bill

12. This part of the bill seeks to prohibit smoking in certain wholly enclosed public places, by making it an offence for a person in charge of no-smoking premises to knowingly allow others to smoke there, or for an individual to smoke where smoking is prohibited. The bill also seeks to ensure that no-smoking signs are displayed conspicuously inside and outside no-smoking premises.

13. The bill defines no-smoking premises as premises that are wholly enclosed and –

i) to which the public has access;
ii) which are being used wholly or mainly as a place of work by persons who are employees;
iii) which are being used by and for the purposes of a club or other unincorporated association; or
iv) which are being used wholly or mainly for the purposes of health and care services.

14. The bill also makes provision for Scottish Ministers to prescribe in regulations premises to be included in or excluded from the ban.

15. The Executive’s action plan on tobacco control (A Breath of Fresh Air for Scotland, 2004) includes a commitment to extend smoke-free provision within all enclosed public places, in order to protect non-smokers from the health risks posed by exposure to second-hand smoke. The Policy Memorandum accompanying the bill states that–

A complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.²

Overall Views of Those Submitting Evidence

16. The Committee recently gathered a significant volume of evidence on the consequences for health of exposure to environmental tobacco smoke and the potential impacts of a partial smoking ban, when considering the general principles of the Prohibition of Smoking in Regulated Areas (Scotland) Bill³. In its call for evidence on the Smoking, Health and Social

² Smoking, Health and Social Care (Scotland) Bill, Policy Memorandum, p3
³ The Prohibition of Smoking in Regulated Areas (Scotland) Bill, introduced as a members’ bill by Stewart Maxwell MSP, proposed a ban on smoking in enclosed public places where food is served and consumed.
Health Committee, 6th Report, 2005 (Session 2)

Care (Scotland) Bill the Committee asked those with an interest in proposals for a smoking ban to focus on the specific proposal contained in the bill.

17. The Committee received a range of views on the proposed smoking ban.

18. Opponents of the bill include the Scottish Licensed Trade Association, the Against an Outright Ban Group\(^4\), the Tobacco Manufacturers’ Association, and a number of companies operating in the food, drink and leisure industry. Opposition to the ban rests on a number of arguments, including: a perceived lack of public support; the potential for displacement activity which may increase levels of smoking and drinking in the home; questions about whether an outright ban would have a greater impact on smoking cessation rates than a phased reduction in tobacco use in public places; the potential for the introduction of better ventilation to protect non-smokers from exposure to environmental tobacco smoke; and the potential adverse economic impact on the leisure industry. Amicus, a private sector trade union representing members in a variety of sectors, also opposes the ban on a number of these grounds.

19. As drafted the bill includes clubs and other unincorporated associations in the scope of the smoking ban. The Committee heard oral evidence from two members of the Committee of Registered Clubs Association (CORCA), one representing the Coal Industry Social Welfare Organisation (CISWO), the other representing Royal British Legion Clubs. Both witnesses described a range of views among members of their own organisations and members of CORCA, varying from support for the ban on health and safety grounds, support for the ban with an exemption for private clubs, and opposition to the ban. (HC Col 1794)

20. Similarly, in oral evidence Ian Tasker of the Scottish Trades Union Congress (STUC) indicated that, while the STUC ‘broadly supports a smoking ban on the basis of the impact on the health of Scottish citizens’ there is not a consensus among its affiliated trade unions on the policy. He also flagged up concerns about the timescale for implementation of the proposed ban. (HC Col 1822)

21. Supporters of the bill include a number of health boards, a range of health related charities and voluntary sector organisations, various trade unions, including public service union UNISON, and professional organisations representing health sector staff. Support for the ban focuses on the need to tackle the adverse health effects of exposure to environmental tobacco smoke; the potential for smoking rates (in term both of number of smokers and the amount smoked) to decline in response to the ban, with positive health benefits; public support for further tobacco control measures; and potential economic benefits.

\(^4\) The AOB Group was formed in autumn 2004. Its members include the Scottish Licensed Trade Association, the Scottish Beer and Pub Association and the Scottish Wholesalers’ Association.
22. The British Hospitality Association (BHA) Scotland Committee also supports the proposed smoking ban on the basis that: it would be unambiguous, making enforcement easier; it splits responsibilities and penalties equitably between operators and customers; it even-handedly applies to hospitality establishments and other workplaces; and it provides clear health benefits (BHA written submission). The BHA raised some concerns about the practical implications of the bill’s provisions, which are explored in the ‘issues raised’ section below.

23. The provisions contained in this part of the bill are also supported by the Confederation of Scottish Local Authorities (COSLA) and the Royal Environmental Health Institute of Scotland (REHIS). Both organisations have an interest, among other things, in the way that the bill is enforced. Their evidence, together with that of the Association of Chief Police Officers in Scotland (ACPOS), highlights a number of issues that could impact on the effective enforcement of a smoking ban, as outlined below in the ‘issues raised’ section.

24. The Committee’s thinking on enforcement and other implementation issues was also informed by a study visit to Ireland in February 2005 where members witnessed first hand the operation of the workplace smoking ban introduced the previous year. During that visit members met with licensed vintners’ representatives, enforcement officers, trade union representatives and health department officials and officials from the Office for Tobacco Control.

Committee’s Overall View

25. In its stage 1 report on Prohibition of Smoking in Regulated Areas (Scotland) Bill\(^5\) the Committee accepted ‘that evidence exists of adverse health effects from passive smoking’ (paragraph 29) and that reducing exposure to environmental tobacco smoke, through a partial ban on smoking, would have a positive impact on health. The Committee remains of the view that this is the case. The majority of the Committee also concluded that a partial ban on smoking in enclosed public places (as proposed in the earlier bill) would not be sufficient to achieve the health benefits that the bill’s proposer sought and that, therefore, the bill did not go far enough.

26. The majority of members of the Committee are of the view that a ban on smoking in enclosed public places would impact positively on public health and that a voluntary approach to tobacco control would not ensure the same outcome. The majority of members, therefore, support the proposal contained in this part of the bill, believing that it will help to save lives.

\(^5\) HC 1st Report 2005, Stage 1 Report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, SP Paper 263
27. The Committee recommends that action is taken to monitor the health impacts from a ban should the bill be enacted.

28. Members of the Committee have a number of outstanding concerns about enforcement of the proposed ban, which are outlined below.

Specific Issues Raised by Those Submitting Evidence

Health Impact of Passive Smoking

29. A number of those submitting evidence on proposals for a ban on smoking in enclosed public places offered conflicting views about the health impacts of passive smoking, rehearsing arguments put to the Committee during its earlier consideration of the Prohibition of Smoking in Regulated Areas (Scotland) Bill.

Displacement

30. The Scottish Licensed Trade Association (SLTA) cited anecdotal evidence from Ireland of a shift from pub sales to ‘take-home’ alcohol trade (HC Col 1776) and expressed concern that smoking in a domestic setting would increase, with potential adverse health consequences for the children of smokers. The Committee requested official research findings on this issue during its study visit to Ireland, but was advised that none exist.

31. In its evidence ASH Scotland indicated that it had concerns about passive smoking in the home in relation to impacts on children’s health. Sheila Duffy told the Committee–

   It is important that we communicate clearly to people the reason why the bill is under consideration, because people who understand why smoking has ended in public places in Scotland are unlikely to expose their children to smoke at home. (HC Col 1819)

32. The Committee acknowledges that there are some concerns about a potential impact on exposure to passive smoke in a domestic setting arising from the ban although no specific evidence was available. It recommends that any implementation of a ban on smoking in enclosed public places be monitored to establish the impact on exposure to passive smoking in the home and that public information campaigns continue to highlight this issue.

Exemptions

33. The Draft Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of smoking in Certain Premises) Regulations 2005, among other things, prescribe a number of no-smoking premises and exemptions.
34. The BHA Scotland Committee supports the proposed exemption for ‘designated hotel rooms’, however, in its evidence it makes the case for all hotel bedrooms to be included in the exemption. The BHA expressed concerns about the difficulties of enforcing the ban on smoking in hotel bedrooms which it says are by nature private places. In a supplementary written submission the BHA states—

It would clearly be impossible for a hotelier reasonably to detect whether an individual is smoking in a bedroom. Random checks by enforcement officers would interfere with privacy and clearly be unacceptable without a warrant. Logically it would be practically unworkable for them to enforce a ban on smoking in hotel bedrooms.

35. The BHA favours including an exemption for all hotel bedrooms either on the face of the bill or in the regulations.

36. In his evidence, the Minister for Health and Community Care indicated that the list of exempt premises contained in the draft regulations to the bill had been compiled on ‘largely humanitarian’ grounds. Adult hospices are included on the draft list of exemptions on this basis, as are psychiatric hospitals. It is intended that, as long as a smoking policy is in place, premises considered to be peoples’ homes will be exempt from a ban on smoking. Similarly adult residential homes (but not children’s homes) are intended to be exempt. (HC Col 1838)

37. On the basis that hotel bedrooms are considered to be a client’s home for the night or nights of occupancy, where an hotelier opts to have smoking rooms, designated hotel bedrooms (but not public areas) are intended to be exempt from the ban. However, adult day care centres are not included in the draft list of exemptions because, according to the Minister, visits there are only temporary in nature. (HC Col 1838)

38. The Committee is of the view that, as long as a smoking policy is in place, an exemption on humanitarian grounds should be extended to adult day care centres. These centres provide important respite services for the carers of vulnerable adults and effectively fall into the category of ‘home for the day’.

39. The Committee supports an exemption from the proposed smoking ban for designated hotel rooms.

Alternatives

Partial Ban

40. In May 2004 the SLTA asked the Executive to introduce legislation with three elements: a smoking ban at the bar counters in all pubs in Scotland; a smoking ban wherever hot food is served, within three years; and a commitment that 50% of the total floor space in all pubs in Scotland be given over to non-smoking areas. It was also suggested that a review be
conducted at the end of the third year and appropriate further steps taken. (HC Col 1764)

41. ASH Scotland opposes this approach, which it says lacks an evidence base. Sheila Duffy told the Committee—

Such partial policies are costly and, by delaying effective protection, they lead to increases in health inequalities. (HC Col 1814)

42. When considering the Prohibition of Smoking in Regulated Areas (Scotland) Bill the Committee concluded that a partial ban on smoking would not go far enough to achieve the public health objectives to which that bill aspired. The Committee\(^6\) remains of the view that a partial ban on smoking in public places does not go far enough.

**Ventilation**

43. The Tobacco Manufacturers’ Association (TMA) acknowledged that there are health risks associated with smoking, making it ‘quite right that that public health authorities promote risk awareness programmes’. While disputing that it had been conclusively proven that exposure to environmental tobacco smoke results in death or disease, the TMA did concede that second hand smoke can be ‘annoying and, indeed, irritating to non-smokers’. For that reason they propose the creation of designated smoking areas with proper ventilation in a range of public places. (HC Col 1765)

44. Having reviewed a range of evidence about the efficacy of ventilation systems when considering the earlier Prohibition of Smoking in Regulated Areas (Scotland) Bill, the Committee concluded that ventilation did not provide an adequate alternative to a smoking ban in terms of health objectives. The Committee\(^7\) remains of the view that ventilation would not provide an adequate alternative, because it does not remove carcinogens.

**Timing**

45. The SLTA advocated the introduction of a phased ban on smoking, alluding to positive experiences in other countries in this regard and suggesting that this would offer health benefits while minimising financial damage to business interests. (HC, Col 1774)

46. In its written evidence the STUC expressed concerns about the timescale envisaged for the introduction of a ban on smoking in public places, suggesting an alternative lead-time of three years. A longer lead-time would, it argued, allow transitional arrangements to be put in place to minimise potential job losses and provide an opportunity for joint

\(^6\) One member of the Committee dissented from this position

\(^7\) One member of the Committee dissented from this position
campaigning to address smoking rates among those who work in the hospitality industry.

47. Witnesses representing ASH Scotland conceded that there would be a ‘busy job ahead’ in relation to communicating the reasons why a ban is being considered, but suggested that a longer lead time may not be necessary given that Scotland was in a position to learn from the experience of bans in other countries. (HC Col 1818)

48. In oral evidence the Minister maintained that it was possible to introduce a smoking ban in Scotland quickly because of the benefit of experience from elsewhere. He also stressed that preparatory work is underway under the auspices of the Smoke-free Areas Implementation Group and indicated that resources were being put into a ‘comprehensive set of public awareness and information campaigns’. (HC Col 1894)

49. The Committee\(^8\) believes that the timetable for implementing the smoking ban is not unreasonable. However, the Committee considers it important that awareness-raising about the ban and ongoing work with industry to prepare for the ban is intensified.

**Economic Impact and Opportunities**

50. Research commissioned by the SLTA and conducted by the Centre for Economic and Business Research, concluded that, if the Irish ban was replicated in Scotland there would be a loss of revenue of more than £100 million; a loss of profit of £90 million; a negative shift in jobs of 6%; and a decrease of £56 million in the revenue take from the licensed trade (HC Col 1776). However, Committee members are aware from their discussion with representatives of the licensed trade in Ireland that a number of other factors have played into the downturn in the Irish licensed trade, including increased excise duty, new licensing restrictions and more rigorous enforcement of drink driving laws.

51. Asked about potential savings from the point of view of reduced cleaning and refurbishment costs and reduced fire risk arising from a smoking ban, Stuart Ross of the SLTA indicated that 60% of people who currently use pubs are smokers. While he acknowledged that there may be potential savings he expressed concern that there was a ‘big’ risk that those people will transfer their drinking habits from on-sales to the take-home trade. (HC Col 1784)

52. George Ross of the Royal British Region Scotland expressed concern that a ban on smoking could result in reduced club membership, threatening closure of some clubs. He also described a restriction faced by clubs in relation to the use of club branch funds for investment in the development of premises because of charity regulations. (HC Col 1791)

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\(^8\) One member of the Committee dissented from this position
53. Committee members are aware from their study visit to Ireland that the owners of a number of licensed premises have responded to the smoking ban by applying to their local council for permission to provide tables and chairs for customers outside their premises. Similarly, a number of proprietors have invested in smoking shelters and outdoor heaters, to accommodate customers who choose to smoke. In oral evidence to the Committee, Gordon Greenhill from the City of Edinburgh Council indicated that local authorities would welcome similar moves in Scotland, on the basis that there is no medical evidence on passive smoking in the open air and as long as outdoor areas are managed properly (HC Col 1806). The Committee is, however, aware that not all no-smoking premises have the same scope for outdoor development.

54. In its consideration of the Financial Memorandum for the Smoking, Health and Social Care (Scotland) Bill, the Finance Committee was unable to come to a firm conclusion about the costs to business of a comprehensive ban on smoking in public places or about the potential benefits to business arising from a ban. It was similarly unable to form a clear view about how the SLTA’s proposal for a phased ban would impact on the financial implications of the bill. However, the Minister, in evidence, maintained that he expects the bill to have a ‘nil or a positive economic impact’. He went on to tell the Committee—

We cannot allow one area of business to dictate the health of the nation; hence we want to ensure that the bill is comprehensive in its scope and properly enforced. (HC Col 1837)

55. The Committee recommends that action is taken to monitor the economic impacts arising from a ban should the bill be enacted.

Compliance and Enforcement

56. A number of witnesses addressing questions of enforcement indicated that they anticipate that the majority of people would comply with a legal smoking ban. Gordon Greenhill, of the City of Edinburgh Council, indicated that having considered the Irish experience and from local experience of serving fixed penalty notices he assumed that if someone is asked to put out a cigarette they would do so (HC Col 1802).

57. Keith McNamara from the Royal Environmental Health Institute for Scotland indicated that in discussions with his Irish counterparts the importance of pre-ban promotion had been raised. He told the Committee—

Believe it or not, the ban in Ireland seems to have been widely accepted. This is largely thanks to a major promotional campaign by central Government and because local people who work on the ground visited premises to provide information and an opportunity to ask questions on a one-to-one basis. (HC Col 1802)
58. David Mellor of the Association of Chief Police Officers in Scotland indicated that he anticipated that police involvement in enforcement would be fairly insignificant. He told the Committee that the police would support an enforcement strategy that was based on environmental health officers ‘gathering evidence via observation, then going back and confronting people at a later time’, on the basis that this would be ‘less likely to create friction and public order situations’. (HC Col 1806)

59. However, as drafted the bill introduces three offences, two of which apply to those in control of a no-smoking premises and one that relates to individuals who smoke in a no-smoking premises. There was some disagreement among witnesses about the circumstances in which environmental health officers would be expected to issue fixed penalty notices to individual smokers ignoring a ban and in which circumstances those in control of no-smoking premises would be the focus of enforcement activity, given that there is no hierarchy of offences in the legislation.

60. The Committee is very concerned that if it is left to individual local authorities to determine local enforcement strategies, inconsistency in enforcement may arise. In particular, the Committee is concerned that there may be potential public order consequences if environmental health officers seek to issue fixed penalty notices to customers in licensed premises during busy weekend opening hours.

61. The Committee recommends that enforcement be focused primarily on the role of those in control of a no-smoking premises and that the bill is amended at Stage 2 to this effect. The Committee also recommends that guidance be issued centrally on enforcement strategy.

62. In evidence the Minister indicated that while he saw no need to amend the offences listed in the bill guidance on enforcement would be appropriate. He also indicated that the Executive is already working with the licensed trade to raise awareness of its obligations under the legislation. (HC Col 1843)

63. In a supplementary written submission addressing enforcement issues, COSLA indicated that it plans to meet with the Association of Chief Police Officers in Scotland to discuss enforcement issues with a view to developing jointly badged enforcement guidelines to ensure a consistent approach across Scotland. Given concern over the potential for differing enforcement strategies, the Committee welcomes this development but recommends that enforcement activity is monitored over time.

Cost of Enforcement

64. In its report on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill, the Finance Committee raised concerns that the costs of enforcement of the proposed smoking ban are largely unknown. In evidence to the Committee, Alan McKeown indicated that COSLA would
make a further assessment of the enforcement costs for local authorities associated with the proposed smoking ban in light of information contained in the Draft Regulations (which had not be published when original estimates had been made).

65. The Committee heard it argued in Ireland that the smoking ban there was largely self-enforcing and the Executive has indicated that it expects the cost of enforcement to diminish over time. **However, to the extent that the bill will add to the duties of environmental health officers, the Committee considers it important that enforcement costs are fully funded and monitored over time in order to avoid any deterioration in other services they provide.**

**Irish Experience**

66. In Ireland the Office of Tobacco Control (OTC) was set up to assist in the implementation of policies and objectives of the government on the control and regulation of tobacco products. It is also responsible for coordinating the national inspection programme in cooperation with environmental health offices and for delivering a communication strategy in advance of and following the ban. **The Committee is of the view that the activities of the OTC contributed to high compliance rates in Ireland and notes that the bill does not propose an equivalent to the OTC for Scotland.**

**Penalties**

67. In Ireland, where compliance with all aspects of the smoking ban are considered to have been consistently high (note of Health Committee study visit to Ireland, 7-9 February 2005, Annex A), fines are set at the same level for individuals and people in charge of a no-smoking workplace. While there is no escalation of the fine level for repeat offenders in Ireland, fine levels are considerably higher than is proposed in the Executive bill.

68. The Minister, in evidence, maintained that the ultimate sanction for a license holder guilty of repeat offences would be a loss of licence. He told the Committee –

   Speaking bluntly, I believe that it is easy to spot cases in which someone is taking an economic gamble by saying that they can afford to get caught X number of times. In cases in which a landlord is deliberately buying their way out of their obligations under the legislation by simply paying fines, the ultimate sanction of license removal would prevail. (HC Col 1846)

69. **The Committee recommends that consideration be given either to increased levels of fines or to an escalating penalty for repeat offenders.**
Purpose of These Sections of the Bill

70. Section 9 of the bill makes provision for free oral health assessments and dental examinations for all by 2007. Section 10 of the bill makes a similar provision for free eye examinations and sight tests. It is intended that the oral health assessment and eye examination will allow for a wider assessment than is provided within current dental checks and sight tests and will include an element of preventative care.

Overall Views of Those Submitting Evidence

Free oral health assessments

71. All those who gave oral evidence to the Committee, namely the British Dental Association, the Scottish Consumer Council, Fife Local Health Council and health boards (Glasgow and Highland) and all those submitting written evidence were in favour of the proposal. The British Dental Association did caveat its support with concerns about policy implementation. These concerns are detailed below.

72. The Scottish Consumer Council (SCC) supports the removal of charges for dental checks, stating in written evidence—

    The SCC welcomes this proposal as removing the initial barrier to treatment for people who may otherwise be deterred from receiving services because of fear of the cost.

73. The British Dental Association (BDA) supports the proposed free oral health assessment. BDA Director Andrew Lamb, stated in oral evidence—

    The properly funded health assessment will require more than just a quick look at a patient’s oral tissue; it will require an assessment of the individual patient’s needs, and the ability to talk through with the patient their particular problems and to focus on a preventative approach. (HC Col 1628)

Free eye examinations

74. All those who gave oral evidence to the Committee, namely Optometry Scotland, the Scottish Consumer Council, Fife Local Health Council and health boards (Glasgow and Highland) and all those submitting written evidence were in favour of the proposal. Optometry Scotland did caveat its support with concerns about the lack of information on the exact nature of the eye examinations. These concerns are outlined below.
75. In support of the proposal, the Royal College of Nursing stated in written evidence that—

We believe that the introduction of free eye examinations and sight tests will help to identify visual problems earlier which should help to reduce the number of serious sight problems experienced by people in Scotland in the long term.

76. In oral evidence Hal Rollason, Optometry Scotland, stated that the proposal when implemented would—

produce considerable health gains to the nation by introducing improvements in the eye care that is available to the public; better preventative eye care, which leads to a reduction in visual impairment; and a meaningful step towards the long-term goal of eliminating avoidable blindness...Such measures will also achieve a significant reduction of inappropriate referrals to hospital eye departments. (HC Col 1629)

Committee’s Overall View

77. The Committee\(^9\) supports the Executive's proposals to introduce free oral health assessments and eye examinations and believes that, if properly implemented, they have the potential to improve standards of oral health and reduce the number of long term sight problems in Scotland.

Specific Issues Raised by Those Submitting Evidence

Implementation of proposal for free oral health assessments

78. A number of organisations raised issues concerning the capacity of existing dental services to deliver the more detailed 'oral health assessment' which may take longer, cost more to provide and have a higher uptake level than existing exams when available for free. In oral evidence, Andrew Lamb, Director of the BDA, outlined the current shortage of dentists and the resulting waiting lists and limited access for patients. He went on to state that—

Given this situation, the BDA are of the view that the proposed oral health assessments for all cannot be provided by existing dental services. (HC Col 1635)

\(^9\) One member of the Committee dissented from this position
79. The Minister suggested in evidence that the funding and measures recently announced in the Executive’s ‘Action Plan for Improving NHS Dentistry’ should help to address these existing barriers to implementation (HC Col 1852). However, the Finance Committee report on the Financial Memorandum records—

dissatisfaction that the Ministerial Statement on dental services was not made prior to the introduction of this legislation as this could have provided a policy and funding context for some of the provisions of the bill.

80. The Committee shares the concerns raised by the BDA about the capacity of existing dental services to implement the proposal.

81. While the Committee welcomes the funding brought forward in the Executive’s Action Plan to seek to address this issue, the majority of the Committee supports the view of the Finance Committee that this information should have been available at the bill’s introduction.

Funding

82. The costing provided for the provision of both oral assessments and eye examinations is based ‘on an increase of up to 25% on the numbers of people who currently pay for checks’ (Financial Memorandum, paragraph 212). When questioned on the logic behind this calculation, the Minister stated that it was—

based on our experience of the change in the public’s behaviour when we introduced the free sight-check for the over-60s. That was the only sound piece of evidence that showed how people behaved once a check became free. (HC Col 1852)

83. When questioned on the increase in cost caused by the introduction of the oral health assessment, Dr Hamish Wilson, Scottish Executive Health Department, stated that—

We intend to discuss with the dental profession the nature and frequency of the oral health assessment and the effect that that might have on the existing dental check. (HC Col 1851)

84. The Committee believes the Executive’s calculation does not take into account the additional cost of providing oral health assessments and eye examinations in place of standard dental checks and sight tests. The Committee reiterates its support for the view of the Finance Committee, namely that information on the cost of these assessments and examinations should have been available at the bill’s introduction.

85. The Committee seeks assurances from the Executive that additional funds will be made available should the cost of implementation of this proposal exceed the amount outlined in the Financial Memorandum.
The Committee is of the view that negotiations with the dental and ophthalmic professions to agree the nature of the oral health assessment and eye examination should have occurred in advance of the introduction of the bill. In the absence of this information, the Committee is unable to scrutinise accurately the cost of the proposal and is therefore only in a position to approve the policy in principle.

The Committee recommends that the Executive should update the Committee on further negotiations with the professions and the impact on the cost of the proposal of decisions taken in these discussions.

Uptake of services

Hal Rollason, Optometry Scotland, noted in oral evidence that there are no difficulties with access to the current sight test in Scotland as there is no shortage of optometrists. However, when asked about the uptake of existing NHS entitlement to a free sight test, Hal Rollason noted that there are ‘all sorts of “at risk” groups who do not currently have proper care’ (HC Col 1632). This information suggests that some of the groups most likely to get the health benefit from proper eye examinations and oral health assessments are the groups currently not taking advantage of free sight tests and dental checks.

The Committee recommends that, in order to maximise the benefit of the proposals, the Executive should undertake follow-up work to ensure its effective implementation. This work should include educating and advertising on the availability of and the nature of the new eye examination and oral health assessment. It should also undertake the collation of information on uptake levels.

The Committee also strongly recommends that the Executive should work with health boards in targeting those vulnerable groups which are already eligible for free sight tests.

The Committee strongly recommends the introduction of a comprehensive dental and sight screening programme for children at the start of primary and secondary school education, in order to treat problems at an early stage and encourage the habit of receiving oral health assessments and eye examinations. The Committee strongly recommends that Ministers bring forward amendments to legislate for such screening programmes at Stage 2.

Definition of eye examination and oral health assessment

In written evidence Optometry Scotland noted that sight tests are effectively available to all at present as 65% of the population are eligible for free NHS tests and the remainder can receive free tests from commercial opticians. In the absence of a definition of eye examination within the bill to demonstrate the distinction between a sight test and the proposed examination,
Optometry Scotland argued that the proposal would confer no health gain. However, in oral evidence, Optometry Scotland accepted that the proposals would confer a health gain.

93. The Committee believes that detailed definitions of both the eye examination and the oral health assessment could usefully have appeared on the face of the bill to clarify that they are more extensive in nature than the existing tests and checks.

94. The Committee is aware that for enabling legislation such as this ‘the devil is in the detail’ and therefore encourages the Executive to actively engage with professional bodies, patient representatives and health boards in the production of the subordinate legislation which will define the nature of eye examinations and oral health assessments.

95. The Committee also recommends that the Executive provides the Committee, at the earliest opportunity, with draft regulations defining the examination and the assessment to allow members to comment on the regulations before they are formally laid before Parliament.

PART 2, SECTIONS 11, 12, 13, AND 14: GENERAL DENTAL SERVICES

Purpose of These Sections of the Bill

96. These sections of the bill are intended to make changes to the way health boards support general dental services as a result of the Executive’s consultation on ‘Modernising NHS Dental Services in Scotland’. The overarching policy intention is to allow health boards to take a more active role in securing and providing general dental services, including—

- making arrangements with dentists to provide general dental services or to provide such services themselves; and
- providing financial assistance to support service providers including assisting with the cost of premises or upgrading infrastructure.

97. The specific provisions of the bill are as follows—

- Section 11 would remove the existing link between the treatment provided and the fee charged for the service, allowing for the introduction of a more flexible charging system;
- Section 12 would enable NHS boards to enter into arrangements for general dental services with dental bodies corporate;
- Section 13 makes provision for health boards to provide financial assistance as detailed above; and
- Section 14 would allow health boards to make arrangements with dentists to allow them to provide services that are currently provided in
alternative setting, for example migraine or snoring treatments. These arrangements are described in the bill as ‘co-management schemes’.

Overall Views of Those Submitting Evidence

98. All those providing oral evidence and submitting written evidence supported the proposals, including health boards (Glasgow and Highland), patient representatives and the British Dental Association (BDA). A number of those providing evidence had made a submission to the consultation from which the proposals stem.

Section 11

99. The Scottish Consumer Council supports the removal of the link between the item of service and the fee in section 11. Martyn Evans stated in oral evidence—

there is a treadmill effect at the moment. Because of the fee payment structure, dentists have to see their patients more often and have to do work that is not clinically necessary. The bill will alter that fee structure. We do not know what the structure will be, but it will be de-linked from patient charges…[and] that is an important and progressive measure. (HC Col 1640)

Section 12

100. Highland NHS Board approves of health boards taking an active role in providing services, including from dental bodies corporate. In oral evidence, Catherine Lush stated—

I support the concept of flexibility for boards. Within Highland NHS Board, we have already enjoyed an element of flexibility in contracting with general dental practitioners to provide emergency dental services, which has been beneficial for patients in that they have been able to access care locally. Some flexibility at board level will be an important catalyst for change in service delivery. (HC Col 1643)

Section 13

101. In relation to financial assistance from health boards, Martyn Evans, Scottish Consumer Council, stated in oral evidence—

We welcome the assistance and support that health boards will be able to give dentists…This particular provision will lead to a reasonable public investment in more accessible services. (HC Col 1642)
Section 14

102. Greater Glasgow NHS Board support the proposals, including the introduction of co-management schemes. Dr Iain Wallace stated in oral evidence—

the co-management schemes that section 14 allows and the flexibility to have personal dental services, community dental services and GDS working together with salaried GPs are important. Our experience in Glasgow with sedation services and services for the elderly is that such flexibility is beneficial in targeting particular groups. (HC Col 1643)

Committee’s Overall View

103. The Committee supports the proposals in sections 11 to 14 on general dental services and the wider policy intention stemming from ‘Modernising NHS Dental Services in Scotland’ of enabling health boards to take a more active role in securing and providing general dental services. The Committee believes that, if properly funded and implemented, the policy will provide for better access to a wider range of general dental services at a local level.

104. While the Committee welcomes the funding brought forward in the Executive’s Action Plan which is intended to implement the policy, the Committee supports the view of the Finance Committee that this information should have been available at the bill’s introduction. (Finance Committee paragraphs 20-30).

Specific Issues Raised by Those Submitting Evidence

New charging system

105. The BDA makes suggestions about the alternative charging system for treatment in written evidence stating—

The BDA believes the current system of charging is too complex and difficult for patients and dentists alike to comprehend. Any new system must be transparent and easy to understand...easy to operate and avoid unnecessary bureaucracy.

106. The Committee supports the BDA’s view and recommends that the Executive actively engages with professional bodies, patient representatives and health boards when considering the specific details of the new charging system.
107. The Committee also recommends that the Executive provide the Committee, at the earliest opportunity, with draft regulations defining the new system to allow members to comment on the proposed system before the regulations are formally laid before Parliament.

**Appropriate premises**

**Physical access**

108. In oral evidence Martyn Evans, Scottish Consumer Council, raised the issue of physical accessibility to dental practices. He stated that—

in our study on access to primary care services, dentists were the least physically accessible. Indeed, 75 per cent of the dentists whom we reviewed were located up a flight of steps. (HC Col 1642)

109. The Committee is concerned that only 25% of services are physically accessible for those with restricted mobility, making it difficult for these individuals to find suitable local dental services. The Committee recommends that the Executive ensures that the accessibility of premises is treated as a priority by health boards when providing financial assistance to practices under section 13.

**Professionals complementary to dentistry**

110. Research commissioned by the Committee entitled ‘Access to Dental Health Services in Scotland’ included findings on the benefits of employing professionals complementary to dentistry. The research found that a dental therapist could increase a dentist’s output by 45% and that a dental hygienist could increase a dentist’s output by 33%.

111. Catherine Lush raised the issue of premises development in relation to the provision of services complementary to dentistry in oral evidence stating—

I expect dentists to continue to head up the teams, but we will make much better use of professionals complementary to dentistry, who will need premises. The dental therapists and dental hygienists will need to work in surgeries, so the challenge is not only to create the workforce and skill it up, but to ensure that we have the premises for the workforce to work in. (HC Col 1643)

112. The Committee appreciates the importance of employing professionals complementary to dentistry in order to maximise levels of service delivery and to allow for an increase in the provision of preventative care. The Committee therefore recommends that health boards ensure that, when providing financial assistance for the establishment of new dental practices, the premises for these practices can accommodate professionals complementary to dentistry.
PART 2, SECTIONS 15, 16 AND 17:
LISTING ADDITIONAL CATEGORIES OF DENTAL PRACTITIONERS,
OPTOMETRISTS AND OPHTHALMIC PRACTITIONERS

Purpose of These Sections of the Bill

113. Sections 15 to 17 of the bill extend the requirement to register on health board lists to all dentists and ophthalmic medical practitioners. At present non-principal providers such as locums or those assisting in general ophthalmic or general dental services do not require to register. This provision would require these individuals to satisfy the same rules of suitability to register as those currently on the list. Once on a list, these individuals would be subject to the discipline procedures of statutory Discipline Committees and the NHS Tribunal.

Overall Views of Those Submitting Evidence

114. All those who gave oral evidence to the Committee, namely Optometry Scotland, British Dental Association, the Scottish Consumer Council, Fife Local Health Council and health boards (Glasgow and Highland) and all those submitting written evidence were supportive of the proposal to extend health board lists.

115. For example, in oral evidence Catherine Lush, Highland NHS Board stated—

   It is important that we respond to patients, who are looking for increased accountability. I see the proposals as an important part of that. (HC Col 1645)

116. Martyn Evans added the Scottish Consumer Council’s support for the proposal in oral evidence—

   The Scottish Consumer Council approves of the extension. We think that it is sensible to have provisions on fitness to practice and to have all those who are practicing on a list. (HC Col 1644)

Committee’s Overall View

117. The Committee supports the Executive’s proposals to extend health board lists to include all dentists and ophthalmic medical practitioners and believes they will allow health boards to ensure all practitioners are regulated and can be held directly accountable for their actions.
Specific Issues Raised by Those Submitting Evidence

118. Sections 15 – 17 require new entrants onto health board lists to provide certain information such as an enhanced criminal record certificate (provided by Disclosure Scotland) and to declare gifts and financial interests which might influence service delivery. These sections also allow the Executive to apply this disclosure requirement to existing practitioners should the Executive choose to do so.

119. During a roundtable discussion on this issue, Martyn Evans, Scottish Consumer Council, asked Executive officials—

why those who are on the list currently will not be subject to the same disclosure requirement, as it is in patients’ interest to know that there is nothing for them to be concerned about in relation to a person’s fitness to practise. (HC Col 1644)

120. When questioned on this issue during the Minister’s evidence session, Executive official Dr Hamish Wilson stated that—

the potential volume of checks if we were suddenly to include all existing practitioners as well as all new practitioners is relevant. We need a sensible and practical approach to allow us to do the most effective thing quickly. (HC Col 1859)

121. The Committee believes that those on the existing health board lists should be required to disclose the same information as new entrants to ensure that all those on the extended lists are regulated on the same basis. The Committee recommends that individuals on existing lists should be required to disclose information under the same timescale as those newly required to register.

PART 3:
PHARMACEUTICAL CARE SERVICES

Purpose of This Part of the Bill

122. Section 18 places responsibility for planning services on health boards, namely identifying the service need and securing or providing pharmaceutical care services (PCSs). This is a shift away from the existing system where pharmacists apply to set up a business and health boards consider such requests. It also shifts financial accountability for these services onto health boards, the intention being for the central budget to be distributed between boards.

123. Section 19 provides for NHS contracts between health boards and pharmacists to provide PCSs where each contractor will provide ‘essential’ services and can opt to provide ‘additional’ services should health boards...
identify a need. Section 19 also provides for a process for the resolution of disputes between health boards and contractors.

124. Section 20 makes provision for a pharmaceutical list held by health boards to include all ‘principal pharmacists’ currently listed as practising and all ‘non-principal’ pharmacists. This provision is similar to those included in sections 15 to 17 on persons providing dental or ophthalmic services, and were similarly supported in all oral evidence and written submissions received. The Committee’s conclusions and comments in relation to sections 15-17 therefore apply to the provisions in section 20 of the bill (see paragraphs 113 – 121).

125. Section 21 enables health boards to provide financial support to those providing or proposing to provide pharmaceutical care services.

**Overall Views of Those Submitting Evidence**

126. All those who gave oral evidence supported the provisions in Part 3, namely the Scottish Pharmaceutical General Council, the Scottish Pharmaceutical Federation, the Scottish Consumer Council, Fife Local Health Council, Greater Glasgow NHS Board and Highland NHS Board. All those who submitted written evidence also supported the provisions.

127. The Scottish Pharmaceutical General Council, which has already formally agreed the framework for the PCS contract with the Scottish Executive, broadly supports the provisions in Part 3. Alex MacKinnon, SPGC, stated in oral evidence—

> We fundamentally support the overarching aim of improving patient care through better use of pharmacists’ key skills. The proposals represent a major service redesign and a major change in the way in which community pharmacists work. They will move from providing pharmaceutical services to providing pharmaceutical care services. I fundamentally believe that we will reposition community pharmacy as an integral part of the modernising primary care team. (HC Col 1647)

128. The Scottish Pharmaceutical Federation broadly supports the provisions in Part 3. In relation to the introduction of health board planned services, James Semple stated in oral evidence—

> We are happy that the Executive has not gone down the route favoured by the National Consumer Council, which was the OFT route of having a free market. The best idea is for health boards to maintain the ability to plan services properly and to put them where they are needed, not just where the nearest honey pot is to which all contractors will rush to make money. (HC Col 1646)

129. Mary Morton, Highland NHS Board, supported this point in oral evidence, noting the benefits of planning pharmaceutical services in remote areas.
instead of relying on whether contractors wish to provide services in these areas (HC Col 1648).

Committee’s Overall View

130. **The Committee supports the Executive’s proposals for the provision of planned pharmaceutical care services. The Committee believes that, if properly implemented the proposals could ensure the provision of a wider range of pharmaceutical services throughout Scotland on the basis of the needs of individual communities.**

Specific Issues Raised by Those Submitting Evidence

Regulations

131. The Scottish Pharmaceutical Federation (SPF) and the Scottish Pharmaceutical General Council (SPGC) both raised the issue of the importance of the detail of the regulations in Part 3 in clarifying the specific nature of ‘pharmaceutical care services’. James Semple, SPF, commented—

> Although we completely support the thrust of the bill, the devil is in the detail. We need to wait until we see the regulations, as that is where the day to day problems might arise. We warn against the law of unintended consequences….Representatives of the profession must be involved at all points in the process. (HC Col 1649)

132. **Executive officials have agreed to provide the draft regulations to the Committee for Stage 2. The Committee recommends that the Executive actively engage with professional bodies, patient representatives and health boards when considering the specifics of the new system.**

National criteria and guidelines

133. Representatives of the SPGC and Highland NHS Board both highlighted the importance of national criteria and guidelines to aid consistent delivery of services across all health board areas. Alex McKinnon, SPGC, stated—

> we take the view that where something is agreed on a national basis according to national service frameworks and standards, that should not be diluted as it goes down through the boards. It is important that we have a national set of criteria and guidelines against which the pharmaceutical care services can be formulated. (HC Col 1647)
134. The Committee recommends that the Executive, in consultation with the key stakeholders, produce national criteria and guidelines on pharmaceutical care services to support the effective implementation of the legislation.

PART 4:
DISCIPLINE

Purpose of This Part of the Bill

135. This part of the bill strengthens the disciplinary powers over family health service practitioners (general practitioners, dentists, pharmacists and opticians). In particular, it introduces a new ground for disciplinary action, ‘unsuitability by reason of professional or personal misconduct’, and ensures that anyone who is barred from practising for one health board will in future be barred from practising for all.

Overall Views of Those Submitting Evidence

136. The main professional bodies representing those covered by the new disciplinary provisions are supportive of them. These include the British Medical Association (BMA), the British Dental Association (BDA), the Royal Pharmaceutical Society of Great Britain, and Optometry Scotland.

137. The proposals are also supported by those patient representative bodies who responded to the call for evidence. These included the Scottish Consumer Council, Forth Valley Local Health Council, and Borders Local Health Council, whose chair outlined the need for ‘twenty-first century legislation that enables clear and unambiguous approaches to dealing with issues of suspension and discipline of all professional groups that are involved in health care. The public expects no less.’ (HC Col 1662).

138. The proposals are also supported by the Scottish NHS Confederation. In its written evidence the Confederation states, ‘We fully support the bill’s provisions to strengthen the grounds and procedures for the discipline of Family Health Service Practitioners. We believe that these are sensible and logical changes which are necessary both to strengthen the protection of patients across Scotland and to meet the expectations of the public’.

Committee’s Overall View

139. The Committee supports the Executive’s proposals to strengthen the disciplinary procedures contained within part 4 of the bill.
Specific Issues Raised by Those Submitting Evidence

140. A number of those submitting evidence raised concerns about the implementation of the discipline aspects of the bill.

Link with Regulatory Bodies

141. The main issue raised in evidence was the need to ensure a link between the criteria and evidence applied by the professional regulatory bodies in undertaking disciplinary procedures and those adopted by the NHS in Scotland. This point was made by both the BMA and the BDA in oral evidence. (HC Col 1663, HC Col 1667)

142. Allied to this concern is a lack of a definition of ‘unsuitability by reason of professional or personal misconduct’. The BMA, in its written evidence, points out that the General Medical Council and the other regulatory bodies already have clear definitions for such conduct and that these should be adopted by the Executive to allow proper harmonisation between procedures.

143. The Minister, in evidence, indicated that consultations are on-going at a UK level to ensure that there is no duplication of work between the regulatory bodies and the NHS Tribunal, but that the outcome of these are unlikely to be known prior to conclusion of consideration of the bill. (HC Col 1861)

144. The Committee recommends that the Executive should strive to ensure that the disciplinary process created by the bill, and the definitions under which it operates, are harmonised with those of the professional regulatory bodies.

Remuneration Whilst Under Suspension

145. In oral evidence a number of issues arose in regard to the treatment of professionals whilst under suspension, and the principle of them continuing to receive their net income. Some professionals (e.g. GPs) are salaried and will continue to receive their net income from the NHS, whereas others (e.g. opticians) are not, and do not appear to be catered for. Officials present agreed that the Executive accepts the principle of professionals continuing to receive income whilst under suspension, and agreed to consider the issue in consultation with the individual professions. (HC Col 1668)

146. The Minister, in evidence, reported that this was being discussed with the professional bodies and that his intention overall was that suspension should have a neutral effect since it suggests that any allegations have yet to be investigated and conclusions reached (HC Col 1861).

147. The Committee recommends that the Executive should ensure that the treatment of the different professions covered, whilst suspended, should be equitable.
PART 5, SECTION 24:
HEPATITIS C PAYMENTS

Purpose of This Section of the Bill

148. This part of the bill creates a statutory basis for the making of payments to those with Hepatitis C who have been infected through NHS treatment. These payments are already being made under common law by the Skipton Fund on behalf of the Scottish Executive (and all other UK administrations).

Overall Views of Those Submitting Evidence

149. The Haemophilia Society Scotland and the Royal College of Nursing Scotland both supported the proposal contained within the bill. There was no opposition expressed in any written or oral evidence to the proposal.

Committee’s Overall View

150. The Committee supports the Executive’s proposal to provide a firm legal basis under Scots law for the making of payments to Hepatitis C sufferers.

Specific Issues Raised by Those Submitting Evidence

151. The Haemophilia Society Scotland, in both written and oral evidence, raised a number of specific criticisms concerning the criteria and operation of the payment scheme.

Exclusion of Those Who Died Before 29 August 2003

152. The Haemophilia Society objects to the exclusion from the scheme of dependants of those who died prior to 29 August 2003, which is set out in section 24, paragraph (1), sub-para (c). This view is supported by the Royal College of Nursing.

153. The Committee has some sympathy with this view and invites the Executive to consider the issue. From the limited evidence available there would seem to be a modest number of potential claimants whose dependants have been excluded from an ability to claim through the adoption of this inevitably arbitrary date.

154. The administrators of the Skipton Fund also indicated in oral evidence that the total number of claims UK-wide is likely, in their opinion, to be closer to 6,500 rather than 8,000 as originally estimated (HC Col 1701). On this basis, the funds currently set aside for payments by the Scottish Executive are unlikely to be exhausted.
155. The Minister, in evidence, maintained that he did not believe that the date should be changed as it was intended to focus the scheme on the living. He told the Committee—

We must also bear in mind what this is all about - trying to assist those who are suffering as a result of contracting hep C through past engagement with the NHS. Sadly, it is not about those who, unfortunately have passed away; it is about supporting those who are still with us. (HC Col 1862)

156. The Minister also indicated that he was not inclined to keep the matter under review, but that the amount devoted to the fund is likely to remain in place as there will be a long tail to the fund.

Appeals Procedure

157. One of the Haemophilia Society’s criticisms of is that there is no appeals process in place yet. This will inevitably be a concern to those who have been turned down for acceptance under the scheme. Given that the Fund has been operating since July 2003, this appears to the Committee to be a reasonable criticism.

158. The Minister, in his written submission, expressed the hope that he would soon be able to confirm a date by which the appeals panel would be operational. In oral evidence the Minister indicated that, as this is subject to agreement by all the UK administrations, he had spoken to John Reid, the UK Secretary of State for Health, on the issue. (HC Col 1863)

159. The Committee believes that an appeals procedure should be put in place as soon as possible.

160. The Committee recommends that the bill be amended to include the requirement for an appeals procedure, and that detail of the appeals procedure should be included in the regulations.

161. The Haemophilia Society also suggested that the proposed appeals panel should contain a haematologist rather than a GP. It would seem to the Committee that there should be scope for including both a haematologist and a GP on the appeals panel.

Structure of the Skipton Fund

162. A number of concerns were raised about the nature and structure of the Skipton Fund as a private company. However, in evidence the Committee heard that its administration costs were 0.25% of payments, that its Directors are not remunerated, and that it is projecting zero profits over the medium-term.

163. The Committee is content, from the evidence that it has heard, concerning the Skipton Fund’s management of public funds.
Definition of Scottish Claimant

164. The Haemophilia Society suggested that those who can claim should be defined according to whether they were infected as a consequence of treatment by NHS Scotland rather than their place of residence at the time of making a claim, as is currently proposed in the bill (section 24 (2)(b)). This would, for instance, avoid difficulties where claimants move homes.

165. The Minister clarified in his written evidence and confirmed in oral evidence (HC Col 1864) that a claimant only has to be resident at the time of making the claim, and may subsequently move without affecting the claim. He also clarified that if they move, for instance to England, they could claim there if they had not already done so in Scotland.

166. Given the evidence, the Committee believes that the definition of Scottish claimant in the bill should be amended to reflect those who have been infected by NHS treatment in Scotland, irrespective of current residence.

Taking Into Account of Skipton Fund Payments in Other Payments

167. The Haemophilia Society pointed out in oral evidence that guidance from the Skipton Fund indicates that these payments will not be affected by payments received by beneficiaries from litigation or other schemes. However, it argued, that the wording of section 24(3) (b) of the bill appears to allow for Skipton Fund payments to be taken into account in any other claims. (HC Col 1690)

168. In his written submission the Minister stated, ‘Clearly this section must properly reflect what has previously been said by Scottish Ministers. I will consider this section and amend as appropriate.’

169. The Committee welcomes the Minister’s clarification on the issue, and looks forward to the submission of an amendment to ensure that sufferers receive the full benefit of Skipton Fund payments.

Role of Clinicians in Completing Application Forms

170. The Committee was disappointed to learn that difficulties appeared to have been encountered by some claimants in receiving assistance from clinicians, and particularly consultants, in completing application forms to the Fund (HC Col 1683). The Skipton Fund representatives reassured the Committee that this issue now appeared to have been dealt with.

171. The Minister, in evidence, outlined that some problems had been experienced, particularly in the Greater Glasgow NHS Board area, but indited that these now appear to have been resolved.

172. The Committee believes however that this matter should be kept under review and that should problems reoccur, the Executive,
through the Chief Medical Officer should write to all consultants
underlining their responsibility.

Claims by Dependents

173. The legal advisers to the Haemophilia Society also questioned the Skipton
Fund rule which states that if eligible persons died after 5 July 2004, they
must have made a claim whilst alive in order for their dependants to benefit.

174. In his oral evidence, the Minister recognised this point as valid and gave a
commitment to examine the issue and return to the Committee with
clarification. (HC Col 1865)

175. The Committee welcomes this commitment.

PART 5, SECTIONS 25, 26 AND 27:
AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001

Purpose of These Sections of the Bill

176. This part of the bill proposes a number of amendments to the Regulation of
Care (Scotland) Act as a result of difficulties that have arisen since its
implementation.

177. The changes are that:

- certain independent health services be able to be exempted from the
  Care Commission regime;
- a duty be placed on the Care Commission to take into account
  representations that it receives in response to notices that it issues; and
- a duty be placed on social work employers to provide information to the
  Scottish Social Services Council where employees have left their
  employment due to misconduct.

Overall Views of Those Submitting Evidence

178. The Committee took evidence from Executive officials on these sections of
the bill on 11 January 2005. These sections of the bill were not consulted
on by the Executive but, according to the Policy Memorandum, the
proposals are supported by the main bodies affected; the Care Commission
and the Scottish Social Services Council.

179. The Royal College of Nursing Scotland (RCN) submitted written evidence
on this part of the bill. The RCN expressed some concerns about the
proposed exemption of independent care services, but supported the new
duty proposed for social work employers. No other written evidence was
received on this matter.
Committee’s Overall View

180. The Committee supports the Executive’s proposal under sections 25-27 of the bill.

PART 5, SECTIONS 28 AND 29:
DE-REGISTRATION WITH THE CARE COMMISSION

Purpose of These Sections of the Bill

181. These sections of the bill propose to amend the care and housing legislation to retrospectively make lawful the provision of care housing support services by bodies whose registration with the Care Commission lapsed inadvertently.

Overall Views of Those Submitting Evidence

182. The Committee took oral evidence from Executive officials on 11 January who explained that these sections of the bill were necessary to cover for an oversight which allowed the registration of a large number of bodies providing care and support services to fall in 2003. Technically the services and payments made by them at this time became unlawful. The situation arose inadvertently, and the Executive wishes to ensure that the legal situation is remedied so that all this activity is deemed lawful.

183. No written submissions were received on these sections of the bill.

Committee’s Overall View

184. The Committee recognises the case for making this legislative arrangement, but regrets the need to do so due to the oversight in implementing the previous legislation.

PART 5, SECTION 30:
AUTHORISATION OF MEDICAL TREATMENT

Purpose of This Section of the Bill

185. This part of the bill seeks to amend the Adults with Incapacity (Scotland) Act 2000 in two ways. It extends the types of health professionals who can issue a certificate that an individual is incapacitated (and therefore allows medical treatment to be administered without their express permission). Dentists, nurses and ophthalmic opticians would, therefore, be allowed to
authorise treatment in their respective disciplines. It also extends the duration of such certificates from a maximum of 1 year to 3.

**Overall Views of Those Submitting Evidence**

186. None of those bodies representing patients who would be covered by the provisions of the bill object to it. Alzheimer Scotland is content to support the proposals, Enable has no objection to it, and the Scottish Association for Mental Health is not opposed to the main provisions, subject to some important conditions.

187. The professional bodies affected by the proposals are all supportive of them. These include the Royal College of General Practitioners, the Royal College of Nursing, the British Dental Association, and Optometry Scotland.

**Committee's Overall View**

188. The Committee supports the Executive's proposal to extend the types of professionals who can issue an incapacity certificate.

189. The Committee does not support the extension of the maximum duration of a certificate from 1 year to 3 years.

190. The Committee's reasoning is outlined below.

**Specific Issues Raised by Those Submitting Evidence**

**Training**

191. The arrangements regarding incapacity certificates, which this part of the bill seeks to amend, were introduced in 2000 by the Adults with Incapacity (Scotland) Act. None of the bodies that gave evidence to the Committee believe that those professionals who had to administer the certificate had been given adequate training since the Act was introduced.

192. The written evidence of Alzheimer Scotland reflects the general view. It states that the Act 'was introduced without doctors being provided with the necessary guidance and training on the assessment of mental capacity. This has not yet been remedied.'

193. In oral evidence, the Minister and Executive officials admitted that the take-up of training under the 2000 Act had been 'patchy'. (HC Col 1867)

194. The Scottish Association for Mental Health argues in its written evidence that, 'It should be a requirement that health professionals, to whom powers are to be extended, undertake accredited training in assessing capacity before they are empowered to sign incapacity certificates.'
195. The Minister and officials, in evidence, indicated that training would be made available for all groups covered by the bill, and that individuals would not be empowered to sign off incapacity certificates unless they have been through the training.

196. The Committee believes that the introduction of this legislation and the extension of powers to dentists, nurses and ophthalmic opticians must be accompanied by accredited training for these groups.

197. The Committee supports the proposal that professionals will not be empowered to sign off incapacity certificates until they have received accredited training.

198. There is also a need to ensure that all doctors already covered by the legislation have been properly trained in its implementation.

199. The Committee supports the view expressed by witnesses that this training should be provided on a multi-disciplinary basis by NHS Education. It also recommends that the patient representative bodies be consulted on the design of the training. This does not appear to have happened to date.

200. The Committee recommends that the requirement for training be included in the regulations covering this section of the bill, and requests that draft regulations be published before the bill is considered at stage 3.

201. The Committee notes that there is no provision within the Financial Memorandum for the costs of training that will be necessary under the bill.

**Extension of Range of Health Professionals who can issue Incapacity Certificates**

202. At present only a registered GP can sign an incapacity certificate. All the patient groups that gave evidence indicated that they were aware that this could lead to delays in treatment and the alleviation of pain, e.g. in receiving dental treatment.

203. Subject to the proviso above on training, the Committee has no objection to the extension of the ability to sign incapacity certificates to dentists, nurses and ophthalmic opticians.

204. The Scottish Association for Mental Health argues in its written submission that the power to issue a certificate should be restricted to senior grades of nurse only. The Committee does not support this view, but believes rather that nurses should be eligible on the basis of whether they have received proper accredited training.
205. The question of whether the power to issue an incapacity certificate should be extended to other groups was raised with the Committee. In their written evidence the BMA advocates the inclusion of clinical psychologists, and the Chartered Society of Physiotherapists advocates the inclusion of physiotherapists. In oral evidence, the Minister indicated that he was open to the further extension of groups able to issue certificates, if persuaded of the case. (HC Col 1866)

206. The Committee believes that the principle that it is the individual’s level of capacity that is being assessed, and not their need for treatment must remain paramount.

Extension of Duration of Incapacity Certificate to 3 Years

207. The extension of the maximum duration of an incapacity certificate from 1 year to three years was supported by the professional bodies who gave evidence, including the Royal College of General Practitioners, the BMA, and the Chartered Society of Physiotherapists.

208. The patient representative bodies that submitted evidence expressed a number of reservations about this provision.

209. Enable suggested in written evidence that where a three year certificate were granted an annual review should still be undertaken. In its written submission the Scottish Association for Mental Health argued that whilst longer certificates might apply to those with advanced dementia or profound learning disabilities, they should not apply to those with mental health problems.

210. Alzheimer Scotland raised a concern in its submission that the proposed extension of the duration of the certificate would diminish the importance of regular and comprehensive reassessment of any ongoing treatment.

211. It also raised a parallel concern over the inappropriate prescribing of psychotropic medication to people with dementia in care homes – a group who might be expected to be subject to longer-term incapacity certificates. In his oral evidence, Dr Jacques of Alzheimer Scotland, argued that ‘lengthening the period of certification might be seen to encourage very long-term use of medication without review’. (HC Col 1712)

212. The Committee has received additional evidence on inappropriate prescribing from Mr Hunter Watson and shares Alzheimer Scotland’s concern with regard to the bill.

213. In its written evidence, Enable stressed that its primary concern is to ‘make sure any changes to the legislation provide a definite benefit to adults with incapacity rather than health or other professionals.’ 

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214. The Committee shares Enable’s view that changes to the legislation should be governed by patient welfare and for this reason is not minded to support the extension of incapacity certificates to 3 years.

215. The Committee believes that, even with tight regulation, there is a significant risk of three year certificates being employed much more extensively than is intended, with a consequent reduction in patient care. If it is good practice to carry out an annual review for patients, then the assessment of capacity and issue or not of a certificate should remain part of that process.

PART 5, SECTION 31: JOINT VENTURES

Purpose of This Section of the Bill

216. This part of the bill proposes new powers to allow the formation of joint ventures for the provision of facilities or services and for the exploitation of intellectual property rights in the NHS.

217. Section 31 (subsection 1) seeks to enable Scottish Ministers and NHS bodies to enter into joint venture agreements with contractors, local authorities and private sector providers, to support primary and community care and joint working premises, and other infrastructural developments.

218. Section 31 (subsection 2) seeks to allow Scottish Ministers to form or participate in companies for the purpose of developing and exploiting intellectual property generated by the NHS. It is intended that this power is restricted to the purpose of making more income available to the health service.

Overall Views of Those Submitting Evidence

Facilities and Services

219. The NHS Confederation supports the principle of allowing joint ventures, which it considers will give boards additional options for the development of premises and facilities and will allow the NHS to take part in the kinds of joint ventures that are already undertaken by local authorities.

220. COSLA is also in favour, in principle, of joint ventures to the extent that they recognise advantages in shared premises for health and local authority services. COSLA, however, raised some concerns about the practical application of the policy and about the level of involvement of local authorities in policy development discussions in this area.
221. Witnesses representing private sector contractors Turner & Townsend Management Solutions and EC Harris, both with experience of heath sector PFI/PPPs (public finance initiative/public private partnerships) and joint venture initiatives using the English LIFT (local improvement finance trust) model, were in favour of the proposal. Support was expressed in terms of: benefits arising from private investment in and joint planning of health and social care facilities; improved performance of PFI and joint venture initiatives, based on increased public sector experience; and flexibility.

222. However, the Royal College of Nursing indicated that it was unconvinced by the experience in England and both the Scottish Trades Union Congress and the public sector union, UNISON, oppose the policy, questioning whether it represents value for money for the public.

**Intellectual Property**

223. In its written submission the NHS Confederation expresses support for the potential to use joint venture companies as a vehicle for exploiting intellectual property development in the health service, describing this as an ‘untapped resource that the NHS has neither the time nor expertise to take forward.’

224. In its written evidence, Universities Scotland also indicated support for this proposal, which it views as a ‘catching-up exercise’ in relation to similar powers held by Ministers at Westminster.

**Committee’s Overall View**

225. The Executive intends to provide for new powers to form and participate in joint ventures in the health service by introducing potentially wide-ranging enabling legislation.

226. Much of the evidence available to the Committee related to the experience of NHS LIFT projects in England. While a number of these projects are now underway, the Committee is of the view that it is too soon to make an objective judgement about the performance of this model. The Committee is also aware that other joint venture models are possible under the Executive’s proposals; however, it appears that a limited amount of consideration has been given to alternative models by the relevant public sector agencies. The Committee considers it important that a range of alternative joint venture models are considered, including the mutual model.

**Specific Issues Raised by Those Submitting Evidence**

**Joint Venture Models**

227. It was clear from the evidence received by the Committee, and confirmed in correspondence with the Minister for Health and Community Care, that the
NHS LIFT model operated in England is only one model that could be applied in Scotland under the powers proposed in the bill. In a written submission to the Committee, the Minister indicated that, ‘The powers we are seeking are generic and do not restrict either Scottish Ministers or NHS Boards to one particular model’. However, the Minister also indicates that while it will be possible for alternative models to be developed, there are cost and time implications in doing so, both nationally and for local partners.

228. The Committee was advised in oral evidence from Howard Forster, of EC Harris, that 42 NHS LIFT projects are currently being pursued at different stages of progress, and that few as yet have been completed.

229. The Committee was also informed, in correspondence from the Minister, that the National Audit Office is due to issue a report in April on the NHS LIFT initiative in England.

Risk and Cost

230. Responding to questions about risks and costs associated with joint venture initiatives, a number of witnesses expressed the view that previous public and private sector experience in handling PFI/PPP contracts offered lessons that could be positively applied to any future joint venture initiatives.

231. David Fox outlined to the Committee the key stage review process implemented by the Scottish Executive, which helps ensure that promoters of PFI/PPP projects ‘get it right’ (HC Col 1724). Howard Forster, EC Harris, told the Committee that—

In the mainstream PFI market, cost escalations are mainly due to delays in projects and inflationary pressures during those delays. That has not been apparent in the LIFT market; on the whole, the first 42 schemes that have been bid on have been straightforward. (HC Col 1723)

232. Susan Aitken, of the NHS Confederation told the Committee—

The NHS came rather late in the day to joint ventures, which gives us some advantages. We can learn lessons that Scottish local authorities have already learned from being involved in joint ventures. Through the LIFT scheme in England, we have learned that we can use the best bits of models and discard the bits that have not worked. (HC Col 1741)

233. However, it was apparent to the Committee that representatives from COSLA and the NHS Confederation had only limited knowledge of existing NHS LIFT projects in England.

234. In response to a written question from the Committee about how public finance and public service delivery will be safeguarded should a joint venture company initiative fail, the Minister indicated that the risk exposure of a joint venture will depend on the structure it takes and that sharing of risk provides an incentive for partners to make the joint venture a success.
He also indicated that standardised documentation will be used to ensure that any partnering agreement between the public and private sectors requires a joint venture to perform its obligations without recourse to government or public funds.

Jobs and Conditions

235. In evidence to the Committee, Howard Forster of EC Harris indicated that the facilities management (FM) content in NHS LIFT schemes in England has so far been limited to the provision of ‘hard’ facilities management, such as building services (HC Col 1727). To date, therefore, there has been no transfer of employees from one service provider to another.

236. It is not clear to the Committee, however, that this will always be the case. Dave Watson, of UNISON, suggested to the Committee that differences in health service delivery in Scotland might increase the prospects of soft facilities management being included in joint venture initiatives here. He told the Committee—

There are more health centres in Scotland, particularly in the major cities, whereas there are more private GP practices down south. Health centres are traditionally health board premises that have health board staff – both soft FM and hard FM, to use the PFI jargon. The other difference between Scotland and England is that there is far more direct staff provision in Scotland in local authorities and in health boards, whereas in England there has been far more use of contractors. Those differences lead us to be concerned that there might be more staffing problems in Scotland. (HC Col 1752)

237. The Committee, therefore, welcomes the Minister’s confirmation, in a written submission, that the Scottish PPP staffing protocol will apply to joint venture companies established under the bill’s provisions, on the basis that public private joint ventures are a form of PPP.

Commercial Pressures and Conflict of Interest

238. In evidence, witnesses from UNISON and the STUC raised concerns about potential conflicts for public sector employees serving as directors of joint venture companies. Dave Watson, of UNISON, raised the issue of directors’ fiduciary duties to share holders and potential pressure to pursue commercial activity over health related functions where, for example, a higher rent for premises was offered by a commercial operator as compared to a health related service provider, such as a doctor. (HC Col 1756)

239. In evidence the Minister indicated that he had been impressed by projects that offered investment in areas where community regeneration has otherwise been at a standstill. He told the Committee—
If we aggregate public sector expenditure, bringing in health services—say, a dentist, a doctor and a physiotherapist—a post office, a police station, a newsagent’s and a hairdresser’s, that is good news for the community. (HC Col 1870)

240. In earlier correspondence with the Committee, the Minister indicated that ‘influence on the direction taken and prioritisation of the scheme would be achieved through the governance arrangements established for the joint venture company. In the context of a LIFT type development, the Strategic Partnering Board fulfils this role via the Strategic Development Plan’.

241. Dave Watson, of UNISON, also raised a concern that local priorities may become distorted because of the need to ensure the ‘critical mass’ necessary to attract private finance. (HC Col 1751)

242. The Committee notes that, as drafted, the bill does not guarantee that appropriate governance arrangements will be established to ensure that health related priorities are given sufficient weight in joint venture companies. The Committee invites Ministers to address this point at Stage 2.

PART 5, SECTION 32: SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST

Purpose of This Section of the Bill

243. This part of the bill proposes to convert the Scottish Hospitals Research Trust (SHERT) from a non-departmental public body (NDPB) to a charitable trust. The main motivation for this proposal is that SHERT risks losing charitable status if it remains an NDPB. SHERT receives endowments, donations and bequests and allocates them to support medical research in Scotland.

Overall Views of Those Submitting Evidence

244. The Committee took oral evidence from Executive officials on this part of the bill on 11 January 2005. The officials confirmed that the pre-legislative consultation has elicited positive responses to this proposal on the basis of the importance of charitable status, and no objections.

245. The only organisation to submit specific written evidence on this part of the bill was the Royal College of Nursing (RCN) Scotland. The RCN raised some issues about the narrowness of the criteria for the distribution of SHERT funds, but was supportive of the proposal contained in the bill.
Committee’s Overall View

246. The Committee supports the Executive’s proposal to convert the Scottish Hospitals Endowments Research Trust from a Non-Departmental Public Body to a charitable trust.
ANNEX A: REPORTS FROM SECONDARY COMMITTEES AND HEALTH COMMITTEE STUDY VISIT TO IRELAND

Finance Committee

Report on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill

The Committee reports to the Health Committee as follows—

Introduction

1. Under Standing Orders, Rule 9.6, the lead committee in relation to a Bill must consider and report on the Bill’s Financial Memorandum at Stage 1. In doing so, it is obliged to take account of any views submitted to it by the Finance Committee.

2. This report sets out the views of the Finance Committee on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill, for which the Health Committee has been designated by the Parliamentary Bureau as the lead committee at Stage 1.

3. At its meeting on 8 February 2004, the Committee took evidence from representatives from the Scottish Licensed Trade Association (SLTA), COSLA and the Scottish NHS Confederation.

4. The Committee then took oral evidence from officials from the Scottish Executive on 1 March 2005. In addition to receiving written submissions from the SLTA, COSLA and the Scottish NHS Confederation, the Committee also received submissions from: ASH Scotland, the British Dental Association, the Care Commission, Health Scotland, Optometry Scotland, the Scottish Social Services Council and the Scottish Hospital Endowments Research Trust.

5. The Committee would like to express its thanks to all those who submitted their views.

Objectives and the Financial Memorandum

6. The Bill is split into 5 distinct parts. Part 1 of the Bill deals with the Prohibition of Smoking in Certain Wholly Enclosed Places. Part 2 looks at General Dental Services, General Ophthalmic Services and Personal Dental Services, Part 3 deals with Pharmaceutical Care Services, Part 4 deals with Discipline and Part 5 deals with miscellaneous provisions such as joint ventures and amendments to the Regulation of Care (Scotland) Act 2001.

7. The Committee agreed that it would concentrate on 3 specific parts of the Bill – Parts 1, 2 and 3. The additional costs of these provisions as estimated by the Executive are laid out in the Bill’s Financial Memorandum and are summarised as follows:
<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Cost on Scottish Administration</th>
<th>Health Boards</th>
<th>Local Authorities</th>
<th>Cost on Other Bodies</th>
<th>Para Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>£2m for communications ahead of implementation and £1m p.a. for 3 years following implementation. £50,000 - £100,000 in the first year for compliance line. Ongoing costs not known</td>
<td>Gross savings of £5.7m to £15.7m p.a. on NHS costs in the longer term</td>
<td>Enforcement costs to be developed in full RIA.</td>
<td>Between £104m cost to £137 benefit to hospitality sector p.a.</td>
<td>193, 195, 197, 203, 207</td>
</tr>
<tr>
<td>Free Eye and Dental Checks</td>
<td>£7.5m - £17.9m p.a. for eye checks and £9.1m - £12.4m p.a. for dental checks</td>
<td>Nil</td>
<td>Nil</td>
<td>Not known</td>
<td>212</td>
</tr>
<tr>
<td>Dentistry</td>
<td>N/A</td>
<td>£500,000 p.a. additional professional and administrative costs.</td>
<td>Nil</td>
<td>Nil</td>
<td>224</td>
</tr>
<tr>
<td>Listing</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>£10,000-£20,000 one-off NSS database costs.</td>
<td>230</td>
</tr>
</tbody>
</table>

**Part 1 – Prohibition of Smoking**

8. This part of the Bill seeks to ban smoking in wholly enclosed public places. In the Financial Memorandum, the Executive states that it will cost £2m for communications ahead of any ban and £1m per annum for 3 years following implementation. In addition, it will cost between £50,000 and £100,000 in the first year for a compliance line to be set up. The Executive has also estimated that as a result of the ban, there would be a cost of £104m to the hospitality sector which
would be offset by benefits of £137m\textsuperscript{10}. In terms of enforcing the Bill, the Financial Memorandum does not provide costs as precise details of the enforcement role have yet to be determined through consultation with COSLA.

9. The SLTA fundamentally disagreed with the costs to business as estimated by the Executive and questioned the research upon which the Executive’s figures were based. The SLTA claim that research carried out by the University of Aberdeen is incomplete as it only considered one study based on California which does not have a complete smoking ban. In addition, they claim that the study examined hotels and restaurants but not pubs. The SLTA noted that there were only three countries where outright smoking bans have been implemented – Ireland, New Zealand and Norway.

10. For their part, the SLTA produced research which they had commissioned which suggested that “annual profits in licenses premises may decline by £86m”, that “employment in the licensed trade can be expected to decline by 2,300 jobs” and that “some 142 average-sized licensed premises may close down as a result of decreased trade”.\textsuperscript{11}

11. However, the Committee noted that these figures were based on those available in Ireland and the SLTA had previously made it clear that the Irish ban had not been in place long enough for a full evaluation\textsuperscript{12}. When asked about their apparently contradictory position, the SLTA stated:

“We have been put in that position by the timing of the bill. We are saying that we should wait for at least a year to see what the Irish experience throws up, because it is the closest experience to home on which we can work”\textsuperscript{13}

12. In their submission to the Committee, Health Scotland questioned the comments made by the SLTA with regard to the research carried out by the University of Aberdeen. They said:

“The SLTA claim that the research was incomplete but fail to identify any studies that the evidence review missed.

All of the evidence reviewed related to the health and economic impacts of the regulation of smoking in public places and was entirely relevant. It is true that there was little evidence relating to impact on bars and this is made clear in the report. We excluded evidence from New York relating to the one year follow up of the comprehensive ban on smoking because it was not published in a peer reviewed source. However, it should be noted that this report showed a positive impact on bars and restaurants but did not show results for the sectors separately. As with all aspects of the research, the authors have been careful not to overstate the case for regulation.”\textsuperscript{14}

\textsuperscript{10} Smoking, Health and Social Care (Scotland) Bill: Explanatory Notes page 30
\textsuperscript{11} Submission from the Scottish Licensed Trade Association
\textsuperscript{12} Waterson, Official Report, 8 February 2005. Col 2310
\textsuperscript{13} Waterson, Official Report, 8 February 2005, Col 2312
\textsuperscript{14} Submission from Health Scotland
13. Subsequent to the publication of the Bill, the Executive published a Regulatory Impact Assessment (RIA) which gave a cost benefit analysis of 3 options – a voluntary approach, smoke-free legislation and legislation but with exemption for the hospitality sector which gives further details on potential costs to business and benefits to both business and the health service.

14. It is difficult for the Committee to come to a firm conclusion on the costs to business of an outright ban, given the contradictory figures which have been submitted to it not just on costs to business but also with regard to the potential benefits to business from attracting non-smokers into pubs. It is also difficult to make a precise assessment of the potential savings to the health service if the legislation succeeds in helping to reduce the number of smokers and smoking-related diseases. The Committee notes that the SLTA is proposing that a phased ban be introduced. This is a matter of policy and therefore is for the lead Committee to consider but it was not clear from the evidence how much of an impact a phased ban would have on the financial implications of the Bill.

15. The other cost of a smoking ban which the Committee scrutinised was the cost of enforcing the ban. COSLA estimated that enforcement could cost £6m pa for the first two years of the ban although they emphasised that their figures may need to be adjusted in light of the consultation. This cost includes estimates for training and recruitment costs, including the cost of paying for staff and introducing new systems, associated legal costs, additional out-of-hours and street-cleaning costs, the security cost for staff and other associated training.

16. The Committee raised concerns over the increased litter and noise levels outside pubs that might arise as a result of a ban and therefore, an increased need for enforcement. Gordon Greenhill from the Society of Chief Officers of Environmental Health explained that it was already an offence to drop litter and that the Executive has already provided funding to have environmental wards to enforce the legislation on litter. However, he also pointed out that the funding was temporary and would require to be made permanent. He also said that loud shouting in the street is already an offence and that he did not believe that there would be a major problem with increased litter and noise levels. The Committee was not convinced by this argument. The Committee was also sceptical about the Executive’s claim in the Financial Memorandum that the costs of enforcement will diminish over time.

17. Assuming the enforcement will rest predominantly with local authorities, the Committee was concerned about the current difficulties in recruiting and retaining Environmental Health Officers and the impact that any staff shortages could have on the implementation of this part of the Bill.

18. The Executive responded that COSLA had raised these concerns and that “there is an issue about how to get people in at the right level but, as COSLA noted, one does not have to have a fully qualified environmental health officer to provide corroboration or to serve a fixed penalty notice. COSLA and the Executive

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15 McKeown, Official Report, 8 February 2005, Col 2318
16 Greenhill, Official Report, 8 February 2005, Cols 2314 and 2315
have to think about whether there is room for being creative – in the best possible sense of the word – in that area.”  

19. However, the Committee remains very concerned that the costs of enforcement are largely unknown. The Committee certainly welcomes the fact that there will be consultation between the Executive, COSLA and the hospitality sector to establish these costs, however, it is extremely difficult for the Committee to carry out its scrutiny function when the costs are unknown. The Committee acknowledges that some figures have been incorporated into the RIA subsequently published by the Executive. This RIA assesses costs over a 30 year period and assumes £1m in 2006 and £5m in 2007. Costs are then predicted to fall to £2.5m in 2008 and to £1m thereafter for the rest of the 30 year period. The draft RIA states that the figure of £6m in the first two years is based on a submission by COSLA but that figure must be regarded as approximate because, in the absence of detailed Regulations, COSLA were not able to provide a more precise figure. The Executive confirmed that “the outcome of those discussions [with COSLA] will be reported to you [the Committee] in due course and will be incorporated into the final version of the RIA [Regulatory Impact Assessment] later in the year.”

Part 2 – General Dental Services, General Ophthalmic Services and Personal Dental Services

20. This part of the Bill has various provisions, including introducing free eye and dental check-ups, extending the range of general ophthalmic services, improving dental services and providing a national framework for charging for dental services.

21. The current cost of providing free NHS eye and dental checks is £15.2m and £7.7m respectively. The Financial Memorandum estimates that the cost of extending these free checks will be an additional £7.5m - £17.9m for eye checks and £9.1m - £12.4m for dental checks.

22. The Bill provides for a new system of charging to be established. However, the Bill itself does not specify the new payment arrangement and therefore, the Financial Memorandum does not state exactly what the cost implications will be for the Executive. The Memorandum does say that it expects any changes through the General Dental Services contract to be cost neutral. It estimates that NHS boards will require additional staff and that this will cost £500,000 across all NHS boards. In addition, it is estimated that National Services Scotland will incur initial development costs of between £10,000 and £20,000.

23. The Executive explained that the costs of providing free dental check-ups are based on dental examinations for the existing number of registered patients. These costs have then been increased by 25 per cent to reflect the fact that more people might seek dental check-ups if they are free. The Executive did not offer

17 Davidson, Official Report, 1 March 2005, Col 2425
18 Scottish Executive, Draft Regulatory Impact Assessment, published 10 March 2005
19 Davidson, Official Report, 1 March 2005, Col 2422
20 Wilson, Official Report, 1 March 2005, Cols 2432 and 2433
any evidence as to the basis for this additional 25 per cent figure and the Committee recommends that the lead Committee pursues this with the Minister.

24. However, the new oral health assessments proposed by the Bill are likely to be more extensive than the current dental examinations\(^2\) and therefore it can be assumed they will taken longer and are more likely to uncover dental problems which in turn will have to be treated. The Financial Memorandum does not quantify the costs associated with the additional dental hours that will be required as a consequence of the introduction of this part of the Bill. When asked about this, the Executive responded that “we are still working through with the dental profession the details of that oral health assessment and any possible manpower consequences.”\(^22\)

25. When pressed on this, the Executive stated that an external quantification of the current gap in the number of NHS dentists was 215.\(^2\) In addition, an approximation of the number of additional dental hours required was as follows:

“it has been roughly calculated that about 1 million examinations might be substituted by new oral health assessments. At present, approximately 2 million examinations are done under the NHS. and given that it will take an average of, say, 20 minutes for an oral health assessment, we might be talking about 300,000 hours of dentist time, which might come down to about 150 dentists.”\(^2\)

26. The Executive went on to say that other factors could come into play such as professionals\(^2\) other than dentists being able to carry out follow-up treatment.

27. Leaving aside the debate about whether it will be possible to recruit the additional number of dentists which will be needed, the Committee is deeply concerned that it is being asked to scrutinise the financial implications of a Bill where the staffing and service implications which crucially determine the cost do not appear to have costed in a manner that gives the Committee confidence in the figures.

28. There will be consultation not only about the form of new oral health examinations, but also on the issues of fees, capitation and allowances. The Executive has said that the specific costs that are allied to charges under the heading of “provision of General Dental Services” will be cost neutral, but that general improvements in dental services will have a cost and that improvement measures and funding for them will be included in a Ministerial announcement. The Committee deeply regrets that such an announcement was not made prior to the introduction of this Bill.

29. The Committee recognises that there are broader issues of dental services which are not necessarily a direct consequence of the Bill. However, it would argue that the number of additional dentist hours required and the results of the

\(^{21}\) Wilson, Official Report, 1 March 2005, Col 2430
\(^{22}\) Wilson, Official Report, 1 March 2005, Col 2430
\(^{23}\) Wilson, Official Report, 1 March 2005, Col 2430
\(^{24}\) Wilson, Official Report, 1 March 2005, Col 2431
\(^{25}\) Wilson, Official Report, 1 March 2005, Col 2432
consultation on a new charging framework are a direct consequence of the Bill and therefore, it is unacceptable that the Executive is not able to provide even a “best estimate” of costs. When scrutinising the Transport (Scotland) Bill, the Committee raised concerns over the major difficulties in scrutinising legislation where consultations on provisions have not yet been concluded. The Committee is dismayed that the same problems have arisen with this bill. The Committee is extremely concerned that Parliament is being asked to authorise the release of funds when it is not certain of what the cost of legislation is likely to be.

30. Following the evidence given by officials, the Deputy Minister wrote to the convener explaining that she believed that Financial Memorandum was adequate and appropriate. The Deputy Minister argued that the more extensive oral health assessments are part of the dental modernisation package and therefore the cost of these would be part of the overall financial package underpinning the modernisation of dental services. The implication of this being that this is not being directly proposed by the Bill. However, the fact remains that this will flow from the Bill (and indeed the Policy Memorandum makes specific mention of the consultation) and therefore, even if the figures were not included in the Financial Memorandum, then some indication of the likely costs should have been given. The Deputy Minister confirmed that the Ministerial statement would be made on 17 March. However, the Committee would reiterate its point that such a statement should have been made prior to scrutiny of the Bill, to provide a necessary policy context.

Part 3 – Pharmaceutical Care Services

31. This part of the Bill deals with expansion and changes to pharmaceutical care services. The Financial Memorandum estimates it will cost £500,000 across all NHS boards for administrative support for the new planning and monitoring role. The cost of delivering any new or enhanced services will depend on what a Board’s plan actually contains but the Financial Memorandum estimates revenue provision of around £85,000 if a full range of pharmaceutical services is to be delivered and additionally, gives a range of between £30,000 and £85,000 for fitting out premises. The cost to the NSS for the maintenance of “virtual” pharmaceutical lists is estimated to be £10,000 for initial development costs.

32. The Committee raised concerns that £500,000 did not seem adequate for the work that is likely to be involved and also questioned whether health boards will have to make changes, and therefore spend money, or would expenditure be optional. The Executive responded that not all services would add cost and that efficiencies could be sought. When asked what the costs actually represented, the Executive responded that:

“The £500,000 is for support staffing in health boards. As for additional service costs, the planning process that health boards will be required to follow will identify gaps. We cannot quantify those gaps at present because that planning process has not taken place. That is the chicken-and-egg situation again.”

26 Naldrett, Official Report, 1 March 2005, Col 2439
33. The Committee welcomes the fact that the Executive confirmed that if resource implications are identified during the course of negotiations on the contract’s implementation then the case will be taken to Ministers\textsuperscript{27} but once again, it is not clear what these final costs are likely to be.

Conclusions

34. The Committee notes that there are contradictory figures about the potential loss to business from a ban on smoking and recommends that the lead Committee pursue this issue with the Minister.

35. The Committee, whilst welcoming the fact that the Executive will be fully consulting with COSLA and the hospitality industry on enforcement, is very concerned that no firm figures have been produced, and will not be produced until the consultation has concluded, albeit that estimates have now been published in the draft Regulatory Impact Assessment. The Committee has raised this issue of principle with the Minister for Parliamentary Business and with the Minister for Finance and Public Sector Reform and hopes to have early discussions to resolve what is becoming a familiar problem. However, the Committee recommends that the lead Committee seeks assurances from the Minister that the results of such a consultation be reported as soon as possible and certainly before Stage 3.

36. The Executive did not offer any evidence as to the basis for the additional 25 per cent figure it has assumed in calculating the costs of introducing free oral health checks and the Committee recommends that the lead Committee pursues this with the Minister.

37. The Committee was even more concerned about the lack of information with regard to the provision of free oral health assessments. It records its dissatisfaction that the Ministerial Statement on dental services was not made prior to the introduction of this legislation as this could have provided a policy and funding context for some of the provisions of the Bill. As with the enforcement of a smoking ban, the Committee strongly recommends that the lead Committee seeks assurances from the Minister on this matter.

\textsuperscript{27} Naldrett, Official Report, 1 March 2005, Col 2439
The Committee reports to the lead Committee as follows—

**Introduction**

1. At its meetings on 22 March and 12 April 2005, the Subordinate Legislation Committee considered the delegated powers provisions in the Smoking, Health and Social Care (Scotland) Bill at stage 1. The Committee submits this report to the Health Committee, as the lead committee for the Bill, under Rule 9.6.2 of Standing Orders.

2. The Executive provided the Committee with a memorandum on the delegated powers provisions in the Bill, which is reproduced at Appendix 1.

3. The Committee’s correspondence to the Executive and the Executive’s response to points raised are reproduced at Appendix 2.

**Delegated powers provisions**

4. The Committee considered each of the delegated powers provisions in the Bill. The Committee approves without further comment: sections 3(3), 9(2), 10(3), 11(2)(a) and (c), 15, 16, 17, 19, 20, 22(2)(b), 23, 25, 30(2)(b), 30(2)(e)(ii), 30(2)(f)(ii), 33(1), 37(3), paragraphs 2, 5(1), 6(2), 13 and 14 of schedule 1 and paragraphs 1(4), 1(7), 1(9) and 2 of schedule 2.

**Section 4(2) and 4(7) Meaning of “smoke” and “no-smoking premises”**

5. The Committee noted that the bill creates offences of smoking or permitting smoking in no-smoking premises and that what constitutes no-smoking premises is left entirely to regulations made under section 4(2) and 4(7). Section 4(2) of the Bill provides for “no-smoking premises” to be prescribed by regulations and section 4(7) allows the Scottish Ministers to modify section 4(4), in order that kinds of premises may be added or removed.

6. The Committee recognised the need for the definition of no-smoking premises and exemptions to be contained in regulations rather than on the face of the bill, in order to provide the necessary flexibility. The Committee, however, was concerned that draft affirmative procedure simply allows for the approval or rejection of an instrument in its entirety and raised with the Executive that the proposed regulations should perhaps be subject to further scrutiny, such as that which a “super-affirmative” procedure would allow.

7. In its response to the Committee, the Executive stated that the first regulations made under section 4 will be subject to a higher level of scrutiny than would normally be the case for an instrument subject to draft affirmative procedure. The Committee, however, was concerned that there is no guarantee that future regulations made under this section will be subject to the same level of public scrutiny before being laid. Although by virtue of section 34(4) the Scottish...
Ministers must “consult such persons as they consider appropriate” before laying regulations under section 4(2) and (7), they are not required to circulate a draft instrument as part of that consultation.

8. The Committee agreed that it did not wish for any enhanced scrutiny to overburden the enactment of what may be minor amendments to the regulations in future. However, the Committee held concerns in relation to consultation on future regulations that may potentially make significant changes to the bill and highlights this issue to the lead Committee. The Committee has also agreed to write to the Minister to highlight its views in advance of stage 2 of the bill.

Section 11: Charges for certain dental appliances and general dental services

9. Subsections (2), (3), (5) and (6) amend existing regulation making powers to give Scottish Ministers the power to make regulations regarding the way in which certain dental charges are made or recovered. Currently the patient charge for dental treatment and appliances is linked to the item of service fee paid to dentists and unless the patient is exempt or remitted from charges he/she pays 80% of that item of service fee. The effect of the proposed powers will be to break this link with the aim of providing more flexibility and transparency to the charging system.

10. The Committee questioned whether negative procedure provided the best level of parliamentary scrutiny, given that although the existing powers are subject to annulment there are certain constraints on their use. It was suggested that the Executive may wish to consider using affirmative procedure for the first substantive exercise of the powers. The Executive in its response considered that negative procedure had worked well for governance of dental charges in balancing the needs of flexibility and parliamentary scrutiny and was not persuaded of the need for a more onerous procedure for the first exercise of the power. The Committee was content with the Executive’s explanation.

Section 18: Health Boards’ functions: provision and planning of pharmaceutical care services

11. Section 18 inserts new sections 2CA and 2CB into the 1978 Act to place a duty on Health Boards to provide or secure the provision of pharmaceutical care services for persons in their area, and provide for the way in which Health Boards plan to discharge that duty.

12. The Committee asked the Executive whether the new direction making powers in section 2CA(7) of the Drug Tariff should be incorporated into a more formal document, subject to parliamentary procedure. The Executive’s response provided helpful information as to the practical operation of these direction-making powers and the lengthy and technical nature of the directions. The Committee accepts the points made by the Executive in its response.
Section 24: Payments to certain persons infected with hepatitis C as a result of NHS treatment

13. This section makes provision for the making of a scheme by the Scottish Ministers for payments to persons infected with hepatitis C as a result of NHS treatment. Details of the contents of the scheme are set out in the section and there is a requirement on Ministers to publish the scheme. However, the Committee noted that the scheme itself will not be a statutory instrument nor is there any provision for any Parliamentary scrutiny of the scheme.

14. The Committee asked the Executive why it had chosen that the scheme should not be subject to parliamentary procedure. The Executive responded with additional information on the background to section 24, and considers that the obligations on the Ministers set out in that section, along with the fact that the Executive is accountable via the usual auditing and accounting controls, mean that the scheme is subject to an appropriate level of scrutiny.

15. The Committee was not persuaded by the Executive’s argument and recommends that the scheme should be subject to some form of parliamentary procedure to allow it to be formally brought to the attention of the Parliament. It therefore brings this matter to the attention of the lead Committee.

Section 28: Registration of child care agencies and housing support services

16. This power gives Scottish Ministers the flexibility to extend the period of deemed registration of Housing Support services and Childcare Agency services should that prove to be necessary. Subsection (4)(e) gives Scottish Ministers the power to make an Order to substitute a later date than that specified in that subsection. The power is exercisable by statutory instrument subject to negative procedure.

17. The Committee queried the use of negative procedure for the enabling power at section 28(4)(e) of the Bill, as it allows for the substitution of a date that appears on the face of the Bill, and is therefore a “Henry VIIIth” power. The Executive advised the Committee that it does not anticipate that the power at section 28(4)(e) will ever be used, and informed the Committee that it is included as purely a safety measure should the Care Commission be unable to process all applications for registration before the date.

18. The Executive considered the procedure appropriate as the power is very specific and limited in scope and it gives the Scottish Ministers more time and flexibility to extend the date if unforeseen circumstances in processing by the Care Commission were to arise.

19. The Committee was content with the Executive’s response and that negative procedure offers the most appropriate level of scrutiny.
APPENDIX 1

Smoking, Health and Social Care (Scotland) Bill
Memorandum to the Subordinate Legislation Committee

Purpose
This memorandum has been prepared by the Scottish Executive to assist consideration by the Subordinate Legislation Committee, in accordance with Rule 9.6.2 of the Parliament’s Standing Orders, of provisions of the Smoking, Health and Social Care (Scotland) Bill conferring power to make subordinate legislation. It describes the purpose of each such provision and explains why the matter is to be left to subordinate legislation.

Outline and Scope of the Bill
This Bill will enable the Executive to continue to take action to improve the health of the people of Scotland, to continue its programme of NHS modernisation and to improve health and social care services relevant to the needs of the people of Scotland.

A key policy objective for improving health is taking action on the impact of smoking. The Bill’s policy is to introduce a comprehensive ban on smoking in certain wholly enclosed premises.

The Bill also makes provision for the introduction of free eye and dental checks for all, and modernises the frameworks for the delivery of certain dental and pharmaceutical services. The Bill introduces a range of measures to update legislation relating to the listing and disciplinary procedures for family health service practitioners.

The Bill contains provisions to allow Scottish Ministers to make a scheme authorising payments to be made to certain persons who became infected with the hepatitis C virus after having had NHS treatment involving the receipt of blood, tissue or blood products. There are provisions for amendments to the Regulation of Care (Scotland) Act 2001, provisions in relation to child care agencies and housing support services, and provisions to amend the Adults with Incapacity (Scotland) Act 2000. These will further improve the delivery of health and social care.

Included in the Bill are provisions to allow Scottish Ministers to set up or participate in joint venture companies. This will increase the range of options available to Health Boards for the delivery of facilities and services, and enable the Scottish Ministers and NHS bodies to make the most of ideas and intellectual property generated by the NHS. Finally, the Bill makes provision to end the NDPB status of the Scottish Hospital Endowments Research Trust.

The subordinate legislation powers contained in the Bill divide between those that are completely new and those that are required to replace existing powers in legislation being amended by the Bill. The Bill contains subordinate legislation making powers in the following Parts:
Subordinate Legislation Powers

Sections 3 and 4 have subordinate legislation making powers in relation to the prohibition of smoking in certain wholly enclosed places (“the new powers”). The new powers will enable Scottish Ministers to make provision for the display of warning notices and to prescribe premises, parts of premises and classes of premises which are excluded from the definition of “no-smoking premises”. It is considered appropriate that these new powers would be subject to the affirmative resolution procedure of the Parliament.

Sections 9 to 23 of the Bill include a number of primary health care provisions containing powers to make subordinate legislation. The modernising of the existing regime, mentioned above, is achieved by amendment of the National Health Service (Scotland) Act 1978 (“the 1978 Act”) and so the new powers will be inserted into the 1978 Act. Therefore, section 105 of the 1978 Act will apply to the new powers. Accordingly, references in the new powers to anything being “prescribed” means prescribed by regulations made by the Scottish Ministers and regulations made under the new powers will be subject to annulment in pursuance of a resolution of the Parliament. It is believed that negative resolution procedure continues to be appropriate in respect of the new powers. The new powers are not simply adding to existing subordinate legislation making powers as some existing powers are being repealed by the Bill.

Sections 25 and 28 of the Bill include a number of provisions to make subordinate legislation relating to the Regulation of Care (Scotland) Act 2001 (“the 2001 Act”). The new powers in section 25 enable Scottish Ministers to except certain independent health care services from the requirements of the 2001 Act. It is believed that negative resolution procedure is appropriate in respect of the new powers. Section 28 enables Scottish Ministers to make an order to substitute a day for 1 April 2006 where required to prevent childcare agencies and housing support services from inadvertently committing an offence under the 201 Act.

Section 30 of the Bill include a number of provisions to make subordinate legislation relating to the Adults with Incapacity (Scotland) Act 2000 (“the 2000 Act”). The new powers allow Scottish Ministers to extend the range of health professionals who may sign certificates of incapacity and to prescribe...
circumstances when the certificates can extend beyond 1 year. It is believed that negative resolution procedure is appropriate in respect of the new powers.

Section 33 of the Bill enables the Scottish Ministers by order to make incidental and other ancillary provision for the purposes of the Bill or in consequence of it.

Section 34 provides that any order under section 34 (except where section 34(3) applies) will be subject to annulment by a resolution of the Parliament. Section 34(3) provides for orders to which it applies to be laid in draft for approval by resolution of the Parliament. Affirmative procedure is seen as appropriate given the nature of the orders specified in section 34(3) but otherwise it is considered negative resolution procedure is the most appropriate procedure for the other orders under section 34.

Section 37(3) of the Bill confers power on the Scottish Ministers to make the necessary commencement order(s). As this is a commencement provision there is no parliamentary procedure.

Section 3 - Display of warning notices in and on no-smoking premises

Relevant provision: Section 3(3).
Power conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.

Section 3(3) of the Bill gives the Scottish Ministers powers to make regulations to make further provision as to the detail of the manner of display, form and content of the no-smoking signs which are required to be conspicuously displayed inside and outside no-smoking premises. The Executive will draft and consult on these regulations, in compliance with section 34(4) of the Bill, to coincide with the Bill’s passage through Parliament. It is considered appropriate to confine this sort of detail to subordinate legislation rather than primary legislation because it may be necessary over time to change the notice display requirements.

In deciding whether to adopt negative or affirmative resolution procedure, careful consideration has been given to the degree of parliamentary scrutiny that is felt to be required for the regulations, balancing the need for the appropriate level of scrutiny with the need to avoid using up parliamentary time unnecessarily. Affirmative procedure is used where the order or regulation making powers allow for the modification of any enactment or where there is significant public interest. In view of the public interest in the subject matter, the regulations under this provision will be subject to affirmative resolution procedure.

Section 4 - Meaning of “smoke” and “no-smoking premises”

Relevant provisions: Subsections 4(2) and 4(7).
Power conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.

Section 4(2) of the Bill provides for “no-smoking premises” to be prescribed by regulations made by the Scottish Ministers. The kind of premises to be prescribed as “no-smoking premises” are those which are wholly enclosed and, as set out in section 4(4), (a) to which the public or a section of the public has access, (b) which are being used wholly or mainly as a place of work by persons who are employees, (c) which are being used by and for the purposes of a club or other unincorporated association, or (d) which are being used wholly or mainly for the provision of education or of health or care services. The regulations will set out detailed provisions, including any exemptions which may be prescribed, but the scope of the prohibition is intended to be comprehensive. Again, it is not felt to be appropriate for primary legislation to contain such detail.

The regulations to be made under section 4(2) may also define or elaborate the meaning of certain expressions used, namely “premises”, “wholly enclosed”, “the public” and “has access”. The regulations may also define or elaborate the meaning of “premises” by reference to the person or class of person who owns or occupies them and so as to include vehicles, vessels, trains and other means of transport (except aircraft). Section 4(8) allows the regulations to provide as to how the no-smoking notice statement is to be expressed in the case of each of the means of transport referred to in the regulations, allowing bespoke no-smoking signs to be created for each means of transport most appropriate to that particular form of transport.

Section 4(7) allows the Scottish Ministers to modify section 4(4) so that other kinds of premises may be added, or existing kinds removed. The effect of this would be to add to or remove from the kinds of premises which may be prescribed as “no-smoking premises” under section 4(2).

Again it is considered to be more appropriate for detailed provisions to be confined to subordinate legislation as requirements may change over time. Again, the Scottish Ministers intends to draft and consult on regulations as the Bill proceeds through Parliament, and the regulations will be subject to affirmative resolution procedure.

Section 9 - Free oral health assessments and dental examinations

Relevant provision: Amends section 70A(2) and 71 of the 1978 Act and section 20 of the NHS (Primary Care) Act 1997.

Powers conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.

This section modifies current regulation making powers and excludes the power to make provision prescribing charges for oral health assessments and dental
examinations provided after 1 April 2006. These provisions will allow for such
dental checks to be provided free of charge under both general dental services
and personal dental services (pilot and permanent arrangements).

Section 11 - Charges for certain dental appliances and general dental
services

Relevant provisions: Subsection (2) amends section 70;
Subsection (3) amends section 70A(2);
Subsection (5) repeals section 71A; and
Subsection (6) amends paragraph 2 of
Schedule 11.

Power conferred on: The Scottish Ministers.
Parliamentary procedure: Negative Resolution of the Scottish Parliament
(section 105(2) of the 1978 Act).

This section amends existing regulation making powers and gives Scottish
Ministers the power to make regulations regarding the way in which certain dental
charges are made or recovered. Currently the patient charge for dental treatment
and appliances is linked to the item of service fee paid to dentists and unless the
patient is exempt or remitted from charges he/she pays 80% of that item of service
fee. Breaking this link would provide more flexibility and transparency to the
charging system. These provisions will allow for such flexible charging in both
general dental services and personal dental services (pilot and permanent
arrangements). The regulations will provide for a more flexible charging regime.

Section 15 - Lists of person undertaking to provide or assist in the provision
of general dental services

Relevant provision: New subsection (2) and (2B) substituted for
section 25(2) to (2B) of the 1978 Act.

Power conferred on: The Scottish Ministers.
Parliamentary procedure: Negative Resolution of the Scottish Parliament
(section 105(2) of the 1978 Act).

Currently, under section 25(2) of the 1978 Act regulations as to arrangements for
the provision of general dental services shall provide for only those individual
dentists who have undertaken to provide general dental services in a Health Board
area to be included in a list prepared and published by the Health Board. New
subsection (2) gives Scottish Ministers the power to make regulations to provide
for a list in two parts, to provide for the listing of dental practitioners and dental
bodies corporate who undertake to provide general dental services in the first part
of the list and the listing of those who are approved to assist in the provision of
general dental services in the area of the Health Board in a second part of the list.

By subsection (2A) such regulations may provide for matters that may be provided
for in the preparation, maintenance and publication of the list including that the first
part of the list be further sub-divided to distinguish, for example, those persons
who will not undertake to provide the full range of GDS. They may also include provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

New subsection (2B) gives Scottish Ministers the power to make regulations to provide that a person who assists in the provision of general dental services, and does not undertake to provide such services, in a Health Board area, cannot so assist unless he/she is on the second part of the list for that area.

There are already regulation-making powers in current section 25(2) and 25(2B), both subject to negative resolution and both providing a degree of flexibility for responding to changes. The provisions which substitute section 25(2) and (2B) similarly also contain regulation-making powers subject to negative resolution and this will also allow flexibility. For example, by subsection (2A)(c), the documents to be supplied on application or the procedure for applications to be made and dealt with may be changed or expanded in light of experience.

Section 16 - Lists of persons performing personal dental services under section 17C arrangements or pilot schemes

Relevant provision: Inserts a new section 17F(1) in the 1978 Act.
Power conferred on: The Scottish Ministers.

Section 17F(1) gives Scottish Ministers the power to make regulations providing that a person may not perform personal dental services, whether under permanent arrangements under section 17C of the 1978 Act or through pilot schemes, unless they are included in a list maintained by the Health Board. By section 17F(2), such regulations may also provide for matters that may be included in relation to such lists, including their preparation, maintenance and publication. They may also include provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

A regulation-making power subject to negative resolution is seen as the appropriate approach, rather than making provision in the 1978 Act itself, due to the flexibility of such a power to take account of changing circumstances. For
example, by subsection (2)(c), the documents to be supplied on application or the procedure for applications to be made and dealt with may be changed or expanded in light of experience.

**Section 17 - Lists of person undertaking to provide or assist in the provision of general ophthalmic services**

**Relevant provision:** New subsections (2) and (2B) substituted for section 26(2) of the 1978 Act.

**Power conferred on:** The Scottish Ministers.

**Powers exercisable by:** Regulations made by Statutory Instrument.

**Parliamentary procedure:** Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).

Currently, under section 26(2) regulations as to arrangements for the provision of general ophthalmic services shall provide for only those ophthalmic medical practitioners or opticians who have undertaken to provide general ophthalmic services in a Health Board area to be included in a list prepared and published by the Health Board. New section (2) gives Scottish Ministers the power to make regulations to provide for a list in two parts to provide for the listing of opticians and ophthalmic medical practitioners who undertake to provide general ophthalmic services in the first part of the list and the listing of those who are approved to assist in the provision of general ophthalmic services in the area of the Health Board in a second part of the list.

By subsection (2A), such regulations may provide for matters that may be provided for in the preparation, maintenance and publication of the list, including that the first part be further sub-divided to distinguish, for example, those who provide domiciliary visits to nursing homes and similar establishments. They may also include provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

New subsection (2B) gives Scottish Ministers the power to make regulations to provide that a person who assists in the provision of general ophthalmic services, and does not undertake to provide such services in a Health Board area, cannot so assist unless he/she is on the second part of the list for that area.

New section 26(2)(b) provides a power for Scottish Ministers to make regulations as to arrangements which include provision conferring on any person in accordance with a procedure prescribed by the regulations, a right to choose the medical practitioner or ophthalmic optician by whom his eyes are examined or his sight tested or from whom any prescription for the supply of optical appliances is to be obtained.
There are already regulation-making powers in current section 26(2) subject to negative resolution and providing a degree of flexibility for responding to changes. The provisions which substitute section 26(2) similarly also contain regulation-making powers subject to negative resolution. For example, by subsection (2A)(c), the documents to be supplied on application or the procedure for applications to be made and dealt with may be changed or expanded in light of experience.

Section 18 - Health Boards’ functions: provision and planning of pharmaceutical care services

Relevant provisions: Inserts new sections 2D and 2E into the 1978 Act.
Power conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.

This section inserts new sections 2D and 2E into the 1978 Act. These new sections places a duty on Health Boards to provide or secure the provision of pharmaceutical care services for persons in their area, and provide for the way in which Health Boards plan to discharge that duty.

New section 2D(3)

This allows the Scottish Ministers to prescribe the information that must be published by a Health Board in relation to the pharmaceutical services provided or secured by that Health Board. The purpose of this is to make provision to ensure patients receive detailed information about the pharmaceutical care services available to them.

It is not thought appropriate that the Bill should specify the detailed information which requires to be published. It is considered appropriate that the Scottish Ministers should have the flexibility to amend the detail of the information to be provided in light of experience or other changes.

New section 2D(5)

This allows regulations to be made that set out what are and are not to be regarded as pharmaceutical care services for the purposes of the 1978 Act and which a Health Board has a responsibility to provide.

New section 2D(6) sets out examples of the sort of provision regulations under subsection (5) of that section may make. Sub-section (a) of this section allows Scottish Ministers to classify which pharmaceutical care services are to be classified as ‘essential’ and ‘additional’. ‘Essential’ services are those that will be provided in accordance with nationally negotiated contract terms. The kinds of services that it is anticipated that the Regulations will be used for are as follows: for Essential it is expected that they will collectively comprise a chronic medication service; minor ailments service; acute medication service and a public health service. ‘Additional’ services will largely comprises services that are, as now,
negotiated locally, e.g. domiciliary oxygen therapy and methadone dispensing services.

Regulations under sub-section (b) of new section 2D(6) would detail the manner or circumstances in which the services will be provided. For example, regulations may prescribe that the chronic medication service will be provided to suitable patients who choose to opt for that service and will include patient medication reviews and counselling in accordance with agreed clinical protocols.

Regulations under sub-section (c) may provide that pharmaceutical care services may include for example the act of dispensing and that the prescribable and dispensable medicines and appliances will be specified in a list directed by Scottish Ministers. In this regard, new section 2D(7) requires Ministers to publish directions under regulations provided by section 2D(5) in a document to be known as the Drug Tariff. The Drug Tariff already exists and, inter alia, lists or details the drugs, medicines and appliances that can be ordered and dispensed as part of the provision of pharmaceutical care services. It is frequently necessary to amend the detail in the Drug Tariff and given this requirement it is considered that the most appropriate way of dealing with such matters is by means of direction.

Sub-section (d) of new section 2D(6) will, where the pharmaceutical care service includes the act of dispensing, detail the persons who can order medicines and appliances, e.g. a registered medical or dental practitioner, and provide for the circumstances in which those items may be ordered.

The above illustrates the sort of detailed provision that might be made under new sections 2D(5), (6) and (7), which it is thought demonstrates it is more appropriate for subordinate legislation.

**New section 2E(1)**

This section allows regulations to provide for the way in which Health Boards should prepare and maintain a plan to discharge their duty at new section 2D(1) to provide and secure pharmaceutical care services for persons in their area.

New section 2E(2) sets out examples of the sort of provision regulations under subsection (1) of that section may make and provides that they cover both substantive matters, under section 2E(2)(a) with regard to what the plan should identify and contain and, under subsections (b) to (g), procedural matters, such as the manner in which the plan should be prepared, kept under review, etc..

The need to prepare and maintain a pharmaceutical care services plan is a new duty for Health Boards and one where the matters to be taken into account and reviewed will be informed by practice and experience. It is expected that, initially at least, it will be necessary to amend the detail of such matters in light of experience of the new regime and, in the circumstances, subordinate legislation will give the required level of flexibility to respond to developments in an appropriate and timely way.

New section 2E(3) provides that regulations under subsection (2)(a) to that section may be specified by direction. Subsection 2(a) lists examples of what a Health
Board pharmaceutical service plan should identify. It may be necessary to amend
the detail of such matters in light of experience of operation of the new regime and
to clarify any areas of uncertainty. Given the level of detail and the likely need for
flexibility it is considered that the most appropriate way of dealing with such
matters is by means of direction.

Section 19 - Pharmaceutical care service contracts

Relevant provisions: Inserting new section 17R(1);
Inserting new section 17S(1) and (2);
Inserting new section 17U(1) and 4(b); and
Inserting new section 17V(1) and (2) into the

Power conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.
Parliamentary procedure: Negative Resolution of the Scottish Parliament
(section 105(2) of the 1978 Act).

Section 19 inserts new sections 17Q to 17V into the 1978 Act, replacing the
existing sections on general pharmaceutical services arrangements. The new
sections govern the terms and content of the pharmaceutical care service (PCS)
contracts and who may provide or PCS under the contracts. They contain broad
regulation making powers, which will be used to set out the detail of the rights and
obligations under the new PCS contract. When making regulations under the new
sections it is intended to replace the extensive and heavily amended NHS
(Pharmaceutical Services) (Scotland) Regulations 1995.

New section 17R(1)

This section provides a power to set in regulations those services which must be
provided under the contract - the essential services. New subsection (2) allows
these services to be described by reference to the manner or circumstances in
which they are provided. This power may be used for example to separate out of
hours services from those provided during the normal daytime period. Currently
section 27 to 28 of the 1978 Act, which are repealed by the Bill, allow for provision
to be made in regulations defining the pharmaceutical services to be provided
under general pharmaceutical services arrangements.

Subordinate legislation is considered more appropriate for this sort of detail than
primary legislation. This is especially the case here as it may be necessary to
amend the detail of such matters in light of experience of operation of the new
PCS contract.

New sections 17S(1) and (2)

New section 17S(1) sets out the persons with whom a Health Board may enter into
a PCS contract and confers power for the Scottish Ministers to prescribe the
conditions that would apply in relation to a Health Board entering into a PCS
contract with a contractor. The conditions may relate to the suitability of the
contractor to hold a PCS contract: for example, that the persons or firms eligible to
provide PCS under the contract should not have been convicted of certain offences, or been disqualified from providing or performing NHS services.

New subsection (2) enables regulations to set out what effect a change in membership of a partnership is to have on a PCS contract which is with a partnership. The intention is to allow the membership of the partnership to change without requiring a new contract to be entered into merely because such a change in membership has taken place.

The matters in new section 17S(1) and (2) are considered to be more suitable for secondary legislation than primary legislation, given the level of detail required and the fact that there is a need for flexibility as new circumstances arise.

**Section 17U(1) and (4)(b)**

Section 17U(1) confers a broad regulation making power on the Scottish Ministers allowing the imposition of further requirements that must be included in all PCS contracts.

Although there may be differences, in many respects it is intended that the regulations made under this section will cover areas that are similar to those currently set out the NHS (Pharmaceutical Services) (Scotland) Regulations 1995.

Section 17U(2) sets out examples of the sort of provision regulations under subsection (1) of that section may make, which it is thought demonstrates it is more appropriate for subordinate legislation.

Section 17U(3) sets out details of the type of provision that might be made in regulations making the sort of provision suggested in subsection (2)(d) of that section, so that it is clear provision can be made about when a provider under a PCS contract can or must accept a patient and when they can end their responsibility to that patient.

Section 17U(4) expands on the sort of provision that might be made in regulations making provision of the sort envisaged in subsection 2(f) including clarification in subsection (4)(b) that such regulations may include provision allowing the suspension or termination of any duty under the contract in relation to services of a prescribed description.

Section 17U(5) further expands on the way in which services prescribed under section 17U(4)(b) might be prescribed i.e. by reference to the manner or circumstances in which they are provided.

It is clear that regulations made under 17U may contain considerable detail and that it may be necessary to amend the detail of those regulations from time to time. As a result, it is considered that the most appropriate way of dealing with such matters is by means of subordinate legislation.
New section 17V(1) and (2)

Section 17V(1) creates a regulation making power to set national procedures for internal dispute resolution of disputes as to the terms of the proposed PCS contracts. The regulations may provide for the proposed terms to be referred to the Scottish Ministers and for the Scottish Ministers, or a person appointed by them, to determine what the terms of the contract should be. Regulations as to disputes as to the terms of an actual contract may be made under new section 17U(1) as explained in 17U(2)(j).

Section 17V(2) creates the regulation making power to enable the parties to a PCS contract to opt instead to have the contract treated as an “NHS Contract” entered into under existing section 17A for any purposes of that section.

Subsection 17V(4) provides for regulations to set out the application of section 17A in cases where a partnership elects to become a health service body; and where there is a change in the membership of the partnership.

It may be necessary to amend the detail of such matters in light of experience of operation of the new PCS contract. Given the level of detail and the likely need for flexibility it is considered that the most appropriate way of dealing with such matters is by means of subordinate legislation.

Section 20 - Persons performing pharmaceutical care services

Relevant provisions: Inserting new section 17W(1) into the 1978 Act.

Power conferred on: The Scottish Ministers.

Power exercisable by: Regulations made by Statutory Instrument.


New section 17W(1)

Section 20 inserts new section 17W(1) into the 1978 Act. The new section provides regulation-making powers governing the way in which persons performing pharmaceutical care services (PCS) are listed. The restructuring brought about by the Bill of the way in which PCS are secured or provided for by Health Boards amends the current listing arrangements that list the providers of pharmaceutical services and not those that perform the services. The current regulation making powers relative to listing are contained in existing section 27, all of which is repealed by the Bill.

The regulations made under subsection (1) of new section 17W may provide that registered pharmacists may not perform pharmaceutical care services unless their name appears on a list held by the Health Board as respects whose area they will work. For example, where (A) a Health Board employs a salaried pharmacist to perform PCS provided directly by the Board; or (B) where a PCS contract holder undertakes to provide pharmaceutical care services under a PCS contract as respects a Board’s area, the registered pharmacists performing PCS in both (A) and (B) would need to have their name included on the Health Board’s list in order to be permitted to do so.
Subsection (2) of the new section 17W sets out the issues that may be included in the regulations, showing the level of detail that will require to be included in the regulations. These include, for example, how the list will be drawn up and maintained; what criteria an individual will have to meet to qualify to be on the list; the process by which decisions on applications will be made and mandatory grounds under which a Health Board would have to reject an application.

Subsection (3) of the new section 17W, explains that regulations made under the powers in section 17W(1) as explained in 17W(2)(j), i.e. provision as to disclosure of certain information, may authorise the disclosure of information by a Health Board to the Scottish Ministers, or by the Scottish Ministers to a Health Board.

As can be seen from the matters mentioned at new section 17W(2), the arrangements for listing require a considerable level of detail. That and the need to be able to have flexibility mean that these matters are more appropriate for subordinate than primary legislation.

**Section 22 - NHS Tribunal: disqualification by the NHS Tribunal**

**Relevant provision:**
- Section 22(2)(b) amending section 29(4)(b) of the 1978 Act;
- Section 22(3)(c) amending section 29A(5) of the 1978 Act;
- Section 22(6) amending section 32(2) of the 1978 Act; and
- Section 22(7)(a) inserting section 32A(7) into the 1978 Act.

**Power conferred on:** The Scottish Ministers.

**Power exercisable by:** Regulations made by Statutory Instrument.

**Parliamentary procedure:** Negative Resolution of the Scottish Parliament (section 105(2) of the 1978 Act).

Currently under section 29(4)(b) of the 1978 Act regulations may provide, in the case of certain representations to the NHS Tribunal, the time limits within which they must be made. The representations this applies to are ones in respect of a practitioner that the second condition for disqualification by the Tribunal is met, which is that of fraud. The amendment allows regulations to prescribe the time limit within which any representations that a condition for disqualification is met must be made.

By virtue of section 29A(5) of the 1978 Act, regulations may make provision securing that a practitioner who is subject to an inquiry by the Tribunal in a fraud case may not be added to any list of practitioners held by an Health Board until the proceedings have been concluded. The amendment is to the effect that, in the future, those subject to an inquiry in any case may be prevented by the terms of regulations from being added to any list.

Regulations under section 32(1)(a) may set out the procedures of the NHS Tribunal. By virtue of section 32(2) of the 1978 Act, they may provide that in a
case where representations are made to the Tribunal against the same person on
grounds of efficiency and fraud, it may inquire into one case before another and
may adjourn the other, if they think it appropriate, indefinitely. The Tribunal would
otherwise be required under the Act to inquire into all representations by Health
Boards. The power may be exercised to allow the Tribunal flexibility in inquiring
into representations. The Bill adds a third condition for the disqualification of
practitioners - that of unsuitability – and the amendment ensures that the
regulations may take account of it.

Section 17P(1) of the 1978 Act provides that regulations may make provision as to
suspension from a list of health care professionals who perform primary medical
services. Amendments made to the 1978 Act in the Bill provide that regulations
under section 25(2), section 26(2), new section 17F(1), and 17W(1) may make
provision as to suspension from a list of those providing and approved to assist in
the provision of general dental services, providing and approved to assist in the
provision of general ophthalmic services, performing personal dental services and
performing pharmaceutical care services respectively.

The new subsection allows regulations to provide that where a Health Board has
suspended a person in accordance with regulations made under those provisions
and makes representations to an applies for interim suspension by the Tribunal,
that suspension may continue until the Tribunal determine whether or not to direct
interim suspension. Other regulations which make provision as to lists and
suspension and the Tribunal are subject to negative resolution and that degree of
scrutiny is also considered appropriate here.

**Section 23 - NHS Tribunal: corresponding provision in England or Wales or
Northern Ireland.**

**Relevant provision:** Section 23 inserting new section 32D of the

**Power conferred on:** The Scottish Ministers.

**Power exercisable by:** Regulations made by Statutory Instrument.

**Parliamentary procedure:** Negative Resolution of the Scottish Parliament
(section 105(2) of the 1978 Act).

This section inserts new section 32D into the 1978 Act. Historically, certain
decisions of the NHS Tribunals in England and Wales and in Northern Ireland
under provisions in force there which correspond to provisions in force in Scotland
have applied in Scotland also. At present section 31 deals with decisions outwith
Scotland for the disqualification of practitioners while the present section 32D
applies to decisions for their suspension. Section 31 is to be repealed and the
new section 32D now provides that regulations may provide for the effect of
decisions in other parts of the UK which correspond (whether or not exactly) to
disqualifications and suspensions by the Tribunal in Scotland.

The provisions in force in England and Wales and Northern Ireland do not
correspond exactly with the Scottish regime. The Tribunal in England and Wales
has been abolished. The Family Health Services Appeal Authority now has the
power to direct the national disqualification of practitioners but other decisions,
including those dealing with conditional disqualification, can be taken by local
health authorities. There are other differences, for example, the sanction of local
disqualification whereby a practitioner is disqualified from only the list or lists
where his or her name is entered for the time being and not from all similar lists
will in future not apply in Scotland. Accordingly the power allows the Scottish
Ministers to provide in regulations for the effect to be given to a corresponding
decision, which may include providing for the effect of decisions which correspond
(whether or not exactly) with a decision on conditional disqualification to be
determined in a manner prescribed in regulations by the Scottish Ministers.

A regulation making power is seen as the appropriate approach rather than
making provision in the 1978 Act itself. For England and Wales many of the
corresponding provisions are themselves in subordinate legislation and regulations
will provide a degree of flexibility to be able to respond to changes in the future.
Other regulations which make provision as to lists and the procedures of the
Tribunal are subject to negative resolution and that degree of scrutiny is also
considered appropriate here.

**Section 25 - Independent health care services**

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<tr>
<th>Relevant provisions:</th>
<th>Section 25 amends section 2(5) of the 2001 Act.</th>
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<tr>
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<td>Power exercisable by:</td>
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This section amends Section 2 (5) of the Regulation of Care (Scotland) Act 2001.
It provides Scottish Ministers with a power to make regulations which except
defined services from the definition of an ‘independent healthcare service’ in the 2001 Act.

This power already exists for other care services defined in the 2001 Act where
appropriate – see for example section 2(6) concerning “nurse agencies”. The
current definition in the 2001 Act goes wider than the policy intention which was to
regulate wholly private services. The power to except could be used, for example,
to except from the definition services provided by a General Practitioner on behalf
of a third party such as examinations for insurance companies.

It is thought that it is appropriate to except services by subordinate legislation as
this allows flexibility to take account of changing circumstances. As noted above
there is precedent in the 2001 Act for such a power and for regulations made in
exercise of such a power to be subject to negative procedure.

**Section 28 – Registration of child care agencies and housing support services**

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<tr>
<th>Relevant provisions:</th>
<th>Subsection (4)(e).</th>
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<td>Power conferred on:</td>
<td>The Scottish Ministers.</td>
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Subsection (4)(e) gives Scottish Ministers the power to make an Order to substitute a later day for 1 April 2006.

The purpose of the power is to give Scottish Ministers the flexibility to extend the period of deemed registration of Housing Support services and Childcare Agency services should that prove to be necessary.

Section 30 – Amendment of Adults with Incapacity Act 2000: authorisation of medical treatment

Relevant provisions: Section 30(2)(b) and 30(2)(e)(ii).
Power conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.

These two provisions enable Scottish Ministers (a) to extend, if appropriate, the range of health professionals who may sign certificates of incapacity under the Act and (b) to prescribe the circumstances in which certificates of incapacity can extend beyond 1 year. This follows concerns that the current provisions were unduly restrictive and reflects the views obtained in a consultation exercise and discussion with key stakeholders.

It is considered that subordinate legislation is the most appropriate approach due to the flexibility of such a power to take account of changing circumstances. Similarly, the circumstances where a certificate of incapacity can be extended beyond 1 year may also require revision at a later date after experience has been gained in applying the approach. Regulations will be by negative resolution in accordance with section 86 of the 2000 Act, which should allow the appropriate degree of Parliamentary scrutiny.

Section 33 - Ancillary provisions

Relevant provisions: Section 33.
Power conferred on: The Scottish Ministers.

Section 33 provides for Scottish Ministers to make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary for the purposes, or in consequence, of the Act.

Section 37: Short title and commencement

Relevant provision: Section 37(3)
Power conferred on: The Scottish Ministers.
Parliamentary procedure: No parliamentary procedure.
Section 37 provides for the short title and commencement arrangements for the Bill.

Section 37(3) gives the Scottish Ministers power to appoint by order a day when the provisions of the Bill shall come into force. Section 37(4) explains that different days can be appointed for different purposes.

It is standard procedure for such commencement provisions to be dealt with by subordinate legislation. Whilst the order, in common with the usual practice for such orders, is not subject to any parliamentary procedure as such, the Subordinate Legislation Committee will have the opportunity to consider the instrument in terms of its remit.

Schedule 1 – Fixed penalty for offences under sections 1, 2 and 3

Relevant provisions: Paragraph 2; Paragraph 4(1); Paragraph 5(2); Paragraph 12; and Paragraph 13 (a) and (c).

Power conferred on: The Scottish Ministers.

Power exercisable by: Regulations made by Statutory Instrument.


Schedule 1 sets out the details of how the fixed penalty system, introduced by section 5, will work for offences committed under sections 1, 2 and 3 of the Bill.

Paragraph 2 gives the Scottish Ministers the power to set via regulations a time limit relating to the offence after which a fixed penalty notice may not be given.

Paragraph 4(1) allows the Scottish Ministers to prescribe by means of regulations the amount of the fixed penalty for an offence under section 1, 2 or 3.

Paragraph 5(2) allows the Scottish Ministers to prescribe by means of regulations the discounted amount for a fixed penalty offence. A lesser amount is payable by offenders, in terms of paragraph 6(1) where earlier payment is made.

Paragraph 12 allows the Scottish Ministers to make regulations about the application by councils of fixed penalties, also about keeping accounts and the preparation and publication of statements of account, relating to fixed penalties.

Paragraph 13 empowers the Scottish Ministers to make regulations prescribing the circumstances in which fixed penalty notices may not be given and the methods for payment of penalties. Paragraph 13 also allows the Scottish Ministers to modify paragraphs 4(2) and 5(1) of the Schedule so as to modify the period for payment of the fixed penalty and the period for when payment of the discounted amount is to be made to qualify for the discount respectively.
Once again, the detail of the provisions are such that it is more appropriate for secondary rather than primary legislation. Regulations made under the relevant provisions of Schedule 1 will again be subject to affirmative resolution by the Scottish Parliament.

Schedule 2: Minor and consequential amendments.

| Relevant provision:       | Paragraph 1(7) amending section 32(1)(a) of the 1978 Act. |
|                          | Paragraph 1(9) amending section 32E(1) of the 1978 Act |
| Power conferred on:      | The Scottish Ministers |
| Power exercisable by:    | Regulations made by Statutory Instrument. |
| Parliamentary procedure: | Negative resolution of the Scottish Parliament (section 105(2) of the 1978 Act). |

Currently under section 32(1) regulations provide for the procedures to be followed by the Tribunal when it inquires into cases under sections 29 to 31 of the 1978 Act. Section 31 is repealed. The effect of the amendment is that the regulations will in future provide for inquiries under sections 29 to 30 to be held in accordance with such procedures as may be prescribed by or determined under regulations.

Currently under section 32E(1) regulations may provide for payments to be made to practitioners who are suspended in terms of section 32A(3) or 32D(2) dealing with suspension by the Tribunal in Scotland or under provisions in force in England and Wales or Northern Ireland respectively. The present section 32D(2) is substituted by the regulation-making power in new section 32D(3).
On 23 March 2005, the Committee asked the Executive for further explanation of
the following matters:

Section 4(2) and 4(7): Meaning of “smoke” and “no-smoking premises”

1. The Committee notes that the bill creates offences of smoking or permitting
smoking in no-smoking premises and that what constitutes no-smoking premises
is left entirely to regulations made under section 4(2) and 4(7). The Committee
appreciates the need for the definition of no-smoking premises and exemptions to
be contained in regulations rather than on the face of the bill, in order to provide
the necessary flexibility. The Committee, however, is concerned that draft
affirmative procedure simply allows for the approval or rejection of an instrument in
its entirety and in this instance would propose that any regulations should be
subject to further scrutiny. The Committee has in the past proposed “super-
affirmative” procedure for some regulation-making powers, whereby the Executive
would lay its proposals in draft for consultation with the Parliament before a draft
instrument was laid. The Committee considers that in this instance it would be
useful for the Parliament to consider and debate proposals for the definitions of
no-smoking premises before a draft instrument is laid and asks the Executive for
its comments.

Section 11: Charges for certain dental services

2. The Committee considered that although the existing powers are similarly
subject to annulment there are certain constraints on their use. The Committee
considered that there is no such limitation to the new powers in this bill and
therefore questioned whether annulment provides the correct level of
parliamentary scrutiny. The Committee considered that the changes could be of
sufficient importance to merit the first substantive exercise of the powers as
amended being subject to affirmative procedure. The Executive is asked to
comment.

Section 18: Health Boards’ functions: provision and planning of
pharmaceutical care services

3. The Committee considered that the new direction making powers in section
2CA(7) of the Drug Tariff should perhaps be incorporated in a more formal
document subject to parliamentary scrutiny. In the case of directions under section
2CB(3) the Committee again examined the question of whether the relevant
criteria should be incorporated in a more formal document subject to
Parliamentary scrutiny. The Executive is asked to comment.

Section 24: Payments to certain persons infected with hepatitis C as a result
of NHS treatment

4. Although there is a requirement for Ministers to publish the scheme, the
Committee asks the Executive for comment as to why it has chosen that the
scheme should not be subject to some form of Parliamentary scrutiny.
Section 28: Registration of child care agencies and housing support services

5. The Committee questioned whether the power to amend the date specified in the bill by subordinate legislation, subject to negative procedure, provides the correct level of scrutiny given that this is a Henry VIIIth power. The Executive is asked to comment.

The Scottish Executive responded as follows:

Section 4(2) and 4(7): Meaning of “smoke” and “no-smoking premises”

1. I understand that there is still some question as to the detail of what might comprise the additional scrutiny procedure proposed as “super-affirmative”. The Minister for Parliamentary Business last year expressed continuing reservations on the issue, but undertook to review the position in light of any clarification of what the Committee envisaged a super-affirmative procedure would look like, the sort of circumstances and criteria that might justify its use and the sort of benefits that might be anticipated. Ministers would wish to examine the detail of the proposed additional scrutiny procedure to enable them to provide a fully informed response to any suggestion by the Committee that the procedure be invoked in relation to any specific regulations.

2. As regards the specific question of invoking such an additional scrutiny procedure in relation to the regulations to be made under section 4(2) and (7) of the Smoking, Health and Social Care (Scotland) Bill, Ministers appreciate that the definition of “no-smoking premises” under the regulations is an important element of the new no-smoking regime and on that basis are happy to accept that such a definition should be subject to some form of additional scrutiny. However, the draft regulations are currently out to wide public consultation for this very purpose and I am sure that the Health Committee, and indeed all MSPs, will take this opportunity to consider and comment on the detail of the way in which these sections of the Bill would operate.

Section 11: Charges for certain dental services

3. At the present time the level of dentists’ remuneration is linked to patient charges. Section 71 of the 1978 Act provides a regulation making power in respect of charges for general dental services (GDS). Section 71A makes provision on the calculation of charges for dental appliances and treatment.

4. In terms of certain constraints on existing powers it is assumed that the Committee is referring to section 71A (4) and (5). While the provisions as amended do not contain any express constraint that Ministers shall not provide for a charge which exceeds the amount which Scottish Ministers consider to be the cost to the health service of the dental service supplied or provided, Ministers shall, of course, not exercise the power in that way nor authorise any charges that appear to them to be inappropriate.
5. To date the negative resolution procedure has worked well for governance of
dental charges and other NHS charges and in balancing the need for
administrative flexibility with parliamentary scrutiny. Accordingly, the Executive
does not consider that a sufficient case is made for making the powers, as
amended, subject to affirmative resolution procedures in relation to the first or any
particular exercise of them.

Section 18: Health Boards’ functions: provision and planning of
pharmaceutical care services

6. Section 2CA(7) requires Ministers to publish directions under regulations
provided by section 2CA(5) in a document to be known as the Drug Tariff. The
Drug Tariff already exists and is provided for at regulation 9 of the NHS
(Pharmaceutical Services) (Scotland) Regulations 1995. Amongst other things,
the Tariff lists and details the drugs, medicines and appliances that can be ordered
and dispensed as part of the provision of pharmaceutical care services. It is a
lengthy (over 400 pages) and largely technical document that is published
quarterly but, by necessity, subject to monthly review and amendment as and
where appropriate. Against this background we continue to consider that the most
appropriate way of dealing with the provision made at 2CA(6)(c), as qualified by
2CA(7), is by means of direction, which is in line with current practice with regard
to the Drug Tariff. In addition this level of scrutiny is consistent with the existing
level of scrutiny for the Drugs Tariff.

7. In new section 2CB(2) lists what are currently considered to be the most
important criteria that should be listed in regulations and thereby subject to
scrutiny by the Parliament. The intention is, where necessary, to add detail to
those main criteria. It is important that in working to the stated criteria, that Health
Boards work to a common database in assessing and determining the relative
pharmaceutical care service needs. The intention is that the direction will be used
to provide, or point to, the data on which the plan must be developed. For
example, they should all work to the same set of population statistics and the
same categories and descriptors of epidemiology of disease or service, and they
should all report using the same units of measure, e.g. the number of prescriptions
for condition [X] dispensed per [10,000] of the population. As is evident, this data
is of a technical nature. Additionally, the sources and measure of the data will be
subject to review and change in light of practical experience. On this basis we
continue to consider that this level of detail, required to support the main plan
criteria stated in regulations, renders it appropriate to directions.

Section 24: Payments to certain persons infected with hepatitis C as a result
of NHS treatment

8. Following the advice of the Expert Committee led by Lord Ross, it was
agreed by the four UK administrations in 2003 that a single UK wide scheme
would be established to provide ex-gratia payments to qualifying persons who had
been infected with Hepatitis C through contaminated blood products. Cabinet
approved the allocation of £15 million as Scotland’s contribution to the fund, taking
account of other pressures on the NHS budget. The Skipton Fund Limited was
established by the Department of Health (England) as a limited company to administer the scheme on a UK wide basis on behalf of the four administrations.

9. In order to promote the efficient operation of the scheme, it was agreed that DH England would assume responsibility for the administration and funding of the scheme on behalf of all the administrations.

10. Section 24(1) of the Smoking, Health and Social Care (Scotland) Bill provides specific statutory cover for the making of payments under the scheme. Subsection (2) of that section also prescribes certain matters which must be included in any scheme, such as the procedure to be followed in making a claim under the scheme and how claims are to be determined. Scottish Ministers remain accountable to the Scottish Parliament for all payments made to the Skipton Fund, and this is reflected in section 24(4) of the Bill. The use of funds by the Skipton Fund will additionally be subject to scrutiny by the Scottish Executive via the usual auditing and accounting controls. Nevertheless, the scheme remains a non-statutory, ex gratia arrangement entered into jointly by the four administrations.

11. In light of all of the above, it is felt that an appropriate level of scrutiny is assured.

Section 28: Registration of child care agencies and housing support services

12. Section 28 of the Bill is concerned with persons providing certain child care agencies and housing support services (as defined under the Regulation of Care (Scotland) Act 2001) on 1 April 2003 who were deemed to have their service registered with the Care Commission until 30 September 2003. Where a provider did not make an application to the Care Commission for registration before 1 October 2003 or did not have their application granted by 1 April 2004 their deemed registration lapsed and continuation of the service was unlawful. The effect of section 28 is that where such a person applied for registration by 30 September 2004, they are to be treated as if their deemed registration had not lapsed and, subject to the earlier occurrence of certain events, they are deemed to be registered until 1 April 2006. Section 28 of the Bill also provides that, where, before 1 April 2006, the application for registration is granted or refused, registration is cancelled, or if the provider ceases providing the service, the deemed registration ceases on the date that happens.

It is not anticipated that it should be necessary to extend the deemed registration period beyond 1 April, 2006, however the use of the provision in section 28(4)(e) of the Bill is thought necessary to ensure that, if for any reason, the Care Commission is unable to process all relevant applications before 1 April, 2006, the Scottish Ministers can extend the date without the need for further primary legislation. It is considered that the use of negative procedure is appropriate for two reasons. Firstly, the scope of the power is extremely limited and, secondly, taking into account the Parliamentary time required for affirmative procedure, it affords the Scottish Ministers more time to extend the period were unforesen difficulties in processing by the Care Commission to arise at the last minute.
HEALTH COMMITTEE STUDY VISIT TO IRELAND
7 – 9 FEBRUARY 2005

Background

In order to help inform its consideration of proposals for a ban on smoking in certain wholly enclosed public places, contained in the Smoking, Health and Social Care (Scotland) Bill, the Health Committee undertook a study visit to Ireland in February 2005.

The study visit involved a series of meetings in Galway and Dublin, focussing on the decision to institute a workplace smoking ban across Ireland and the subsequent implementation of the ban.

The Irish smoking ban was introduced on 29 March 2004.

Attached at Appendix A is a list of organisations and individuals with whom the Committee met. This report lists the key issues raised with members in these meetings.

Vintners' Federation of Ireland (Galway)

The Vintners’ Federation of Ireland (VFI) was established in 1973 from a number of smaller associations for the protection and betterment of the livelihood of the individual publican and currently has approximately 6,000 members.

During their presentation and in response to questions from Committee members, VFI representatives raised the following points:

- Pub owners are concerned about the cumulative impact on business of a series of recent policy and regulatory changes, including:
  - More vigorous enforcement of drink-driving regulations;
  - Increases in excise duty;
  - New rules in relation to the granting of licenses allowing access for children (under 18s are no longer allowed in bars after 9pm); and
  - The workplace smoking ban.
  These factors taken together, rather than the smoking ban alone, are considered to have had a negative impact.

- Pub owners are similarly concerned that they had previously been expected to invest in expensive ventilation equipment which they had anticipated would obviate the need for further restrictions on smoking in their premises.

- The smoking ban is exacerbating increased competition from supermarkets and other outlets in terms of the off-sales market.

- Anecdotal evidence exists that the ban had:
  - made elderly drinkers feel most disadvantaged;
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- increased the amount of drinking and socialising at home thereby increasing children’s exposure to alcohol and passive smoke;
- had a differential economic impact on rural pubs, with a number either closing or opening for fewer hours during the week; and
- had a differential economic impact on those pubs which did not have the space to erect an outside ‘smokers’ shelter’.

- In some areas local councils have accommodated pubs with no external property, by renting pavement space to allow out-door tables.
- Anecdotal evidence was offered by one pub proprietor of a fall in drink sales of up to 25%. This had been partially, but not totally, offset by increased food sales.
- A different proprietor indicated that his customer numbers had fallen by between 5 and 10% during the week. Little change in numbers had been experienced with regard to weekend trade.
- While a number of pub proprietors are seeking to diversify, this has not been possible for all and has resulted in mixed outcomes.
- Proprietors have received a mixed response to the ban from tourists.
- Concern was expressed that pub proprietors can be fined under the legislation not only if a patron was caught smoking, but also if evidence was found that smoking had occurred or if their outside premises were found to be littered with cigarette butts.

Health Service Executive, Western Area (Galway)

In their presentations and in response to questions from Committee members, Health Service Executive, Western Area representatives raised the following points:

- In advance of the smoking ban a series of acts were passed to limit smoking, including:
  - Tobacco (Health Promotion & Protection) Act, 1988 – which restricted tobacco sales and established a framework for regulations which restricted consumption in certain areas; Tobacco (Health Promotion & Protection) Regulations, 1995 – which prohibited smoking in cinemas, taxis, bus, schools, bingo and health centres and restrictions on smoking in restaurants, cafés, canteens; and
  - The Health (Misc. Provisions) Act, 2001 – which raised the smoking age from 16 to 18 year olds and aimed to prevent underage sales of cigarettes.

- A number of local pre-ban initiatives were also taken by the Western Health Board (now known as the Health Service Executive, Western Area) including:
A range of research work on the health impact of environmental tobacco smoke;
‘Breathe Easy Bars’ and ‘Smoke Free Dining’ initiatives;
Introduction of Smoke Free Schools & School Buses; and
Test purchasing campaigns which led to legal proceedings for non-compliance.

Immediately prior to the 2004 workplace smoking ban a number of measures were taken, including:
The distribution of information packs to all licensees by the Office of Tobacco Control (OTC), containing the signage which needed to be displayed, workplace policies, information on how the ban would operate and procedures for what to do if someone is caught smoking;
‘Smoke Free At Work’ TV & radio adverts;
Introduction of a national ‘lo-call’ compliance line;
Commissioning of permanent signage;
Briefing sessions / staff meetings;
Overtime agreement for Environmental Health Officers (EHO) who carry out inspections;
Agreement of a letter of demarcation between local authorities and health boards (on responsibilities for enforcement);
Development of tobacco returns software;
Development of an inspection protocol and inspection record; and
Development of a health and safety statement for inspection staff.

During the initial implementation process the target was to inspect each licensed premise in the area twice within the first six months – with at least one inspection taking place out of hours.

A number of problems of definition were apparent in the early months of the ban, including the definition of ‘compliance’ and ‘outdoor area’.

In 2004 the Western Health Board received 56 complaints (30 of which arose in the first 3 months) mainly regarding the hospitality sector. To date the WHB has pursued two complaints through legal proceedings: 1 regarding outdoor areas and 1 regarding after hours smoking.

The 2004 the WHB carried out a total of 2036 inspections in the Mayo (licensed premises -1017 visits; hotels-102 visits; and restaurants- 175 visits).

Inspection Compliances/Smoking Compliance – Mayo:
76% licensed premises compliant;
91% hotels compliant; and
98% restaurants compliant.

Inspection Compliances/Smoking Compliance – Galway city:
89% licensed premises compliant;
95% hotels compliant; and
94% restaurants compliant.
The Health Service Executive, Western Area estimates the following costs associated with enforcement (in the Mayo area):

- Overtime allocation of €18,000;
- Overtime spending €19,000; and
- Around a 20% decrease in food control activities.

Smoke Free at Work Compliance Line (LoCall 1890 333 100) received 92 complaints and 7 queries for the Galway area. Information taken from the compliance line is given to the Senior Environmental Health Officer in each area for follow-up.

Enforcement cases:

- **Connemara Pub** - An anonymous complaint was received by EHO on 16 April 2004 regarding a bar and function room in the remote Ghaeltacht area. The complaint was that the previous night there had been many smokers in the pub. EHO visited the premises on the 20th April 2004 and found cigarette butts on the function room floor, ashtrays in the dishwasher and an absence of signage. The EHO issued a verbal warning to the person in charge followed by a formal written warning. The premises were re-inspected on the 14th May, 2004 at 9.50pm, when 3 people were found to be smoking at the bar counter and 2 ashtrays were found on bar counter (containing 5/6 butts). This resulted in a court hearing on 20 July, 2004. Owners pleaded guilty but argued that they had taken reasonable steps to prevent smoking. The evidence of active smoking and ashtrays was significant. The Connemara pub was fined €1200 and costs of €500.

- **Fibber Magees Pub** - The most high profile case receiving national and international press coverage was Fibber Magees in Galway. The proprietor called for mass non-compliance. It was seen as a serious challenge to the legislation and to the authority of the State. The Attorney General became involved and a High Court Injunction was issued. The proprietor was fined €6,400 and cost of €3,000.

A number of premises are exempt from the ban due to a fear of constitutional challenge, including: hotel bedrooms; nursing homes; non-acute, long stay facilities including community nursing units, community hospitals, welfare homes, district hospitals and former county homes; residential facilities for people with physical, intellectual and sensory disability; and psychiatric hospitals. However, psychiatric units attached to acute hospitals are not exempt.

Premises exempt from the smoking ban are covered by:

- Department of Health and Children Guidance Document;
- Health and Safety at Work Act;
- Common law duty of care; and
- Are under no obligation to permit smoking or provide smoking areas.
A number of problematic areas are apparent, including:
- Outdoor shelters (a guidance document now being drafted);
- Growth in incidence of after hours smoking;
- Pubs which are compliant have been losing customers to non-compliant pubs; and
- Taxis and hackneys - difficult to determine when a taxi becomes a workplace – for example when a taxi driver is on the way home from work in his taxi can he smoke?

A number of post ban initiatives are being taken by the Health Service Executive, Western Area including:
- “Towards a Tobacco Free West” Policy on Tobacco Risk Reduction;
- EHO Compliance building in health care premises, school buses, etc;
- Enforcement in relation to, underage sales, non-compliant workplace areas and facilities etc; and
- A series of ongoing research activities on impact at work and in the home.

Galway Hospitals have implemented a smoke-free hospital policy since 2003 – part of a national initiative, the ‘Minimum Standard Smoke-Free Hospital Policy’ launched by the Health Minister. The policy has the following features:
- Strong endorsement by the Health Minister;
- Part of the European Smoke-Free Hospitals Network;
- Developed through a process of consultation and consensus, with an incremental approach;
- Built on and improved implementation of earlier prohibition of smoking in hospital settings;
- Long-term goal to achieve a totally smoke-free environment in hospital settings;
- Implementation guided by a multidisciplinary Committee involving representatives from: nursing management, human resources, health promotion, environmental health, senior management, and the unions, as well as a consultant cardiologist, a smoking cessation officer, a staff nurse and a porter. This Committee developed and monitored the implementation of a ten-step action plan

Smoking is permitted in hospital grounds and the health authorities provide ‘gazebos’ for the use of staff and patients.

Minister of State at the Department of Health and Children (Dublin)

In discussion with the Committee the Minister and his accompanying official raised the following points:

- There has also been a cultural shift in Ireland, it is becoming increasingly like the rest of Western Europe with a move away from entertainment and drinking being centred on the pub to being focused on drinking at home.
While there is an acknowledged economic downturn in the hospitality industry, the decline started before the smoking ban in enclosed workplaces was introduced.

- Compliance rates for the smoking ban have been very high. There have been isolated incidents of challenges to the ban including Fibber Magee’s in Galway, but this was dealt with effectively by the authorities. Publicans want consistency and a level playing field.

- Introducing the legislation as a workplace health and safety measure defused some of the opposition to the ban.

- Cigarette sales decreased in Ireland by 10% in 2003 and 17% in 2004. This has led to a decrease of over €100 million in the revenue generated from cigarette sales. While Ireland has the third highest cigarette prices in Europe after Norway and the UK, the market for the illegal trade of cigarettes in Ireland is thought to be very small.

- Cross-party support for the ban, together with support from a range of voluntary organisations and trade unions, played an important part in enacting the legislation.

Responding to a range of questions, the Minister:

- Indicated that he did not think the fall in legal sales of cigarettes had been distorted by an increase in illegal sales;

-Acknowledged that urban pubs generally have a higher turnover than rural pubs and therefore have more scope for investing in outdoor areas (where space is available);

-Indicated that, despite the Health Service Executive Western Area having raised the issue of a fall in food inspections resulting from new responsibilities for environmental health officers in relation to the smoking ban, he had not received any representations on this matter;

-Acknowledged that limited work had been undertaken to assess the economic impact of the ban;

-Suggested that the ban had not led to a big increase in the number of job losses, while acknowledging that students and casual workers are the groups most likely to have been affected by employment changes in the hospitality/pub sector. Information on the impact on these groups is difficult to measure as they are often not officially registered as employees and are therefore underrepresented in official figures; and

-Indicated that there had been little experience of smokers using pubs across the border as a consequence of the ban (partly because the border is heavily policed, there is an increased emphasis on enforcement of drink
driving legislation and journeys would often require a round trip of up to 15 miles).

IMPACT (Dublin)

IMPACT (the Irish Municipal, Public and Civil Trade Union) is the largest public sector trade union in the Republic of Ireland, with over 40,000 members in health, local government, education, the civil service, state-owned companies, telecommunications, aviation, and the voluntary and community sector. IMPACT organises the environmental health officers who are responsible for enforcing the smoking ban.

The IMPACT representative raised the following points:

- Up until around 3 years ago trade unions in Ireland supported a voluntarist approach to tackling environmental tobacco smoke in the workplace.

- A number of key factors in place before the ban were important in its successful implementation, including:
  - The strong health case made to the public;
  - A determined Health Minister;
  - The role played by the Office of Tobacco Control;
  - Cross party political consensus;
  - Strong support from civic society (voluntary sector, trade union and employers’ organisations);
  - Intervention from the Health and Safety Authority (in the form of an authoritative report on the dangers of ETS, the inadequacy of ventilation and the particular hazards for bar workers); and
  - Strong public support (60% when the ban was first proposed)

- A number of key factors are important in the implementation and enforcement of the ban, including:
  - Relatively significant levels of fines;
  - The cumulative nature of fines for repeat offences;
  - Signage requirements in the legislation; and
  - Environmental health officers’ approach – seek to support compliance rather than punish non-compliance.

- The trade unions generally accept that there has been some economic impact on business arising from the ban but, as yet, there are no conclusive figures on this in the public domain. They consider that the health and safety of their members should take precedence over the potential economic impact of the policy.

- There are outstanding concerns about lack of adequate protection for those working in exempt workplaces (such as prisons and residential care homes).
Dáil Select Committee on Health and Children

A range of opinions on the smoking ban were expressed by individual members of the Dáil Select Committee on Health and Children:

- Several members claimed that the smoking ban has saved publicans money previously spent on cleaning. There were now no cigarettes or ashtrays to clean up and there had been a reduction in the frequency with which wallpaper, carpets and upholstery in pubs require to be replaced.

- One member of the Dáil Committee believed that the Gallagher tobacco group cutting 80 jobs at its plant in Lisnafillan outside Ballymena, Co Antrim was a direct result of the ban.

- It was suggested that the ban was in part responsible for increasing the number of women drinking in the home. It was suggested that women, in particular, did not like smoking in outdoor areas or pub doorsteps.

- One Dail Committee member empathised with smokers, highlighting that many now feeling like they are being treated as second class citizens. Smokers are exposed to the elements by having to stand outside pubs and suggestion was made that facilities need to be improved with regulation of outside areas becoming less stringent.

- One Dail Committee member believed that had more publicans introduced ventilation it would have been harder to impose the ban.

Office of Tobacco Control

The Office of Tobacco Control (OTC) is a non-departmental public body which was set up to assist the Minister for Health and Children in the implementation of policies and objectives of the Government on the control and regulation of tobacco products. They are also responsible for coordinating the national inspection programme in cooperation with the health boards. The OTC employs 14 people.

In discussion with members of the Health Committee, the OTC’s representative raised the following points:

- The national compliance figure for the first six months of the smoking ban was 94%. Compliance figures take account of the prohibition of smoking in workplaces and the regulations which allow the provision of outdoor smoking areas.

- The OTC considers that the health debate in relation to passive smoking in enclosed places has been settled through the publication of a number of reports – comparative studies looking at smoking related health issues and levels of exposure to environmental tobacco smoke in Northern Ireland and the Irish Republic are now underway.
• A significant amount of effort was invested in public awareness campaigns in advance of the ban – particularly, the public was encouraged to recognise public houses as workplaces as well as places to socialise. The campaign brought together public health issues with issues of health and safety in the workplace.

• After the announcement of the smoking ban in 2003 the OTC began to consider what information and advice it would require to issue to employers. In advance of the ban an information pack and materials for public display were issued to owners of licensed premises. Advice was also issued on ‘reasonable steps’ to be taken to avoid smoking.

• A number of provisions in the smoking legislation are yet to be implemented. For example, provisions for banning point of sale tobacco advertising are yet to be signed off by the Minister and are currently being challenged by the tobacco industry.

• Over the counter tobacco sales are falling in Ireland. Health education, increased prices and the impact of the ban have all influenced this position.

• The OTC has undertaken limited work on assessing the economic impact of the smoking ban.

March 2005
APPENDIX 1

Health Committee Study Visit to Ireland

Programme of Meetings

Vintners' Federation of Ireland
Terry Tyson, Galway City Chairman, accompanied by local publicans.

Health Service Executive, Western Area
Seamus Mannion, Regional Manager Community Services;
Paul Hickey, Senior Environmental Health Officer, Galway;
Siobhain Honan, Environmental Health Officer, Mayo;
Irene O'Byrne, Smoking Cessation Officer, UCHG; and
Michelle Spellman, Assistant Staff Officer, Community Services.

Sean Power TD, Minister for State, Department of Health and Children
Accompanied by Eamon Corcoran, Principal Officer, Public Health Division, Department of Health and Children.

IMPACT
Bernard Harbour, National Secretary.

Dáil Select Committee on Health and Children
Dr. Jimmy Devins, Fianna Fail, Committee Vice-Chairman, accompanied by various members and the Committee Clerk

Office of Tobacco Control
Ray Mitchell, Acting Chief Executive, accompanied by Gearoid O'Dufaigh, Assistant Principal, Tobacco Control Unit, Department of Health and Children
ANNEX B: EXTRACT FROM MINUTES

HEALTH COMMITTEE

EXTRACT FROM MINUTES

29th Meeting, 2004 (Session 2)

Tuesday 7 December 2004

Present:

Roseanna Cunningham (Convener)     Mr David Davidson
Helen Eadie                         Janis Hughes (Deputy Convener)
Kate Maclean                        Mr Duncan McNeil
Shona Robison                       Mike Rumbles
Jean Turner

The meeting opened at 2.01 pm

1. **Items in private**: The Committee agreed to take item 5 in private.

5. **Proposed health bill (in private)**: The Committee considered arrangements for its consideration of the bill.

The meeting closed at 3.38 pm.

Simon Watkins
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

1st Meeting, 2005 (Session 2)

Tuesday 11 January 2005

Present:

Roseanna Cunningham (Convener) Mr David Davidson
Helen Eadie Janis Hughes (Deputy Convener)
Kate Maclean Mr Duncan McNeil
Shona Robison Mike Rumbles
Jean Turner

The meeting opened at 2.00 pm

1. Smoking, Health and Social Care (Scotland) Bill: The Committee received a briefing on the Bill at Stage 1 from the following Scottish Executive officials—

   Roderick Duncan, Tobacco Control Division, Bill Team Leader

   Part 1 – Prohibition of smoking in certain wholly enclosed spaces
   Colin Cook, Head of Substance Misuse Division
   Mary Cuthbert, Tobacco Control Division, Team Leader;

   Part 2 – General dental services, general ophthalmic services and personal dental services
   Eric Gray, Primary Care Division, Team Leader, Dental and Ophthalmic Services, Fraud and Disciplinary Team
   Dr Hamish Wilson, Head of Primary Care Division;

   Part 3 – Pharmaceutical care services
   Chris Naldrett, Primary Care Division, Team Leader, Pharmacy Issues Team
   Dr Hamish Wilson, Head of Primary Care Division;

   Part 4 – Discipline
   Richie Malloch, Workforce and Policy Division, Team Leader, General Medical Services Team
   John Davidson, Workforce and Policy Division, General Medical Services Team;
   Dr Hamish Wilson, Head of Primary Care Division;
Part 5 – Miscellaneous

*Infection with hepatitis C as a result of NHS treatment*
Sylvia Shearer, Health Planning and Quality Division, Team Leader, Blood Transfusion Services Branch;
Andrew MacLeod, Head of Health Planning and Quality Division;

*Amendment of Regulation of Care (Scotland) Act 2001 and child care agencies and housing support services*
Adam Rennie, Head of Community Care Division 2
Diane White, Social Work Services Policy Division, Training and Development Team
Stephen Sandham, Regeneration, Fuel Poverty and Supporting People Division, Head of Branch;

*Authorisation of medical treatment*
Jim Brown CBE, Head of Public Health Division; and

*Joint ventures and Scottish Hospital Endowments Research Trust*
Mike Baxter, Property and Capital Planning Division, Team Leader, Private Finance and Capital Unit
Dr Hamish Wilson, Head of Primary Care Division
Patrick McGrail, Community Care Division 2, Joint Future Team
Mike Stevens, Deputy Director, Chief Scientist Office.

Executive officials agreed to provide supplementary information on the financial efficiency of NHS joint ventures in England and Wales including NHS Lift projects in St Helens and Liverpool.

The meeting closed at 4.01 pm.

 Simon Watkins
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

3rd Meeting, 2005 (Session 2)

Tuesday 25 January 2005

Present:

Roseanna Cunningham (Convener)        Mr David Davidson
Helen Eadie                               Janis Hughes (Deputy Convener)
Mr Duncan McNeil                         Mike Rumbles
Jean Turner

Apologies: Kate Maclean and Shona Robison

The meeting opened at 2.01 pm

1. **Items in private**: The Committee agreed to take item 4 in private.

4. **Smoking, Health and Social Care (Scotland) Bill (in private)**: The Committee considered its approach to evidence taking at Stage 1.

The meeting closed at 4.08 pm.

Simon Watkins
Clerk to the Committee
Health Committee, 6th Report, 2005 (Session 2) - ANNEX B

HEALTH COMMITTEE

EXTRACT FROM MINUTES

5th Meeting, 2005 (Session 2)

Tuesday 22 February 2005

Present:

Roseanna Cunningham (Convener) Helen Eadie
Janis Hughes (Deputy Convener) Kate Maclean
Mr Duncan McNeil Mrs Nanette Milne
Shona Robison Mike Rumbles
Jean Turner

The meeting opened at 2.16 pm

2. **Items in private:** The Committee agreed to take items 5 and 6 in private.

4. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

   Dr Iain Wallace, Medical Director, Primary Care Division, NHS Greater Glasgow
   Mary Morton, Acting Chief Pharmacist, NHS Highland
   Catherine Lush, Clinical Dental Manager, NHS Highland
   Martyn Evans, Director, Scottish Consumer Council
   Joyce Shearer, Voluntary Member, Fife Local Health Council
   Andrew Lamb, National Director, British Dental Association
   Hal Rollason, Chairman, Optometry Scotland
   James Semple, Chairman, Scottish Pharmaceutical Federation
   Alex MacKinnon, Head of Professional Services Development, Scottish Pharmaceutical General Council
   Dr Hamish Wilson, Head of Primary Care Division, Scottish Executive Health Department
   Eric Gray, Primary Care Division, Team Leader, Dental and Ophthalmic Services, Scottish Executive Health Department
   Chris Naldrett, Primary Care Division, Team Leader, Pharmacy Issues Team, Scottish Executive Health Department

Executive officials agreed to provide supplementary evidence on whether the Bill requires individuals currently listed as dental, ophthalmic or pharmaceutical practitioners to disclose information for inclusion in the proposed extended lists.

In addition, Executive officials stated that the regulations on the contract for pharmacists would be available in draft for the Committee’s Stage 2 consideration of the provisions on pharmaceutical care services.
5. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting closed at 4.27 pm.

*Simon Watkins*
Clerk to the Committee
HEALTH COMMITTEE
EXTRACT FROM MINUTES
6th Meeting, 2005 (Session 2)
Tuesday 1 March 2005

Present:
Roseanna Cunningham (Convener) Helen Eadie
Janis Hughes (Deputy Convener) Kate Maclean
Mr Duncan McNeil Mrs Nanette Milne
Shona Robison Mike Rumbles
Jean Turner

The meeting opened at 2.02 pm

1. **Items in private**: The Committee agreed to take agenda items on its eating disorders inquiry and its workforce planning chamber event in private. The Committee also agreed to consider themes arising from evidence on the Smoking, Health and Social Care (Scotland) Bill in private.

3. **Smoking, Health and Social Care (Scotland) Bill**: The Committee agreed to delegate responsibility to the Convener for the approval of witness expenses arising from the Committee’s consideration of the Bill at Stage 1.

The Committee took evidence from—

**Part 4 Discipline**

Stewart Scott, Chair, Borders Local Health Council
Margo Biggs, Member, Forth Valley Local Health Council
Alex Matthewson, North Branch Representative, BDA Scottish Council
Dr David Love, Deputy Chairman, BMA Scotland
Hal Rollason, Chairman, Optometry Scotland
Angela Timoney, Chairman, Scottish Executive, Royal Pharmaceutical Society of Great Britain
Dr Hamish Wilson, Head of Primary Care Division, Scottish Executive Health Department
John Davidson, Workforce and Policy Division, General Medical Services Team, Scottish Executive Health Department

Scottish Executive officials agreed to provide supplementary information on: the number of cases which have been considered at NHS tribunals; the number of complaints considered under NHS complaints procedures and whether the provisions in the Bill on discipline apply to NHS 24 staff.

Clerks agreed to seek information on the number of disciplinary cases which have been considered by regulatory bodies.
Part 5 Infection with hepatitis C as a result of NHS treatment

Panel 1
Philip Dolan, Chairman, Scottish Haemophilia Forum
Dave Bissett, Vice-Chairman, Scottish Haemophilia Forum
Frank McGuire, Legal Adviser, Scottish Haemophilia Forum

Representatives of the Haemophilia Forum agreed to provide supplementary information on the number of ex-gratia payment claims which have been delayed at the stage at which input from consultants is required.

6. Smoking, Health and Social Care (Scotland) Bill: The Committee took evidence from—

Part 5 Infection with hepatitis C as a result of NHS treatment

Panel 2
Peter Stevens, Chairman, Skipton Fund
Keith Foster, Scheme Administrator, Skipton Fund

Skipton Fund representatives agreed to provide details of the achievement rate in Scotland for ex-gratia payments to persons infected with hepatitis C as a result of NHS treatment.

7. Smoking, Health and Social Care (Scotland) Bill (in private): The Committee considered the main themes arising from the evidence session. The Committee agreed to notify the Minister for Health and Community Care of outstanding issues raised during evidence on the provisions of the Bill relating to infection with hepatitis C as a result of NHS treatment.

The meeting closed at 5.10 pm.

Simon Watkins
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

7th Meeting, 2005 (Session 2)

Tuesday 8 March 2005

Present:

Roseanna Cunningham (Convener) Kate Maclean
Janis Hughes (Deputy Convener) Mrs Nanette Milne
Shona Robison
Jean Turner

Also present: Carolyn Leckie

Apologies: Helen Eadie, Mr Duncan McNeil and Mike Rumbles.

The meeting opened at 2.01 pm

1. **Items in private:** The Committee agreed to take items 3 and 5 in private.

2. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

   **Panel 1**
   Dr Alan Jacques, Convener, Alzheimer Scotland
   Nicola Smith, Legal Adviser, ENABLE
   Sandra McDougall, Legal Officer, Scottish Association for Mental Health; and

   **Panel 2**
   Dr Mairi Scott, Chair, Royal College of General Practitioners (Scotland)
   Pat Dawson, Head of Policy and Communications, Royal College of Nursing
   Robert Hamilton, Senior Dental Officer, British Dental Association.

3. **Smoking, Health and Social Care (Scotland) Bill (in private):** The Committee considered the main themes arising from the evidence session.

The meeting was suspended at 3.18 pm and resumed at 3.51 pm.
4. **Smoking, Health and Social Care (Scotland) Bill**: The Committee took evidence from—

**Part 5 Joint ventures**

*Panel 1*
David Fox, Director, Turner and Townsend Management Solutions
Howard Forster, Partner, Health Sector Leader, EC Harris

*Panel 2*
Alan McKeown, Health and Social Care Team Leader, CoSLA
Tim Huntingford, Chief Executive of West Dunbartonshire Council and Joint Chair of the Joint Premises Board, CoSLA
Hilary Robertson, Director, NHS Confederation
Susan Aitken, Policy Manager, NHS Confederation; and

*Panel 3*
John Park, Assistant Secretary, STUC
Dave Watson, Head of Policy and Information, UNISON Scotland.

Janis Hughes and Carolyn Leckie both declared that they are members of UNISON Scotland.

COSLA officials agreed to seek to provide supplementary information following a visit to joint venture projects in England before the conclusion of Stage 1.

5. **Smoking, Health and Social Care (Scotland) Bill (in private)**: The Committee considered the main themes arising from the evidence session.

The meeting closed at 6.09 pm

**Simon Watkins**
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

8th Meeting, 2005 (Session 2)

Tuesday 15 March 2005

Present:
Roseanna Cunningham (Convener)
Janis Hughes (Deputy Convener)
Mrs Nanette Milne
Mike Rumbles

Also present: Mr Brian Monteith

Apologies: Kate Maclean

The meeting opened at 2.02 pm

1. **Items in private:** The Committee agreed to take agenda items 4 and 5 in private.

3. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from—

   **Part 1 Prohibition of smoking in certain wholly enclosed places**

   **Panel 1**
   Paul Waterson, Chief Executive, Scottish Licensed Trade Association
   Stuart Ross, Chief Executive, Belhaven Brewery, Scottish Licensed Trade Association
   Christopher Ogden, Director of Trade and Industry Affairs, Tobacco Manufacturers’ Association
   Steven Stotesbury, Senior Scientist, Imperial Tobacco, Tobacco Manufacturers’ Association;

   **Panel 2**
   Paddy Crerar, Chairman, British Hospitality Association Scottish Committee;
   Ian McAlpine, Coal Industry Social Welfare Organisation, Committee of Registered Clubs Associations
   George Ross, Royal British Legion Clubs, Committee of Registered Clubs Associations;

   **Panel 3**
   Alan McKeown, Health and Social Care Team Leader, CoSLA
   Gordon Greenhill, Environmental Health Manager, Regulatory Services Department, City of Edinburgh Council.
Keith McNamara, President, Royal Environmental Health Institute of Scotland  
David Mellor, Deputy Chief Constable, Association of Chief Police Officers;

Panel 4  
Dr Rachel Harrison, Senior Policy and Research Officer, ASH Scotland  
Sheila Duffy, Head of Information and Communications, ASH Scotland; and

Panel 5  
Andy Matson, Regional Officer, AMICUS  
Ian Tasker, Assistant Secretary, STUC  
Dave Watson, Head of Policy and Information, UNISON Scotland.

The Committee agreed to conclude its consideration of petition PE819 by Paul Waterson on the implications of the proposed ban on smoking on the hospitality industry by incorporating the issues raised by the petition into its Stage 1 consideration of the Bill.

CORCA representatives agreed to provide copies of the questionnaire issued to Royal British Legion Clubs on the proposals in Part 1 of the Bill and details of the RBLC membership in Lothians, Glasgow and the West.

ASH Scotland representatives agreed to provide supplementary information on risks associated with second hand smoke and evidence from litigation cases in the USA.

Janis Hughes declared that she is a member of UNISON Scotland.

4. Smoking, Health and Social Care (Scotland) Bill (in private): The Committee considered the main themes arising from the evidence session.

The meeting closed at 6.22 pm.

Simon Watkins  
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

9th Meeting, 2005 (Session 2)

Tuesday 22 March 2005

Present:

Roseanna Cunningham (Convener)  Helen Eadie
Janis Hughes (Deputy Convener)  Kate Maclean
Mr Duncan McNeil  Mrs Nanette Milne
Shona Robison  Mike Rumbles
Jean Turner

Also present: Stewart Maxwell.

The meeting opened at 2.02 pm

1. **Items in private:** The Committee agreed to take agenda items 7 and 8 in private.

2. **Smoking, Health and Social Care (Scotland) Bill:** The Committee took evidence from the Minister for Health and Community Care on all parts of the Bill.

   **Part 1 – Prohibition of Smoking in certain wholly enclosed places**
   The Minister agreed to provide the following supplementary information—

   - details of actions planned by the Smoke Free Implementation Group; and
   - an outline of the allocation between health boards of £12m to aid smoking cessation including details of the criteria on which the calculations for the allocation are based.

   **Part 5, Section 24 – Infection with hepatitis C as a result of NHS treatment**
   The Minister agreed to seek legal advice on the provisions relating to the requirement to reside in Scotland when the application for payment from the Skipton Fund is made. The Minister also agreed to seek legal advice on how the requirement to be registered with the Skipton Fund to receive payment relates to the eligibility of those who died after August 2003 but before the Skipton Fund was established.

   **Part 5, Section 31 – Joint ventures**
   Helen Eadie declared that she is a member of the Co-operative Party.
6. Smoking, Health and Social Care (Scotland) Bill (in private): The Committee considered the main themes arising from the evidence session.

The meeting closed at 5.12 pm.

Simon Watkins
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

10th Meeting, 2005 (Session 2)

Tuesday 12 April 2005

Present:

Roseanna Cunningham (Convener)          Helen Eadie
Janis Hughes (Deputy Convener)           Kate Maclean
Mr Duncan McNeil                          Mrs Nanette Milne
Shona Robison                             Mike Rumbles
Jean Turner

The meeting opened at 2.00 pm

1. **Items in private**: The Committee agreed to take agenda item 4 in private.

4. **Smoking, Health and Social Care (Scotland) Bill (in private)**: The Committee considered a draft Stage 1 report.

The meeting closed at 4.30 pm.

Simon Watkins
Clerk to the Committee
HEALTH COMMITTEE

EXTRACT FROM MINUTES

11th Meeting, 2005 (Session 2)

Tuesday 19 April 2005

Present:

Roseanna Cunningham (Convener)  Helen Eadie
Janis Hughes (Deputy Convener)  Kate Maclean
Mr Duncan McNeil  Mrs Nanette Milne
Mike Rumbles  Jean Turner

Apologies: Shona Robison.

The meeting opened at 2.00 pm

1. **Items in private**: The Committee agreed to take agenda item 6 in private.

6. **Smoking, Health and Social Care (Scotland) Bill (in private)**: The Committee agreed its Stage 1 report, subject to specified changes being made.

The meeting closed at 3.19 pm.

Simon Watkins
Clerk to the Committee
ANNEX C: ORAL AND ASSOCIATED WRITTEN EVIDENCE

11 January 2005 (1st Meeting, Session 2 (2005))

All parts of the Bill

Oral Evidence

Roderick Duncan, Bill Team Leader
Colin Cook, Substance Misuse Division
Mary Cuthbert, Tobacco Control Division
Eric Gray, Primary Care Division
Dr Hamish Wilson, Primary Care Division
Chris Naldrett, Primary Care Division
Richie Malloch, Workforce and Policy Division
John Davidson, Workforce and Policy Division
Dr Hamish Wilson, Head of Primary Care Division
Sylvia Shearer, Health Planning and Quality Division
Andrew MacLeod, Head of Health Planning and Quality Division
Adam Rennie, Head of Community Care Division 2
Diane White, Social Work Services Policy Division
Stephen Sandham, Regeneration, Fuel Poverty and Supporting People Division
Jim Brown CBE, Head of Public Health Division
Mike Baxter, Property and Capital Planning Division
Patrick McGrail, Community Care Division 2
Mike Stevens, Chief Scientist Office

22 February 2005 (5th Meeting, Session 2 (2005))

Part 2 (General Dental; Services, General Ophthalmic Services and Personal Dental Services) and Part 3 (Pharmaceutical Services)

Written Evidence

Scottish Consumer Council
British Dental Association
Oral Evidence
Dr Iain Wallace, NHS Greater Glasgow
Mary Morton, NHS Highland
Catherine Lush, NHS Highland
Martyn Evans, Scottish Consumer Council
Joyce Shearer, Fife Local Health Council
Andrew Lamb, British Dental Association
Hal Rollason, Optometry Scotland
James Semple, Scottish Pharmaceutical Federation
Alex McKinnon, Scottish Pharmaceutical General Council
Dr Hamish Wilson, Scottish Executive Health Department
Eric Gray, Scottish Executive Health Department
Chris Naldrett, Scottish Executive Health Department

1 March 2005 (6th Meeting, Session 2 (2005))

Part 4 (Discipline) and Part 5 (Infection with Hepatitis C)

Written Evidence
Forth Valley Local Health Council
British Dental Association
BMA Scotland
Royal Pharmaceutical Society of Great Britain Scottish Executive
Scottish Haemophilia Forum
Skipton Fund

Oral Evidence
Stewart Scott, Borders Local Health Council
Margo Biggs, Forth Valley Local Health Council
Alex Matthewson, BDA Scottish Council
Dr David Love, BMA Scotland
Hal Rollason, Optometry Scotland
Angela Timoney, Royal Pharmaceutical Society of Great Britain
Dr Hamish Wilson, Scottish Executive Health Department
John Davidson, Scottish Executive Health Department
Philip Dolan, Scottish Haemophilia Forum
Dave Bissett, Scottish Haemophilia Forum
Frank McGuire, Scottish Haemophilia Forum
Peter Stevens, Skipton Fund
Keith Foster, Skipton Fund

Supplementary Written Evidence
Scottish Haemophilia Forum
Skipton Fund
Optometry Scotland
8 March 2005 (7th Meeting, Session 2 (2005))

Part 5 (Authorisation of Medical Treatment; and Joint Ventures)

Written Evidence
- Alzheimer Scotland
- ENABLE
- Scottish Association for Mental Health
- Royal College of General Practitioners (Scotland)
- RCN Scotland
- British Dental Association
- EC Harris
- COSLA
- STUC
- NHS Confederation
- UNISON Scotland

Oral Evidence
- Dr Alan Jacques, Alzheimer Scotland
- Nicola Smith, ENABLE
- Sandra McDougall, Scottish Association for Mental Health
- Dr Mairi Scott, Royal College of General Practitioners (Scotland)
- Pat Dawson, Royal College of Nursing
- Robert Hamilton, British Dental Association
- David Fox, Turner and Townsend Management Solutions
- Howard Forster, EC Harris
- Alex Macleod, Skanska
- Alan McKeown, COSLA
- Tim Huntingford, COSLA
- Hilary Robertson, NHS Confederation
- Susan Aitken, NHS Confederation
- John Park, STUC
- Dave Watson, UNISON Scotland

15 March 2005 (8th Meeting, Session 2 (2005))

Part 1 (Prohibition of Smoking in Certain Wholly Enclosed Spaces)

Written Evidence
- Scottish Licensed Trade Association
- Tobacco Manufactures’ Association
- CISWO
- British Hospitality Association Scotland Committee
- COSLA
- City of Edinburgh Council
- Royal Environmental Health Institute of Scotland
- ASH Scotland
- AMICUS
- STUC
- UNISON
Oral Evidence 196
Paul Waterson, Scottish Licensed Trade Association
Stewart Ross, Belhaven Brewery, Scottish Licensed Trade Association
Christopher Ogden, Tobacco Manufacturers’ Association
Steven Stotesbury, Imperial Tobacco, Tobacco Manufacturers’ Association
Paddy Crerar, British Hospitality Association Scotland Committee
Ian McAlpine, Coal Industry Social Welfare Organisation (CISWO), Committee of Registered Clubs Associations
George Ross, Royal British Legion Clubs, Committee of Registered Clubs Associations
Alan McKeown, CoSLA
Gordon Greenhill, City of Edinburgh Council
Keith McNamara, Royal Environmental Health Institute of Scotland
David Mellor, Association of Chief Police Officers
Dr Rachel Harrison, ASH Scotland
Sheila Duffy, ASH Scotland
Andy Matson, AMICUS
Ian Tasker, STUC
Dave Watson, UNISON Scotland

Supplementary Written Evidence 233
British Hospitality Association Scotland Committee
ASH Scotland
STUC
COSLA

22 March 2005 (9th Meeting, Session 2 (2005))

All parts of the Bill

Written Evidence 244
Minister for Health and Community Care

Oral Evidence 256
Minister for Health and Community Care

Supplementary Evidence 276
Minister for Health and Community Care

ANNEX D: OTHER WRITTEN EVIDENCE

PART 1: Prohibition of Smoking in Certain Wholly Enclosed Places

Organisations 281
Against an Outright Ban – Petition 819
Asthma UK Scotland
Barnardos
Bellhaven Group
Blantyre Bowling Club
BMA Scotland
British Lung Foundation Scotland
Broomhouse Centre
CAMRA
Cancer Research UK Scotland
Carlton Clubs
Chartered Society of Physiotherapy Scotland
Children in Scotland
CPL Entertainment Group Limited
Diabetes UK Scotland
FOREST
Health Economic Research Unit
Howard League for Penal Reform in Scotland
Lynnet Leisure Group
MacMillan Cancer Relief
MacLay Group PLC
NHS Grampian
NHS Lanarkshire
NHS Tayside
Phillip Morris International Ltd
Punch Taverns PLC
RCN Scotland
Roy Castle Lung Cancer Foundation
Royal College of General Practitioners (Scotland)
Royal College of Physicians Edinburgh
Scotland CAN!
Scottish Beer and Pub Association
Scottish Wholesale Association
SmokeFree Liverpool
Tennent Caledonian Breweries
Tobacco Workers’ Alliance

Individuals

Anonymous
Anonymous
Anonymous
Mark Cadle
David Cattanach
Margaret Ellam
John Heatherill
John and Winifred Hughes
Laura Lamb
Collette Lander
Kenneth MacArthur
Charles McCann
Sheila McQueen
Wendy Nganasurian
Andrew Pearson
Andrew Rose
Mike Thistle
Louise Wilson

**Part 2: General Dental Services, General Ophthalmic Services and Personal Dental Services**

MDDUS
RCN Scotland
Which
Andrew Rose

**PART 3: Pharmaceutical Care Services etc.**

BMA
Lloydsphamacy
RCN Scotland
Elizabeth Calder
Francis Flynn

**Part 4: Discipline**

Scottish NHS Confederation

**Part 5: Miscellaneous**

Section 24: Payment to certain persons infected with hepatitis C as a result of NHS Treatment

RCN Scotland

Sections 25-27: Amendment of Regulation of Care (Scotland) Act 2001

RCN Scotland

Section 30: Authorisation of medical treatment

British Dental Association
BMA Scotland
Chartered Society of Physiotherapy Scotland
The Law Society of Scotland

Section 31: Joint ventures

Partnerships UK
RCN Scotland
Universities Scotland

Section 32: Scottish Hospital Endowment Research Trust

RCN Scotland
ANNEX E: PROHIBITION OF SMOKING IN REGULATED AREAS (SCOTLAND) BILL

Hard copies of the Committee’s Stage 1 report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill (published 11 January 2005, SP Paper 263) and accompanying evidence are available from the clerks to the Committee upon request to health@scottish.parliament.uk or on 0131 348 5224.

ANNEX F: UNPRINTED MEMORANDA

W Hunter Watson
Scottish Parliament
Health Committee
Tuesday 11 January 2005

[THE CONVENER opened the meeting at 14:00]

Smoking, Health and Social Care (Scotland) Bill: Stage 1

The Convener (Roseanna Cunningham): I welcome everyone back to Parliament and wish them a happy new year. Let us hope that the work of the Health Committee is as successful in 2005 as it was in 2004.

Today, we will receive a briefing on the policy intentions behind the Smoking, Health and Social Care (Scotland) Bill. The bill team leader is Roderick Duncan, who will be accompanied by a variety of colleagues from the different divisions of the Health Department that have a policy interest in the bill. The bill has five main parts and we have arranged this afternoon’s session to follow that structure.

I ask Roderick Duncan to make a brief introductory statement. He will remain here throughout the evidence session to address general questions. However, if members have questions on specific subjects, we would be obliged if they would wait until the relevant Executive officials are before the committee.

Roderick Duncan (Scottish Executive Health Department): Good afternoon, ladies and gentlemen. I thank the committee for giving us this opportunity to present the contents of the Smoking, Health and Social Care (Scotland) Bill. My role as bill team leader is to co-ordinate the Executive’s activities as the bill moves through the parliamentary process. I do not have in-depth knowledge of the individual policy areas behind the bill, so I ask members not to ask me too many difficult questions about those.

My colleagues will address the detail of the bill, but I will start by providing a high-level summary of it. Part 1 of the bill deals with the prohibition of smoking in certain wholly enclosed public spaces. For some time, we have recognised that smoking is the most important preventable cause of ill health and premature death in Scotland. When the Executive published its tobacco control action plan back in January 2004—the first-ever action plan that was designed for Scotland—it made a commitment to a major public debate on passive smoking. The health evidence about the impact of passive smoking grows all the time. We added to that evidence during the consultation process the estimate of about 865 deaths per annum in Scotland among lifelong non-smokers from the four main diseases related to smoking.

Between June and September 2004, the Executive undertook its consultation, which generated more than 53,000 responses. That was supplemented by opportunities for the public to give ministers their views and discuss the issues on the internet and elsewhere. It was also supplemented by a series of research projects, many of which are covered in the documents that are before the committee. Those projects examined the health and potential economic impacts of introducing the policy.

Part 1 of the bill prohibits smoking in premises that are fully enclosed and to which the public or a section of the public have access. It does so to protect public health. The detailed provisions, including any exemptions that might be considered, will be prescribed in regulations subject to the affirmative procedure. However, given the health evidence that I mentioned briefly,
Ministers have made it clear that they want the most comprehensive approach, which will include premises such as transport cafes, restaurants and large-scale public buildings such as hospitals. That takes into account the fact that 70 per cent of Scots do not smoke, that many who smoke want to give up and that evidence suggests that there is no safe level of exposure to tobacco smoke.

The bill provides for a ban on smoking in the premises that are prescribed in regulations as no-smoking premises by creating offences of permitting others to smoke in no-smoking premises; of smoking in such premises; and of failing to display warning notices in no-smoking premises. The bill also sets out powers for enforcement officers to enter no-smoking premises and creates an offence of failing to give a name and address on request by an enforcement officer.

Part 1 makes a significant contribution to the Executive’s overall effort to improve health in Scotland. Mary Cuthbert and I hope to answer your detailed questions.

**The Convener:** Committee members will be aware that we have much to get through this afternoon, so I ask members to keep it in mind that we will ask questions on part 1 until about half past 2. Nanette Milne has joined us. I ask members to indicate whether they have questions; they should not feel obliged to ask questions for the entire time—I am sure that the officials do not mind either way. Does nobody have a question? Somebody must have a question.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** We have questions on other parts of the bill.

**The Convener:** In fairness to the officials, they will be aware that the committee has taken much evidence that is germane to part 1, so that part will not take up as much time as it would have if we had approached the subject afresh. However, my filibustering has managed to elicit one question. It may not be competent to ask or to answer this question, but why have many different provisions—each valued in its own right—been incorporated into one bill?

**Mr David Davidson (North East Scotland) (Con):** I thought that I would help you out a bit, convener. It may not be competent to ask or to answer this question, but why have many different provisions—each valued in its own right—been incorporated into one bill?

**Roderick Duncan:** Members may be aware that, in his statement to the Parliament in September 2004, the First Minister outlined the intention to introduce a health service (miscellaneous provisions) bill. When the smoking provisions were brought forward as a health measure, it was thought appropriate to include them in that bill. A large part of the Smoking, Health and Social Care (Scotland) Bill relates to smoking, but it also captures several other important health care and social care matters.

**Mr Davidson:** I did not receive an answer—that is obviously not appropriate. Do you have any idea why all the provisions have been grouped together rather than introduced as separate pieces of legislation?

**Roderick Duncan:** Each piece of legislation would be so small on its own that individual bills would not be justified. It was felt that it would be appropriate to bring all the provisions together into a single piece of legislation.

**The Convener:** I have a question for the two other officials. I was interested in the Scottish Parliament information centre’s briefing on the smoking ban, page 12 of which deals with deaths relating to environmental tobacco smoke. I am curious about the fact that three different figures are given for that. NHS Health Scotland and Action on Smoking and Health Scotland estimate that there are around 1,200 deaths a year in Scotland from passive smoking. A University of Glasgow study says that there are “865 deaths per year in Scotland among lifelong non-smokers from the four main causes listed”.

The third source says that, “including other deaths known to be related to smoking, up to 1000 deaths per year might be attributed to ETS exposure among lifelong non-smokers”.

Will the witnesses explain why we have that variety of figures?

**Colin Cook:** Each of those figures is defined differently. As you said, the figure of 865 deaths, which is probably the most often cited statistic, comes from work done by David Hole at the University of Glasgow. As the briefing states, that study looked at the relevant four main causes of death— ischaemic heart disease, stroke, respiratory problems and lung cancer. We need to bear in mind other smoking-related diseases, but the evidence base for those is less robust; nonetheless, some of the other figures include them. We are looking at those over a long period and, in the case of some diseases, the medical effects might take 20 or 30 years to come through. Different timescales and definitions come into play.

**The Convener:** There is a bit of rumbling around the table. Can we take from what you said that we have a variety of estimates and that the figures cannot be said to be more than that?

**Colin Cook:** Yes, but 865 deaths is the central estimate. Other factors also come into play—for example, deaths among ex-smokers who have continued to be exposed to environmental tobacco smoke over time. The 865 deaths were among lifelong non-smokers, but there are other
categories of people to consider. There are different estimates, but they can all be traced and matched. The evidence report that was produced attempts to do that.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am not sure whether this is the right point at which to ask this question, which is about the wholly enclosed places. Hospital grounds, which are usually large, wide-open spaces, are non-smoking areas. I am also thinking about the concourses of railway stations, which are reasonably open, although they are roofed. Are they wholly enclosed spaces?

Colin Cook: We can refine the definition of a wholly enclosed space in regulations. We work on the assumption that it is somewhere with four walls and a roof. However, that will be picked up through regulations as the process continues.

Mrs Nanette Milne (North East Scotland) (Con): We have mortality figures for passive smoking, but are there any morbidity figures?

Mary Cuthbert (Scottish Executive Health Department): All the information is gathered on the basis of estimates and there are no available estimates that relate to passive smoking.

The Convener: Following on from Jean Turner's point, I will ask about the kind of spaces that are likely to be covered by the legislation. We know from the Irish experience that some hotels, restaurants, cafes and pubs have devoted external spaces to smoking with the use of marquees, external heaters and what have you. Is it envisaged that that is likely to happen in a number of places in Scotland, where space is available?

Colin Cook: Clearly, the situation will be driven by the market, but one would expect similar things to happen as have happened in Ireland.

14:15

The Convener: There are no more questions. You have got off lightly, but that is because of the enormous amount of work that the committee has already done on the issue, not because there is not a great deal of interest in it. I thank the officials for coming.

As I said, Roderick Duncan will stay with us as we are joined by officials who deal with parts 2 to 4 of the bill. I invite to the table Dr Hamish Wilson, who is the head of the primary care division and who has an interest in all three parts. To deal with part 4, which is on discipline, we have Richie Malloch, who is the team leader of the general medical services team in the workforce and policy division, and John Davidson, who is also from the workforce and policy division's general medical services team. I ask Dr Hamish Wilson to make a short introductory statement on parts 2 to 4.

Dr Hamish Wilson (Scottish Executive Health Department): With your agreement, convener, it might be best if I introduced each part separately, because, although the provisions are interconnected, they are also distinct.

The Convener: Okay. We will ask you to make three introductory statements. Perhaps you will deal first with part 2, on general dental services, general ophthalmic services and personal dental services.

Dr Wilson: Thank you. Part 2 deals with three main issues and it would be helpful to consider them in turn. The first is the partnership agreement pledge to introduce free dental and eye checks for all before 2007. Sections 9 and 10 make provision for the introduction of free dental and eye checks for all. The present legislation requires charges to be made for certain people for dental and eye checks, but sections 9 and 10 will remove that requirement.

Part 2 will also provide the potential for more comprehensive free oral health assessments and eye examinations. I will exemplify using the second of those. At present, the specific definition of a sight test involves refraction, which is used when a person needs glasses, whereas the phrase "eye examination" can be a much broader term that allows optometrists, for example, to provide an examination for an individual that may not involve refraction and hence the need for glasses. That is particularly appropriate for certain clinical conditions.

In relation to dental services, the consultation—to which I will return when I refer to section 11—revealed strong support for wider oral health assessment, not just the current dental examination that individuals receive from dental practices. We have used the term "oral health assessment" to describe that broader examination, which will allow dental practitioners to perform something that is much broader and more useful for patients than the current examination is.

The bill will remove the requirement to pay for eye and dental checks and it will provide for a broader range of examinations than are allowed for currently. It might be helpful if I stopped there and took questions on those sections, or would you prefer me to deal with all three issues now?
The Convener: I want to deal with the three parts separately. The first—part 2—deals with general dental services, general ophthalmic services and personal dental services.

Dr Wilson: I will carry on then, if I may, with the other two issues.

The next sections of the bill flow from the consultation that the Executive conducted in the earlier part of last year. The consultation paper “Modernising NHS Dental Services in Scotland” was issued, to which there were a large number of responses, and a number of meetings were held throughout Scotland. As a result of that, the proposals for changing primary legislation are quite limited. The response to the consultation was clear: the changes that professionals and members of the public were looking for could be implemented by methods other than primary legislation—for example, by changes to regulations and changes to the way in which dentists are paid. There is a specific dental remuneration system, which can be changed without amending primary legislation. On the face of it, the changes to primary legislation on dental services seem modest, but they are important. I will deal with them in the order in which they appear in the bill.

First, in section 11, there is a provision to make the dental charging regime simpler and more flexible. At the moment, a patient’s dental charge is linked to the dentist’s item-of-service fee. If a patient pays, they pay 80 per cent of that fee. That is how the legislation is currently framed; it does not give the detailed percentage but states the way in which the charge is calculated by reference to the item-of-service fee. By breaking that link, which is what the bill does, we will have the opportunity, through regulations, to have a more flexible and transparent system. Ministers have not yet taken a view on what that system should be, but the bill allows for a more flexible system than currently exists.

Section 12 will allow NHS boards to enter into arrangements for general dental services with dental bodies corporate as well as with dental practitioners. Dental bodies corporate are defined in the Dentists Act 1984, which is reserved legislation. It contains provisions for bodies corporate to provide general dental services under the NHS as well as privately. At the moment, arrangements can be made only with individual dentists, but the provision broadens the ability of NHS boards to make arrangements.

Section 13 is on a particularly important matter, which was raised forcefully during the consultation: the ability of health boards to provide financial assistance and support to persons who provide general dental services. That might include, for example, assistance with the cost of premises and information technology support to staff.

Section 14 will allow health boards to make arrangements with dentists for what we describe as co-management schemes—schemes that allow dentists to provide in the community services that might otherwise be provided in, for example, a hospital setting. The bill will allow such services to be contracted with local dental practices in the high street, which will be able to provide them to patients in the community. Indeed, dentists can provide an important service in relation to other treatments—two examples are migraine and snoring treatments, which are not normally associated with dental services.

Sections 15 to 17 are about the listing of those who provide dental or optical services. At the moment, people who are included on health board lists to provide such services are what we call principals—the main providers of service. Those who are not listed are called assistants and they support those professionals in providing services. Assistants are qualified dentists or optometrists but they are not listed. One of the post-Shipman recommendations was that all such individuals ought to be listed, whether the services that they provide are medical, dental, pharmaceutical—we will come to that later—or ophthalmic, so that individual health boards have responsibility for all the individuals on their lists. That is a clinical governance issue.

Mike Rumbles: You make it clear that part 2 of the bill will allow everybody to have free dental examinations and sight tests. When you say that part 2 will also allow the Executive at a future date to establish more comprehensive oral health assessments and eye examinations, do you mean that that could be done by regulations? I just want to be absolutely clear that ministers will be able to come forward with those proposals not through a bill before the Parliament but through laying regulations before the committee. Is that right?

Dr Wilson: Yes.

Shona Robison (Dundee East) (SNP): In the financial memorandum, providing free dental checks has been costed at between £9.1 million and £12.4 million, based on a cost of £6.80 for one check. This exercise is running simultaneously to the awaited response from ministers to the “Modernising NHS Dental Services in Scotland” consultation, so it is quite possible that there will be substantial changes to the fee structure and to the fee level that could be paid to dentists for carrying out those dental checks, particularly as you have said that there is a desire to have wider oral health assessments than just the basic check. There is a likelihood that the figure of £6.80, on which the financial memorandum is based, could quickly become out of date as the fee structure
and fee level change and as what dentists are expected to provide for the check changes. Is not the financial memorandum likely to become way out of date and substantially inaccurate quite quickly?

Dr Wilson: You are absolutely right. Because discussions with the dental profession on the potential for an oral health assessment and what that might mean are on-going, we do not have new figures for the financial memorandum, which was constructed a number of weeks ago. We have simply had to go on the figures that we had available at the time, so you are right to say that the cost could change.

Shona Robison: How will that be managed in terms of the progress of the bill?

Dr Wilson: As soon as we are aware of the changes that might flow from those discussions and from the decisions that ministers will announce, we will have to come back and make an addendum to the financial memorandum.

Shona Robison: I suppose that the problem is that, in some ways, the timing could not be worse. I have highlighted one aspect where the decisions made by ministers could have an impact on the financial memorandum or indeed on the contents of the bill, but there could be many such aspects. I take it that you are in close liaison with the officials who are working around what the ministers are about to announce.

Dr Wilson: Yes.

Shona Robison: Will you come back and have another session with us on the more realistic figures?

Dr Wilson: Yes. We were able to produce costs only on the basis of the information that we had at the time. In relation to the main service, in addition to the examinations, the bill does not have direct financial consequences other than those that are listed. Clearly, however, if any ministerial announcement includes additional resources for general dental services, that would have to be taken account of as well.

Helen Eadie (Dunfermline East) (Lab): I note from the SPICE briefing that remuneration for dental services across Scotland is set at United Kingdom level. One of my concerns, which I am sure other members will share, is that if there are negotiations going on at the London end of the spectrum, as happened in relation to general practitioners not so long ago, there will be a feeling in Scotland that not enough discussion and negotiation is taking place to reflect Scottish concerns on the issue. What measures are in place to ensure that Scotland is wholly and fully consulted on that point?

14:30

Dr Wilson: There are two aspects to that question. First, the remuneration set by the doctors and dentists remuneration review body for the UK relates to item-of-service fees and, traditionally, we have gone along with that body’s recommendations. Secondly, however, we have introduced in addition to the item-of-service fees and outwith the DDRB certain unique allowances and incentives to encourage practitioners to stay and practise in Scotland. In a sense, we have tried to have the best of both worlds by continuing certain aspects that have been introduced on a UK basis while introducing measures on a Scotland-only basis to meet the country’s particular circumstances.

One of the basic issues for ministers in considering the future is the extent to which we change the relationship with what happens south of the border. In England, they have already indicated that they will take a contractual route that is different from the one that most people in the consultation wanted us to take. The approaches taken in Scotland and in England and Wales are already diverging.

Helen Eadie: I understand that even as we speak negotiations on this issue are taking place at a UK level. How far have they reached with regard to Scotland?

Dr Wilson: Ministers hope shortly to announce the results of the response to the consultation, which will provide a set of proposals for the future of NHS dental services in Scotland. I am sorry, but I cannot provide a precise timescale.

Kate Maclean (Dundee West) (Lab): How do the bill’s provisions for free eye tests compare with those in the general ophthalmic services contract? There has been some criticism that they do not go far enough.

How can we ensure that people such as children who are entitled to free eye tests take them up? For example, it is reckoned that 20 per cent of school pupils have undetected sight problems. Moreover, what provision will there be for people such as those with dementia or learning disabilities who are more difficult to test and need more time for such examinations? I am concerned that, although free eye tests can have a real public health benefit, they have to be carried out properly or there will be no improvement.

Dr Wilson: For that very reason, the wording in the bill has been changed to allow eye examinations, which, subject to discussion with the profession, can be defined in a much broader way than the current sight test. After all, that provision was designed in 1948 for a very specific purpose and has not been altered much since then.
The Convener: Has the wording been changed to take into account Optometry Scotland’s concerns that confining the provision to a sight test would miss the point in many respects?

Dr Wilson: Yes. I believe that the SPICe paper specifically mentions Optometry Scotland’s view. Indeed, we are discussing with the organisation the potential through the eye care services review group of extending eye examinations to broaden the proposed provision into one that is more of a public health measure than the current provision is.

The other issues that Kate Maclean raised, which are important, are more to do with how we implement the changes. I wonder whether we should simply stick to the bill’s content for today. We will take the other matters away and consider them in the context of implementation.

Mr David Davidson: The British Dental Association and Optometry Scotland appear to challenge their members’ capacity to deliver the provisions on time. In other words, there are not enough bodies on the park to do that. Moreover, practitioners might be unwilling to participate unless they are forced to. How will you address that matter in the bill?

Dr Wilson: Legislation cannot address that issue in itself; it has to be a matter for discussion and negotiation with the two professions. Let me take them in reverse order. Optometry Scotland has said that opticians across Scotland have the capacity to deal with a policy of free eye tests for all. In comparison with other health care professionals, opticians are reasonably plentiful. I accept that the situation is quite different with regard to dentistry and that, as people around this table know well, there are severe pressures on dentists. We are in discussions with the profession about the content of the scheme, but believe that it must be set in the context of the whole modernisation process rather than being seen as an item on its own. If, through the modernisation process, we can encourage more dentists into the national health service and retain them within the NHS, we have a much better chance of delivering the oral health assessments that are mentioned in the legislation.

Mr David Davidson: Are you saying that Optometry Scotland says that it has enough people to do what it is currently doing and to take on an additional load?

Dr Wilson: Yes. That is what its representatives have been saying in the eye care services review, of which they are part.

Mr David Davidson: Will we be able to read the reports of that review group?

Dr Wilson: The intention is that a preliminary report will be given to ministers in the near future. I am sure that that can be made available to the committee as soon as ministers have seen it.

The Convener: There appear to be no more requests to question this panel of officials with regard to part 2 of the bill, so perhaps Eric Gray is no longer required and—no doubt much to his delight—he can go.

I ask Dr Wilson to make a brief introductory statement on pharmaceutical services, which are dealt with in part 3 of the bill.

Dr Wilson: I stress the fact that the bill is not about the detail of the new pharmacy contract that is being negotiated with the Scottish Pharmaceutical General Council, which is the representative body for community pharmacists in Scotland. However, the bill sets the legislative framework within which the new contract might be delivered.

I emphasise the fact that the legislation, as drafted, substitutes the term “pharmaceutical care services” for “pharmaceutical services”. That might seem to be a small change, but care is an important word because part of the negotiations with the profession—because of the requirements placed on the Executive in the partnership agreement—relates to the need to make the best use of the skills of community pharmacists. That issue relates to care, not just dispensing, important though dispensing is. Therefore, the provisions in the bill are meant to underpin a new set of arrangements for the delivery of what we are increasingly going to call pharmaceutical care services rather than pharmaceutical services. In summary, the key provisions in the bill enable the implementation of that new pharmacy contract. The bill underpins the new contract arrangements, the detail of which will be laid out in regulations, as is the case with the current contract.

The bill also introduces a duty on health boards to be much more proactive in identifying and providing or securing the provision of pharmaceutical care services for their respective areas. At the moment, the mechanism for the provision of pharmaceutical services is somewhat reactive. When people apply to come on to a pharmaceutical list, there is a process for considering that application and either accepting or rejecting it, and there is also an appeals mechanism. The intention of the legislation is to turn that process around so that health boards proactively plan the provision of services and secure that provision where it is needed.

The third element is about listing. I mentioned clinical governance in relation to dental and ophthalmic services and the issue is exactly the same in relation to pharmaceutical services.
Currently, lists that are held by health boards do not contain the names of the pharmacists who provide the services, other than those of the superintendent pharmacists who are in charge of particular outlets. The intention—again, a post-Shipman requirement—is to identify all the community pharmacists who provide pharmaceutical care services. They will be on the list and will be responsible for their own acts and omissions, and that will underpin the clinical governance requirements on the NHS board.

The final provisions will ensure that health boards have financial responsibility for the contracts that will be delivered through the contractors who provide pharmaceutical care services, by ensuring that funding is seen as a core part of the health boards' budgets. At the moment, the budget for remuneration for community pharmacies is held centrally, and although health boards are formally accountable for it, they have no direct interest in or control over it. The intention is to change that, so that with the planning of services goes the responsibility for funding them. Having said that, it is important to stress that essential services will continue to be negotiated and defined at national level and that there will therefore be consistency of remuneration for community pharmacies throughout Scotland. The only additions to that will be services that not every community pharmacy will be required to provide, which can be contracted locally. We will still have a national service, albeit that remuneration will be done accountably at health board level.

**The Convener:** Do members have questions? Why did I guess that David Davidson would be the first member with his hand up?

**Mr David Davidson:** I am still on the roll of the Royal Pharmaceutical Society of Great Britain, although I do not practise.

Dr Wilson says that there will be national negotiation on the basic fee structure for dispensing purposes and I presume that there will be such negotiation for some form of new establishment contract. Is he saying that health boards will decide which additional services each pharmacy can apply to deliver or will be asked to deliver? How will the funding for that operate?

**Dr Wilson:** Additional services will be defined. There are four essential services in the proposed new national contract: acute dispensing, which is what most people think of as a pharmacy service; a minor ailments service; a public health service; and a chronic medication service. Those will be national services and the tariffs, capitation fees and so on will be laid down centrally. Examples of additional services include services to residential homes and oxygen therapy services. As I said, additional services will be defined and, just as happened with primary medical services, there will be a national specification and a benchmark tariff. Health boards will be able to use those, but at the same time they will be able to flex them to fit particular local circumstances. It is likely that specific pharmacy contractors will provide those additional services; not every pharmacy will provide them, just as at the moment not every pharmacy contractor needs to provide oxygen therapy services. They are distributed around an area to make sure that there is sufficient coverage.

**Mr David Davidson:** Are you saying that from the patient's perspective, which is where we need to come from, people who currently enjoy additional services will continue to do so and the health boards will not be able unreasonably to withdraw services from any particular area of Scotland?

**Dr Wilson:** We expect the pharmaceutical plan, which is mentioned in the bill, to cover the full spectrum of services so that people can be satisfied that the full range of services is available to the whole population, albeit that additional services will not necessarily be available from every community pharmacy.

**The Convener:** No other member has indicated that they wish to ask a question on part 3 of the bill, so that is good news for Chris Naldrett, who can now head off, perhaps wondering why he came along in the first place. I thank him anyway, and I ask Dr Wilson to make a brief introductory statement on part 4 of the bill, on discipline.

**Dr Wilson:** I have mentioned the post-Shipman recommendations more than once this afternoon, and a number of measures in part 4 of the bill flow from them—not necessarily the most recent recommendations, which have just appeared, but those that appeared not long after the events.

In Scotland, we have an NHS tribunal, which is the national disciplinary body for family health service practitioners—that is, doctors, dentists, pharmacists and opticians. Following consultation, a number of measures to strengthen the protection of patients throughout Scotland are proposed in the bill.

The first of those is the removal of the tribunal's sanction of local disqualification. At the moment, an NHS tribunal can, in theory, disqualify someone nationally—that is, throughout Scotland—or only in the area or areas in which they provide services. It seems inappropriate that someone should be disqualified in one part of Scotland only to be allowed to practise in another part of the country. The consultation was clear that that should no longer be the case and, in fact, the NHS tribunal has not used the provision for many years.
The second measure is to add a third ground for disqualification to those that currently exist. That third ground is unsuitability by reason of “professional or personal conduct”. There have been circumstances in which the requirements that are currently placed on the NHS tribunal have not allowed it to consider the disqualification of individuals whose disqualification members of the public would, I suspect, think that the tribunal ought at least to consider. In common with our colleagues south of the border, we are introducing that third ground for potential disqualification.

The third measure is the introduction of an additional ground for suspension. The tribunal can already suspend individuals from practice—that is, not disqualify them, but suspend them for a period of time—and the agreement from the consultation is that we should add:

“that it is otherwise in the public interest to do so.”

There are circumstances in which, to protect patients, it is appropriate to extend the current grounds for suspension. I add that, as mentioned in the SPICe note, we will, through regulations, provide for NHS boards to be able to suspend someone locally, as it might be appropriate to take action quickly in specific local circumstances. However, national suspension is reserved to the NHS tribunal.

The fourth measure is to bring within the NHS tribunal’s jurisdiction all the additional categories of staff that I mentioned in connection with listing. As I mentioned, assistants who support the provision of, for instance, dental or pharmacy services are not covered by the NHS tribunal because they are not on a list. However, because we seek to list them through the bill, they ought to be covered by the NHS tribunal, and provision is made for that.

Finally, there are provisions that will ensure that the Scottish ministers can, through regulations, require that decisions that are made in other parts of the UK also apply to Scotland. It is important that, if someone is disqualified in England, Wales or Northern Ireland, they are also able to be disqualified north of the border, and regulations will allow that to happen.

The Convener: Thank you. I have a question about the Shipman inquiry, which has recently published a report. Does the Executive intend to introduce further measures in part 4 if that seems sensible as the weeks go by?

Dr Wilson: Part 4 would be the appropriate part of the bill in which to do that. As you know, the Shipman inquiry’s “Fifth Report—Safeguarding Patients: Lessons from the Past—Proposals for the Future” has become available only very recently. It is the most recent report and deals with issues that are not dissimilar to those covered in the bill. In fact, the direction in which the bill is moving is consonant with the fifth report’s recommendations, but if there are specific issues, we would bring them back to the committee.

The Convener: Do you anticipate anything additional coming up or do you think that, at the moment, you have gone as far as you can go with post-Shipman recommendations?

Dr Wilson: We are still in discussion with the other health departments about what measures might need to be introduced, but we could come back at stage 2 or stage 3 if we felt that there were significant issues that it was important to include in the bill, because that would be the opportunity to capture anything that comes out of the Shipman inquiry’s fifth report.

The Convener: I will have to demit the chair to my deputy convener for a few minutes, because I have a television interview that I have to do. I ask the committee and witnesses to accept my apologies.

Mike Rumbles: I welcome the more comprehensive nature of the bill’s provisions on disqualification by the NHS tribunal, but to put the matter into perspective, I ask the Executive officials to tell me approximately how many individuals have been disqualified by the system in the past five or 10 years.

John Davidson (Scottish Executive Health Department): There is about one case per year, but there has recently been an increase. There are two cases running at present, but we anticipate that the workload will increase, especially in relation to fraud cases.

Mr David Davidson: I ask the officials to clarify the situation with respect to suspension and disqualification. What is the relationship that the various health departments have agreed or are negotiating with the professions that have registration and statutory disciplinary systems of their own? In some cases, a professional body might not support the NHS view but, in others, the professional body might wish to suggest to the health service that it take action. Such bodies could do so simply by disqualifying somebody from practising. What is the new arrangement under all the changes that have been made in the past year?

Dr Wilson: That arrangement is closely tied up with the recommendations from the Shipman inquiry and what might happen as a result of the inquiry’s fifth report. It is largely focused on the General Medical Council, but will inevitably have implications for the other councils. The intent has always been to make the procedures as consistent as possible while recognising that the NHS and the professional bodies have distinct roles. The NHS has a specific role in relation to the safety of
NHS patients, while the registration bodies have a broader role. However, the health departments have always tried to make those roles as consistent as possible. As the committee knows, the structures north and south of the border are different, so the bodies that deal with the issues in different parts of the UK might be different, but the principles are still the same. Discussions have continued with the professional registration bodies to ensure that they do not envisage any difficulty with the arrangements, and they have been consulted as part of the process.

**Mr David Davidson**: Will a standard system apply over the four health departments in the UK to a professional body that covers the whole UK?

**Dr Wilson**: Yes. The process by which that happens might be different because of the different bodies that are involved, but the principles will be the same.

**The Deputy Convener (Janis Hughes)**: That concludes the questions on part 4 of the bill. For questions on part 5, we will move on to a new panel of witnesses, apart from Mr Duncan. We are a little ahead of schedule due to the discipline of members and their short questions, so I suggest that we have a short break and reconvene at 3 o’clock.

14:52

*Meeting suspended.*

15:01

**On resuming**—

**The Deputy Convener**: We will now deal with part 5 of the bill, which contains miscellaneous provisions.

I welcome our next panel, which comprises a host of miscellaneous officials. Mr Duncan is still with us. Stephen Sandham is from the regeneration, fuel poverty and supporting people division of the Scottish Executive Development Department and Sylvia Shearer is from the blood transfusion services and rehabilitation equipment branch of the Scottish Executive Health Department’s health planning and quality division. Andrew MacLeod is head of the Scottish Executive Health Department’s health planning and quality division. Andrew MacLeod is head of the Scottish Executive Health Department’s health planning and quality division and Adam Rennie is head of community care division 2 of the Scottish Executive Health Department. Diane White is from the Scottish Executive Education Department’s social work services policy division training and development team and Jim Brown is head of the public health division of the Scottish Executive Health Department.

I invite Sylvia Shearer to make some opening remarks on section 24.

**Sylvia Shearer (Scottish Executive Health Department)**: The Skipton fund commenced business in July 2004, following an expert group’s report. The scheme aims to make ex gratia payments to people who became infected with hepatitis C as a result of receiving blood tissue or blood products as part of their NHS treatment prior to 1 September 1991 and who meet certain criteria.

In order to minimise any payment delays to individuals, the payments have been made using common-law powers. To allow payments to be made over the longer term, it is necessary for our ministers to be given legal vires for establishing and being involved with the ex gratia scheme. The bill that is before members therefore makes statutory provision for those payments. To date, the fund has paid out just over £8 million to Scottish claimants and a total of 400 Scottish claims have been processed.

David Davidson asked originally why there are so many parts to the bill, and I think that that partly answers his question. This is our first opportunity to propose such legislation to the committee.

**Mr David Davidson**: My original question was not so much why there are so many parts to the bill, but why some parts of it are not stand-alone pieces of legislation.

**The Deputy Convener**: Members may now ask questions on section 24.

**Mike Rumbles**: I want to consider the necessity for section 24. Payments for what is, basically, no-fault compensation are being made under common-law powers. I heard what you said about ministers thinking that it would be better to firm things up in statute, but I am concerned that if cases arise on other subjects that relate to the health service, people may be concerned about no-fault compensation for victims who have an issue through no fault of their own or the health service and the bill might be used to block any future extension of no-fault compensation.

We already have no-fault compensation for AIDS and hepatitis C victims. No immediate pressure is building for compensation for any other category of victims, but that could happen in the future. I do not want the provision to be used as an excuse for not providing such compensation. You confirmed that ministers are allowed to provide no-fault compensation under common law, so why is the provision necessary?

**Sylvia Shearer**: The bill is not intended to pave the way for other schemes. We see hepatitis C as a special case, as with AIDS and other particular circumstances. We do not wish to set a precedent.
Mike Rumbles: That does not answer my question. I understand that point of view, but if the common law allows the payment to the Skipton fund—as it does—why is the provision being introduced?

Andrew MacLeod (Scottish Executive Health Department): We are using common-law powers to make the payments under the budget resolution because that is allowable as a temporary measure. However, the legal advice is that we cannot make hepatitis C payments in the long term without a statutory provision to do so.

Mike Rumbles: You have had specific legal advice.

Andrew MacLeod: We have legal advice that that is necessary.

The Deputy Convener: Members have no more questions on the provisions on hepatitis C compensation, so we will move to the next sections. I invite Adam Rennie, Diane White and Stephen Sandham each to give a brief introduction on their interests, particularly in relation to amending the Regulation of Care (Scotland) Act 2001 and the registration of child care agencies and housing support services.

Adam Rennie (Scottish Executive Health Department): We deal with several distinct provisions. Section 25 concerns independent health care services and is a fairly technical measure. The Regulation of Care (Scotland) Act 2001 lists various care services that are to be regulated by the Scottish Commission for the Regulation of Care, which include an independent health care service as defined in section 2(5) of the 2001 act.

The scope of the 2001 act goes further than the original policy intention. For instance, if regulation were commenced under the definition in section 2(5) as it stands, that would make the care commission responsible for regulating services from a doctor or dentist that are provided under arrangements for a third party and private services of any description that NHS general practitioners provide.

Section 25 will give ministers the power to except services from the overall definition by regulations. That is in line with many other service definitions in the 2001 act, such as the definitions of a school care accommodation service, a nurse agency or a child care agency, all of which provide for ministers to make regulations to narrow the scope of regulation if that is thought appropriate. Consultation would take place on any proposed use of the power and the regulations would have to be laid before Parliament in the usual way.

If section 25 was technical, section 26 is extremely technical. Section 26 will rectify drafting of the 2001 act. Strictly speaking, section 16 of the 2001 act requires the care commission to proceed with action such as serving an improvement notice on a provider regardless of representations that the provider may make. That was clearly not the intention. The care commission should consider any representations from people who have been notified of its intention to do something, then decide whether to do what the person was consulted on. Section 26 will amend the 2001 act to ensure that the commission considers representations then decides whether to proceed. The same change will be made to provisions on the Scottish Social Services Council, for which my colleague Diane White is responsible. She will also speak on section 27.

Diane White (Scottish Executive Education Department): The change is the same for the Scottish Social Services Council, which maintains registers of all social service workers. As is the case with the care commission, if the council intends to impose a condition on registration, it will issue a proposal notice to the person involved. Even if that person makes representations, the 2001 act is drafted so as not to take those representations into account. Section 26 will make a technical amendment to ensure that any representation is taken into account before any final decision is made. The final amendment in section 26, which also relates to the Scottish Social Services Council, is a technical amendment to the drafting to ensure that it is clear that a potential registrant has a right to appeal to the sheriff against all decisions and proposals.

Section 27 will make a technical amendment relating to the codes of practice that are issued by the Scottish Social Services Council with the consent of Scottish ministers. The 2001 act makes it clear that any employer must take the codes of practice into account when they deal with a conduct issue regarding a social services worker. Section 27 aims to clarify exactly the circumstances and what information should be provided to the council when any registration matters are being dealt with. It also makes it clear that employers are expected to contribute to any registration process and any investigations that the council may undertake.

Adam Rennie: Section 28 deals with the registration of child care agencies and housing support services. As members can see, it is a fairly complex-looking provision. The proposed amendment is necessary to rectify a problem that we identified last year. I will give the committee some background information about how that arose.

When services that were not previously regulated by the care commission are brought within regulation, a procedure has to be set up to
phase that in. Regulation cannot simply be introduced overnight; if that were to be done, suddenly everybody would find themselves breaking the law. All services that are in operation at a particular date are deemed to be registered with the care commission for a specified period. During that period, service providers may apply for registration with the commission. Provided that they apply by the deadline at the end of that period, the deemed registration then continues for a further period, during which the commission determines the application. That procedure has been used for the commencement of various services. In particular, it was used for the commencement of the regulation of housing support services and child care agencies from 1 April 2003.

Due to the complexity of the services concerned, discussions between the care commission and the providers about the application arrangements took much longer than was anticipated. An especially difficult question was what precisely constituted a branch for the purposes of registration with the commission. During those discussions, the deemed registration period ran out, by which time very few providers had applied for registration. As a consequence, many providers were inadvertently acting illegally under the terms of the 2001 act. I hasten to add that everybody was acting in good faith—at the time, very few people realised that the change was taking place. That did not come to light in the Executive until it was too late to take action to extend the deemed registration period. Once the deemed registration period had finished, it was not possible to breathe life back into it.

In July, once we had discovered that and had worked out what to do about it, the Scottish Executive issued a news release urging providers to apply by the end of September 2004 and stating that the Executive would take steps at the earliest legislative opportunity to ensure that the registration status of the services concerned was brought within the law. At the same time, the Lord Advocate granted the providers who were affected an amnesty against prosecution for providing unregistered services, provided that they submitted an application for registration with the care commission before 30 September last year.

The provision in the bill implements the Executive’s commitment to bring the registration status of the providers within the law. The provision looks quite complicated, but basically it will ensure that, if a person was deemed to be registered from 1 April 2003 as a provider of child care agencies or housing support services, that deemed registration will not cease until 1 April 2006, provided that applications for registration were made before 30 September 2004. In effect, it puts something right.

My colleague Stephen Sandham, who is responsible for housing support services in the development department, will talk about section 29, which is related to what I have just spoken about.

15:15

Stephen Sandham (Scottish Executive Development Department): Grants are made by the Scottish Executive to local authorities, under the Housing (Scotland) Act 2001, towards the cost of housing support services for vulnerable people. Local authorities in turn pay grant to providers of those services. One of the grant conditions was that those providers who required to be registered with the care commission were indeed registered. The lapsing of the deemed registration due to the complexity of the registration process—which Adam Rennie discussed in relation to section 28—meant that payments were, in fact, made by local authorities after 1 October 2003 to providers who were not registered, in contravention of the grant conditions. When the problem came to light, action was taken by the Executive on 19 August 2004 to remove temporarily the requirement for providers to be registered with the care commission. That enabled us to continue grant payments to providers to ensure that crucial services continued.

The provisions in section 29 seek to correct the unlawfulness of the payments that were made between 1 October 2003 and 19 August 2004—recognising, as Adam Rennie said, that throughout that period providers were acting in good faith and in ways that, in every other respect, entirely met the grant conditions.

The Deputy Convener: Do members have any questions? No? The evidence was either too complicated or very comprehensive. I therefore thank Mr Sandham, Mr Rennie and Ms White for their contribution.

Jim Brown will make a short statement on the authorisation of medical treatment for adults with incapacity.

Jim Brown (Scottish Executive Health Department): Section 30 proposes changes to part 5 of the Adults with Incapacity (Scotland) Act 2000. Part 5 of that act gives a general authority to medical practitioners to treat patients who are incapable of consenting to the treatment in question. That is done through the issue of a certificate of incapacity. At the moment, only registered medical practitioners can issue certificates of incapacity.

Prior to the 2000 act, to treat a patient without consent, unless in an emergency, could be considered an assault. The general authority to treat that is conferred by the certificate of
incapacity does not extend to particular treatments specified in regulations—treatments such as electroconvulsive therapy or abortion, for which special arrangements apply. It also does not extend to emergency treatment to preserve life or to prevent serious deterioration in a person’s condition.

Guidance on the operation of part 5 of the 2000 act was set out in a code of practice. The operation of part 5, which started on 1 July 2002, gave rise to concerns, among general practitioners in particular, that the procedures and requirements that it set out were onerous and time consuming and that some streamlining was necessary. In addition, other professionals—in particular, dentists—were concerned that they were unable to treat patients attending their surgery, sometimes in pain, because a certificate was not already in place to allow treatment to take place. In consequence, those professionals had to seek out a doctor to issue a certificate.

Accordingly, a two-part consultation process was launched in 2003. The first part of the process sought views on a range of changes or improvements that might be made to the code of practice on part 5 of the 2000 act; the second part of the process took the shape of qualitative research, which was designed to examine the experience of the operation of part 5.

In the light of responses to the consultations—which were complemented last year by a meeting with key stakeholders—it was decided that two changes to the 2000 act should be proposed. First, it is proposed that, as well as medical practitioners, other health practitioners should be permitted to issue certificates of incapacity that are relevant to their specialism. The bill will therefore amend section 47 of the 2000 act to allow dentists, ophthalmic opticians and registered nurses to issue certificates of incapacity. There is also provision to extend the authority to sign certificates to other professional groups. That would be done by regulations, which, of course, would be the subject of consultation and would be laid before the Parliament. It is important to stress that the issue of a certificate will apply only to the particular specialism of the health professional group concerned. For example, a dentist could authorise only dental treatment.

The second proposed amendment to the 2000 act aims to extend the maximum duration of a certificate of incapacity from one year to three years in certain circumstances. The circumstances in which the extended period could be applied will be set in regulations to be the subject of consultation. It is envisaged that the longer-lasting certificates will be dependent on the nature of the illness from which the patient suffers. For example, if a patient were suffering from a progressive degenerative condition with no chance of improvement, it would be open to the certificate issuer to extend the certificate beyond one year.

In proposing the amendments to the 2000 act, the aim has been to help improve the operation of that important legislation while at the same time maintaining its principles and ensuring the continuing benefits and protection that it provides for that vulnerable group of adults.

The Convener: Thank you, and I am sorry that I was not here for the start of your statement.

Mike Rumbles: Jim Brown is right, the amendments to the 2000 act are extremely important for a vulnerable section of the community.

You propose to replace the words, “the medical practitioner primarily responsible for the medical treatment of an adult” with the words “any of the persons mentioned in subsection (1A)”. You stressed the fact that health professionals will be able to issue certificates that are relevant to their specialism. However, the person responsible for anybody’s general health and treatment is their GP, so the GP should and does take an overall look at the individual.

I am a little concerned that we might be removing that responsibility and giving it to an awful lot of other people. The list of health professionals in the SPICe briefing includes GPs, other doctors, consultants and dentists—which is obvious if dental work is required. However, the list also includes hospital trusts, nurses, people in social work and the voluntary sector, health care providers, health care associations and academics.

Jim Brown: First of all, the ability of a general medical practitioner to issue the certificate remains. The other categories described in the bill—for example, dentists, ophthalmic opticians or registered nurses—are additions.

We are aware that concerns were raised in the consultation process about the ability of those health professionals to assess capacity. In other words, there was concern that what is needed before treatment can proceed and before a certificate can be issued is a rounded assessment of the patient’s capacity to respond or not respond to a particular treatment.

We are in touch with NHS Education for Scotland with a view to developing protocols and guidance for health professionals who are affected by the new legislation to ensure that they are equipped in every way to assess capacity to the maximum extent.
Mike Rumbles: We—rightly—recognise the expertise of registered nurses, in giving them more authority for example. However, does the legislation represent a move away from allowing the GP to make the overall assessment of capacity?

Jim Brown: I hope not. The provisions in the 2000 act on the assessment of capacity and what is said in the code of practice will still apply to those groups of professionals, so there is no dilution of the absolute requirement for a thorough assessment process to take place. All that is happening is that we are extending the range of professionals who are able to issue the certificate of incapacity, based on a thorough assessment of a patient’s ability to consent to treatment or otherwise.

Mike Rumbles: Can you give me an example of a situation in which it would be more appropriate for a registered nurse to make the assessment than the person’s GP?

Jim Brown: Nurses have a range of duties—applying dressings to a wound, for example. If a patient were to present at a doctor’s surgery and be incapable of consenting to any kind of treatment—even to having a dressing applied to remedy the situation—and if a certificate of incapacity were not ready, the nurse would have to seek the authority of the general practitioner to carry out the treatment based on a certificate issued by the GP. The change is really an attempt to improve the service rendered to the patient.

The Convener: I see that Mike Rumbles is hesitating. I shall allow David Davidson to ask a question now and we can return to Mike once he has had a think.

Mr David Davidson: Jim Brown talked about the development of protocols with NHS Education for Scotland. New breeds of prescribers—supplementary and independent—are beginning to come through. I am not convinced that they yet have the right training within the existing schemes. Will they be dealt with through the protocols or will they be included in the wording of any eventual regulations?

Jim Brown: Extending the provision would be a matter for consultation. The provision in the bill makes it clear that regulations would apply to

“a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfies such requirements as may be so prescribed”.

Those could include having certain qualifications, for example in the assessment of incapacity.

Mr David Davidson: So they could be covered by the legislation without much change?

Jim Brown: The idea is that, initially, additional groups would be given authority to issue certificates of incapacity, and that would be complemented by guidance on the assessment of incapacity, issued by the department and enshrined in and incorporated into a revised code of practice.

Mr David Davidson: I take as an example a supplementary prescribing registered pharmacist who goes into a care home to assess medication. Within certain protocols, such pharmacists can repSCRIBE and change doses, which is treatment. Would they be included on the basis of a protocol or as of right? Currently, their training does not cover the situation.

Jim Brown: We would need to take that up with NHS Education for Scotland to determine what guidance should be issued to the field in that respect.

Carolyn Leckie (Central Scotland) (SSP): I think that what Mike Rumbles was getting at is similar to the concerns that I have. There is concern that there should continue to be holistic assessment of a patient to take into account all their circumstances and their background. I would be worried about inconsistencies in the assessment of incapacity, depending on which health professional happens to see a patient and in what circumstances they are assessed for incapacity related to mental illness. A patient might go into a maternity hospital because she is pregnant. What level of incapacity is to be assessed? I can see that there might be inconsistencies depending on who approaches the issue. Someone could be assessed as having an incapacity in relation to one aspect of health care, but in relation to another aspect, they might not.

There is a need for an holistic assessment. I am just a wee bit worried, because that kind of holistic assessment and individualised care takes time. In the care home situation that David Davidson referred to, it is quicker to mass prescribe than it is to take time with an individual patient. There are legitimate concerns about opening up the process and about patients being compartmentalised according to different conditions.

Jim Brown: I take that point keenly. That is one of the reasons why we seek to develop guidance that will assist in setting the parameters for the assessment of capacity—or incapacity, as the case may be.

Shona Robison: I thought that I knew where you were going until you used an example to highlight your point to Mike Rumbles. Unless I have picked you up wrong, I am now quite concerned that we could have a situation in which people who have not necessarily gone through specific training in assessing capacity find
themselves in the position of issuing certificates and making judgments. Will the protocol allow only people who have been through a clear training programme to carry out such assessments?

Jim Brown: It is certainly our intention that issuers of certificates should have that experience. The same issue arose in the consultation in relation to general medical practitioners—sometimes even doctors did not fully understand the assessment process. We are anxious to address that.

Shona Robison: Would there be a register of people who have completed the appropriate training and who are therefore qualified to carry out such work—with the appropriate support and with the requirement that they update their training and so on?

Jim Brown: Those are issues that we are considering at the moment.

Mike Rumbles: Pursuing that point, I can see where the Executive is coming from, and I can see the purpose of the proposal. My concern is that no system is perfect and that things will go wrong. I am worried that the proposal might open the door to more things going wrong than might otherwise have been the case. The proposals are as a result of the consultation that took place, and I notice that the SPICe briefing on the miscellaneous provisions says that most of the respondents in the consultation "were health professionals and medical and health organisations, rather than patient interest groups concerned with adult incapacity."

How many responses did you get from patient interest groups or groups concerned with adult incapacity? I want to know what sort of balance we had. I can understand the medical profession—in the widest possible sense of that phrase—wanting the changes; I am concerned about the other side of the coin.

Jim Brown: The written consultation attracted 148 responses, notwithstanding the fact that more than 1,000 consultation documents were issued. Responses were received from 28 GPs; 10 other doctors; 17 dentists; 10 hospital trusts; seven nurses; 11 social work respondents; nine voluntary sector respondents; and 56 others, representing a diverse cross-section of organisations and individuals, including health care providers, health care associations, national representative organisations for health care providers, interest groups, academics, medical protection societies and individuals.

Mike Rumbles: We can pursue that as the bill goes through.

The Convener: Yes. I can see exactly where you are going with that.

Dr Turner: I can understand why, if somebody who needs to see a dentist because they have a terrible abscess has to wait for a GP to give them a certificate, they would want to get that sorted out. However, I can see problems arising with continuity of care. If a patient has other health problems and is on other medication, that complicates the issue a bit. Dentists and ophthalmic opticians have quite a bit of training. In health centres or private companies who carry out procedures, there is more throughput, because we do not have the work force. We are considering a whole lot of different ways of providing service. Not everybody will have the same standard of assessment. We agree that the process is even difficult for GPs.

I am more worried about the proposal now than I was when I first read it. We should be safeguarding the patient and safeguarding GPs, who should be at the hub of the wheel—everything should come back to them. One begins to wonder whether this is the beginning of a dilution of the service to patients. The GP might not know everything that is going on, and that is a worry.

The Convener: There are a range of concerns among committee members about section 30. I appreciate that it might not be easy for the Executive officials to respond to all those concerns at the moment. However, they might want to flag up back at the office the possibility that the proposals will run into trouble if some of the issues are not resolved—at least to the committee’s satisfaction—before we get to the more vital parts of the bill.

Jim Brown: We will do that.

The Convener: Is that a fair assessment of the situation?

Members indicated agreement.

The Convener: I thank the officials for their evidence; they are free to leave.

We move on to evidence on the final sections of part 5, for which Roderick Duncan continues to sit on the sidelines. The officials who have been invited will deal with joint ventures for facilities and services. They are Mike Baxter, who is the property and capital planning division team leader; Dr Hamish Wilson, who is back again; and Patrick McGrail, who is from the joint future team in community care division 2. Mike Stevens, who is the deputy director of the chief scientist office, will deal separately with joint ventures, intellectual property and the Scottish Hospital Endowments Research Trust.
I invite Dr Hamish Wilson to give a short introduction on joint ventures for facilities and services.

**Dr Wilson:** I will keep my comments brief. I introduce the provisions from a primary care perspective because they flow from several national reviews of the various methods by which improved facilities—particularly premises—can be secured to support better delivery of primary and community care services, especially when several agencies are involved, such as health services, local authorities and GPs.

Methods exist to secure premises in the community—for example, through public capital, third-party investment in property that is leased to occupiers or investment by practitioners—but following a review, it was felt that there was a gap in opportunities in Scotland. That was reinforced by experience from south of the border, where provisions were introduced a short time ago to allow Scottish ministers’ counterparts and the equivalent NHS bodies to form or participate in joint venture companies to provide such facilities and services.

The bill is intended to add to the armoury of organisations in Scotland to support the delivery of better facilities in the community. It also allows us to learn from the experience of the approach in England. We will not necessarily follow slavishly the precise methods that have been used south of the border, but we can at least gain from the experience there in the past couple of years.

The provisions are fairly straightforward. They allow the Scottish ministers and, hence, NHS bodies to form or participate in joint venture companies to provide facilities and services in the same way as can local authorities, which already have such a power.

**Helen Eadie:** The proposals are interesting. The SPICe briefing on the miscellaneous provisions refers to

"the proposed structure of joint ventures as companies limited by share capital".

You will be aware that a key policy objective of the Scottish Executive is to develop co-operatives and a co-operative development agency. Will that aspiration be considered so that joint ventures could be not only companies limited by share capital, but companies limited by guarantee? That would encourage mutual development throughout Scotland.

**Mike Baxter (Scottish Executive Health Department):** In producing the proposals, we undertook much research into the different vehicles that could fulfil what we are trying to achieve, which is a co-ordinated and strategic approach to premises development, rather than the individual approach that the techniques that are available to most organisations have developed.

Given the scale of possible development, we need to recognise that the development of new and different models would incur cost and have time implications. There might also be an effect on market acceptance by funders and private sector partners and on their willingness to engage in untried and untested models.

The proposals do not take a one-size-fits-all approach. A range of opportunities is available to the NHS and local government to develop premises and we do not suggest that we want to stifle that. We want to provide something that acts as a conduit to bringing the organisations together. If the NHS or local government made proposals, we would be happy to consider them, but no specific alternative models were proposed in the responses to the consultation that we undertook.

**Shona Robison:** How would the model differ from the public-private partnership model that is already in operation for joint ventures? The SPICe briefing on the bill’s miscellaneous provisions says:

“Section 31 of the Bill proposes to allow Scottish Ministers to”

do a number of things, one of which is to

“invest in, provide loans to or provide guarantees to companies providing … facilities and services”

for those who provide health and care services. How would that work? Will you give us an example?

**Mike Baxter:** On the first point, the powers that we seek are a consequence of the fact that ministers do not have powers to enter joint ventures for provision of health services. That is the vires issue that brings us here. The public finance initiative model that we have is simply a contractual vehicle between the private and public sectors; the joint venture approach differs from that significantly in that there is a long-term investment for the public and private sectors in the joint venture as a vehicle to deliver premises. That is quite a departure from what has happened previously—

**Shona Robison:** I am sorry to interrupt, but local authorities already have the powers to enter joint ventures. Would the bill bring health boards into line with them?

**Mike Baxter:** Yes, it would. Although public-private partnerships are the easiest model to look to, the power would also provide the opportunity for public bodies to work together and to form joint ventures. Therefore, the health service and local government could work together to form joint ventures, which they cannot currently do. Local
authorities have had the powers for some time and have used them in different ways.

On the second point, there are a number of ways under the bill in which ministers and NHS boards could invest and take a financial interest in the joint venture company, such as by providing financial guarantees—the investment of cash and share capital—or by putting land into the deal as a capital investment. The drafting of the bill is reflective of the different types and methods of investment in the joint venture company.

Shona Robison: Where would the risk lie?

Mike Baxter: Because it is a joint venture, the risk would be shared, which is the real dynamic in the joint venture. With the traditional acute services PFI schemes, a large amount of the risk is in the construction, whereas in the joint venture models that we are considering the risk will be spread more over the longer term in the residual value of the property after 15 or 20 years. It is a different animal altogether.

Carolyn Leckie: I am interested in the risk, so will you be more specific about that? You made a comment about making the joint venture more attractive to private participants, which obviously means less risk, increased chances of profit and more secure income for them. I would be interested to hear you expand on the detail of that. What are the calculations and the attractions for the private sector?

What you said about no specific alternatives having been proposed by respondents to the consultation contradicts the SPICe briefing on the bill’s miscellaneous provisions, which says that “A number of alternatives … were suggested”. Will you comment on that and tell us more specifically what the alternatives were?

On the consultation, the briefing says that the majority of respondents were positive and about 10 per cent were negative. However, some respondents were from the private sector and some were from, for example, trade unions. Will you tell us what the balance was? Of the positive comments, how many were made by the private sector and the employers’ side? Were the negative comments from all the trade unions?

Mike Baxter: I will take your last question first. The answer is yes, and the trade unions’ objection is essentially a philosophical one to the involvement of the private sector in provision of health care.

15:45

I turn to the first question about risk. The risk to which I referred was the development of a model that is untried and untested. Given the size of the joint ventures that we are talking about, we are not talking about the creation of many such companies throughout Scotland. A necessary critical mass is required to make such a venture commercially viable and attractive. Therefore, we have limited bites at the cherry in trying to propose something that is novel or different.

According to the consultation responses, the alternative models that were proposed are currently available to local authorities and other parties. The point was that those models were not available to the NHS.

Carolyn Leckie: I will follow up on the risk question because I would like you to be more specific about the positive conclusions of respondents to the consultation, which came primarily from the private sector. The private sector is motivated by profit and I imagine that the attraction for that sector comes from what it expects the returns will be. Will you be specific about why the private sector likes the proposal?

Mike Baxter: It likes it because it proposes a long-term partnership. We are not reinventing the wheel with individual procurement; we are trying to establish something that has long-term flow as regards premises development. We are not looking at any measures in isolation.

The proposal has attractions for both the private and public sectors. From a financial planning point of view, it allows us to consider our infrastructure, how we replenish and develop it in conjunction with other public sector partners and the availability of private capital.

At the moment, the vast majority of primary care and GP premises are privately owned and developed. It is a question of how we can actually bring those kinds of developments together with other NHS and local authority developments, look at services more strategically, reduce the risk of duplication and increase efficiency in use of public resources. At the end of the day, whether we are paying for leases on such premises or investing in companies, we are talking about public money.

Carolyn Leckie: It is an ambitious claim that your proposal would be more efficient for the public purse. Is there evidence to support that? What calculations have been made and can they be made available?

Mike Baxter: We still have detailed work to do on the financial structure of the companies and our possible options. We looked at the experience of the joint venture development model south of the border and the results are certainly encouraging in terms of value for money and how different strands of public resources can be brought together and made to work more effectively.
When we looked at joint ventures and how they developed in England initially, there was a primary care and health focus. That has evolved substantially over the past couple of years and we now have projects that have taken on a focus on regeneration or on education and training. That is all about bringing different strands of money together to deliver more effective services.

Carolyn Leckie: I am interested in the English examples, so I would appreciate your being specific about those you mention. Are you talking about diagnostic and treatment centres?

Mike Baxter: No. I am talking about NHS local improvement finance trusts; the regeneration example that I quoted is the NHS LIFT project in St Helens, in respect of which there has been a significant impact on urban regeneration in deprived areas. There are also examples in Liverpool.

The Convener: If some of that information is available on paper, I invite you to let the committee clerk have a copy and we will make sure that everybody gets hold of it for comparison.

Dr Turner: The matter of joint ventures has provoked most thought—there are so many questions because we did not have enough examples. Would you consider a joint venture like some of the initiatives that occurred after the sale of hospital land? NHS or public money could go into a venture with that of other companies.

A private company can be formed and registered at Companies House. It is quite cheap to do that and it makes it difficult for the public to ascertain what is going on: I have had difficulty finding minutes for such a company. Eventually, after about a year, I discovered that minutes are produced, but that they are not verbatim—they are précised for public view. I was told that minutes are not necessarily kept in a library. I worry about accountability for how money is spent.

Flexibility is another issue. I worked in a health centre that was built in 1982, but by 1990 it was not fit for purpose under a new contract because it was not big enough. To enter long-term contracts is probably comfortable for businesses, but how does that maintain the flexibility that the NHS needs? We do not know where we will be 20 years from now. Different techniques and ways of working will apply because medicine is always changing. I would like examples of how entering a joint venture will deal with that.

In my area, the local authority does not seem to have control over one initiative, although it does over another. Ministers probably have more control over the private company. The situation is extremely difficult to understand. Could I have some answers? If you cannot provide them now, perhaps you could provide them in writing.

The Convener: That was an open-ended question.

Mike Baxter: There are two sides to accountability. For financial accountability, any flows into or out of an NHS board or local authority must be accounted for. Interaction with a joint venture company will take two forms. The share capital investment that we envisage will be recorded on an NHS board’s balance sheet. Lease payments to rent parts of or whole premises will be identified as lease expenditure. The accounting regulations provide a basis for identifying the financial flows into and out of an NHS board in relation to a joint venture company.

As for the flexibility argument, I agree that—as with all capital or infrastructure developments in the health sector—change and how we plan for it are huge issues. Bodies can engage in the joint venture model at different levels. One way to engage is as a shareholder in the joint venture. Another is by being the lessee of part of a building or buildings. The model that we are examining is a lease plus agreement, which would run for 15 years or less with opportunities for break points. Some flexibility is built into the model, but I accept that flexibility is a huge issue across the board for the NHS.

Dr Turner: I take it that the purpose is profit for the NHS.

Mike Baxter: The profits of a joint venture company are shared among shareholders.

Dr Turner: Are the share proportions clear?

Mike Baxter: Yes.

Dr Turner: We should be able to access such information easily.

Mike Baxter: Yes.

The Convener: Members have no more questions for Mr Baxter, whom I thank for appearing.

I invite Dr Wilson to give a brief introduction—I am sorry; I am repeating myself. I invite Mike Stevens to give an introduction on joint ventures, intellectual property and the Scottish Hospital Endowments Research Trust.

Mike Stevens (Scottish Executive Health Department): Section 31(2) also deals with companies, but for the purpose of income generation. Ministers have a range of powers to generate income for the NHS. Those powers were extended to NHS bodies through a power of direction in 1989 and include developing and exploiting ideas and exploiting intellectual property. However, ministers are not empowered to establish or participate in companies in exercising those income-generation powers. That can be a limitation on exploiting intellectual
property when the creation of a small spin-off company to attract external finance is the most appropriate and—sometimes—the only way to exploit ideas.

In addition, the Executive’s growth and innovation grants are available only to businesses that have a base in Scotland. They are not available to public sector bodies such as the NHS or universities, but many of the companies that they support have emerged from the university science base. Section 31 will extend the powers that are available to ministers by allowing them to create companies and participate in their running, but solely for the purpose of generating income. Ministers intend to extend the power to NHS bodies and, in order to ensure that it is used only when appropriate, they propose to prescribe and regulate carefully the circumstances in which it may be used through a power of direction.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** The SPICe briefing note on the bill’s miscellaneous provisions says that NHS bodies in England and Wales have been able to gain additional income as a result of their intellectual property. Will you give some examples of how intellectual property has boosted their income?

**Mike Stevens:** The big benefit is the ability to exploit a particular innovation by collaborating with a private company. It could be that a particular device has been invented in the NHS in Scotland, but if no private company can share in its ownership, the device will sit on the shelf. However, if a device is invented in the NHS in England or Wales, where the power was introduced in 2001, a private company can be set up. The private finance would pay for development of the device and ownership would remain joint with the NHS.

**Mr McNeil:** That is the potential, which we are trying to understand. Are there any clear examples in which the NHS has been able to maximise the benefit or gain from intellectual property?

**Mike Stevens:** There have been no approvals yet of the establishment of companies in England, but the Department of Health’s commercial directorate is considering one proposal. I referred earlier to the power of direction; in England, that power calls into the Department of Health all such proposals, which are carefully scrutinised.

**Carolyn Leckie:** I have some technical questions to ensure that I understand what section 31 means. At the moment, if a technique is developed in the NHS, the fact that it has been developed there means that it is owned and shared by the NHS, which can—as a public body and if it is given the investment—choose to develop the technique further and spread it across the NHS. Section 31 seems to me to say that that is not an option because there is not enough funding and that, therefore, if the NHS can collaborate with a private company to develop an idea, the intellectual property will be shared between the part of the NHS that is participating—which might be an individual hospital, GP surgery or laboratory—and the private sector company. That intellectual property could then be sold within the NHS as a whole, which I would have difficulty with. Is that what section 31 means?

**Mike Stevens:** Yes. At present, if the innovation is a device, the NHS purchases it anyway. We are saying that if the NHS has the capacity to share in ownership and to profit from the development of a device, it will be able to do so through section 31.

**Carolyn Leckie:** My point is that there are ideas within the NHS that do not attract NHS funding but which nevertheless belong to the NHS. However, you are talking about such ideas being part-owned by the private sector, which has not developed them but is involved because you want its money because no public money is available. The ownership of such ideas might be transferred from the NHS to the private sector and then sold back to the NHS.

**Mike Stevens:** The proposal is that the intellectual property would be shared, but only if there was no NHS investment. If the NHS was prepared to invest, it would own the intellectual property outright.

**Carolyn Leckie:** That is my understanding of section 31.

**Helen Eadie:** The SPICe briefing note on the miscellaneous provisions states:

“Future financial benefits as a result of the power are difficult to predict, but nonetheless are expected.”

Can anyone give us any ballpark figures of what we might expect in a year?

16:00

**Mike Stevens:** In a year, we could expect very little, based on the English experience. I can give you some figures for the number of innovations that have been looked at in England and Scotland. In England each year, the NHS considers approximately 500 innovations that might be worthy of further exploration and selects 100 for further development. It is pursuing 24 licensing deals in total. In Scotland, 200 new ideas have been looked at. They have been refined to 35 that are suitable for potential further development, subject to funds being available. Scottish Health Innovations Ltd, which has been set up to manage NHS intellectual property, holds equity in one company, and nine further exploitation proposals are under consideration. Any one of those proposals could generate £20,000 or £200,000, but at this point it is very much a guess.
The Convener: Were there any objections to the proposal to make the Scottish Hospitals Endowment Research Trust stand alone?

Mike Stevens: No.

The Convener: I just wanted to clarify that that proposal is not controversial.

I thank all the officials for coming along. I thank Roderick Duncan in particular for sticking it out, although perhaps it was not too onerous.

I remind committee members that next week’s committee meeting will take place in Stonehaven, albeit without my presence. The meeting will be under the capable convenership of my deputy convener, Janis Hughes. I will see committee members in the last week in January.

Meeting closed at 16:01.
The Scottish Consumer Council welcomes the opportunity to comment on this bill, and will focus on Parts 2 and 3, which deal with dental, ophthalmic, and pharmaceutical care services.

1 Free dental examinations and oral health assessments, and free eye examination and sight tests

The SCC welcomes this proposal as removing the initial barrier to treatment for people who may otherwise be deterred from receiving services because of fear of the cost. However, there remains a real concern about how whether it will be possible in practice to deliver on this commitment. The shortage of dentists providing NHS services is well documented, not least by the recent report to the Health Committee.

For this policy commitment to result in a real improvement in access to services for consumers will require:

- More effective use of the dental team, particularly professions complementary to dentistry (PCD)
- Guidance on how frequently such checks will be available (in light of evidence that 6 monthly dental checks are not clinically necessary for all patients)
- Clear information for consumers about what they are entitled to, and what is included. For example, at present it is standard practice to provide a scale and polish at the same time as carrying out a dental check. However, as this will probably remain chargeable, consumers need to know that it is not necessary to have a scale and polish carried out.

2 Proposals to allow changes in the dental charging regime

The SCC welcomes the proposals in the bill which would allow changes to charges for dental treatment. The current charging regime does not allow consumers to have any clear idea of what the charge of treatment is likely to be, and the level of charges (80% of NHS costs) are a disincentive to those living on a lower income to seek treatment, and are regressive in nature. The SCC believes that any new charging scheme should be based on ability to pay, and should be simple enough for consumers to understand. As the Bill is enabling, there is no indication about whether charges will be based on treatment received or on a flat rate basis. Again, there will need to be clear information available for consumers on any changes to the charging scheme.

In general, the SCC position is that there should be a more thoroughgoing review of patient charges within the NHS, as there is currently inconsistency between different parts of the NHS, for instance in relation to how older people are treated, and exempt groups.

The SCC supports the breaking of the link between the payments made to dentists and the fees charged to patients.

3 Proposals to give NHS boards a more pro-active role in planning, funding and delivering dental services

The SCC welcomes this proposal. It is important that NHS boards are able to proactively address the needs of their local community for dental services. Linked to this are the proposals that NHS boards can contract with corporate bodies, and that they can provide assistance and support to those providing dental services. Again, while these are positive moves, they will not in themselves be enough to tackle the shortage of NHS provision in parts of Scotland. Action taken at national level will continue to be important in encouraging dentists to undertake NHS work, and to work in areas where there is a shortage of NHS provision.

It is important that the value of preventative work is recognised in any new contract with dentists, and that the contract encourages all the members of the dental team to play a full part in meeting the needs of Scottish consumers.
4 Provisions enabling a new contract for pharmaceutical care services

The SCC supports the parts of the Bill which will facilitate the implementation of a new contract for pharmaceutical care services. This is clearly required by the policy developments set out in The Right Medicine and Modernising NHS community pharmacy in Scotland.

5 Proposals to give NHS boards a more proactive role in securing or providing pharmaceutical care services in board area

The SCC supports NHS boards having a more proactive role in relation to pharmaceutical care services. In fulfilling this role, and in contracting with providers, we would hope that boards will recognise the importance of access in the widest sense, encompassing opening hours and flexibility of service, for example, as well as geographical location.

While pharmacy is rightly considered as an integral part of the NHS, it is important to bear in mind that pharmacies operate as businesses providing a service to consumers. The SCC has supported the arguments made by the OFT in relation to control of entry, that competition can provide a useful incentive to improve services, for example providing out of hours services, or home deliveries to patients. NHS boards should be wary of intervening in the market in a way which would deter this kind of healthy competition between providers. Boards should encourage provision in locations which will improve access, including, where appropriate supermarkets, as well as places like railway stations and airports.

SUBMISSION BY THE BRITISH DENTAL ASSOCIATION

Part of Bill: Part 2, sections 9-10
Main Objective: Free dental and eye tests
Do you agree with the main objective of this part of the bill? Yes

If yes, why?
We agree in principle with the main objective of this part of the Bill, but have serious reservations about the ability of the service to meet patient expectations. The BDA believes patient charges are a matter for Government decision.

If not, why not?
Not applicable

Are there any other comments you would like to make?

With regard to the policy intentions outlined in Part 2 of the Bill, the BDA has serious reservations on two grounds;(a) funding and (b) workforce.

The funding of the Scottish Executive’s free dental checks pledge is of major concern to the BDA. In its response to “Modernising NHS Dental Services in Scotland”, the BDA favoured the development of a fully funded, comprehensive oral health assessment as part of basic oral healthcare provision. The existing dental examination Item 1(a) in the Statement of Dental Remuneration is insufficient to determine the needs of patients and to identify and discuss and agree with them the care regimes they should receive as part of a modern dental service.

Dental workforce shortages in Scotland will also affect the ability to deliver this initiative. Evidence to support this statement is contained in the NHS Education for Scotland 4th Workforce Planning Report “Workforce Planning for Dentistry in Scotland” published in June 2004. The Report states that in 2003 “Potential gaps in service provision may be identified by comparing the supply and utilisation model projections and the principal results suggest a current shortfall of 215 General Dental Practitioners.” The BDA is concerned that the anticipation of free dental checks may raise
patients’ expectations of accessing NHS dentistry. Where there are existing access problems the public will become even more dissatisfied.

The Scottish Executive has based its costs for the implementation of this initiative on the current system and “on an increase of up to 25% on the numbers of people who currently pay for dental check-ups.” The BDA finds it difficult to see how this increase in numbers of patients will be realised, especially with current evidence showing the numbers of patients being de-registered in some areas. Evidence of a downward trend in adult and child registrations is contained in the Scottish Dental Practice Board’s Annual Report of 2003/2004, figures that the Scottish Executive recently presented to Parliament.

In the report commissioned by the Scottish Parliament Information Centre for the Health Committee published on 1st February doubts about the likelihood of meeting the pledge on free dental check ups were raised. It was reported that “only 3.5% of primary care dentists stated they intended to increase the amount of time spent treating NHSScotland patients over the next two years (see section 5.12.1)”. “62% of retired dentists could see no incentive to induce them to return to providing NHSScotland dental services and thus plans to increase provision of services by encouraging retired dentists to return to practice are unlikely to be successful (see section 5.12.3).”

“A significant increase in NHSScotland provision, required to meet pledges to make free NHSScotland check-ups available to all by 2007, and improve access to dental services, is more likely to succeed where the incentives on offer appeal to the greatest proportion of dentists. This is unlikely to be achieved with the type of incentives currently available”.

In addressing workforce shortages, the Scottish Executive must also recognise and take action on the funding of under-graduate and post-graduate education and training.

In 2000, a recommendation was made by the Scottish Advisory Committee on the Dental Workforce (SACDW) to standardise the output of the two dental schools in Scotland by setting an output target of 120 dental graduates (70 from Glasgow and 50 from Dundee), over the 5 year period 2000-2005. (Reference: “Workforce Planning for Dentistry in Scotland – A Strategic Review”).

The Scottish Executive Health Department has set a revised output target of 134, which is reflected by an intake target in 2004/2005 of 151.

The BDA believes that without significant investment in the two dental schools in Scotland, then this increase in intake will be difficult to support. The BDA understands that some of the education and training of dental students is likely to take place in a primary care setting (outreach). However, once again, this will require major investment in facilities and staff training and recruitment.

The BDA acknowledges that the proposed increase in Professionals Complementary to Dentistry (PCDs) may help to free up dentists’ time (although it has not been made clear as to how these numbers are to be increased). This is more likely to be the case if PCDs have enhanced roles within the dental team - a trend that will be facilitated under the planned new regulatory regime for PCDs. However, we note the Section 60 Order (under the Health Act 1999) that is required to amend the Dentists Act 1984 so as to enact this change has been delayed by six months and the GDC now expects the PCD reforms will not be implemented until 2006.

Moreover, an article published in the British Dental Journal (Vol.198 No 2 Jan 2005 page 105) showed the majority of registered dental hygienists in Scotland do not work in wholly NHS practices, but in either wholly private practice or in mixed NHS/private (39% and 41% respectively). One of the authors is Dr J R Rennie, Postgraduate Dental Dean and Deputy Chief Executive of NHS Education Scotland.

Part of Bill: Part 2, sections 11-17

Main Objective: Changes to dental and ophthalmic services
Do you agree with the main objective of this part of the bill?  Yes/No

Response: The British Dental Association (BDA) has laid out its written evidence so that it correlates to the individual sections of Part 2, as numbered above. For this reason, we have not provided a “Yes” or “No” response at this part of the questionnaire as there are a number of nuances in the policy objectives.

If yes, why?  (refers to above)

Section 11 – “Charges for certain dental appliances and general dental services”

Response: The BDA agrees with the separation of patient charges and Item Of Service fees in order to make the system more flexible. We therefore agree with the main objective here.

The BDA believes the current system of charging is too complex and difficult for dentists and patients alike to comprehend. Any new system must be transparent and easy to understand, with the main drivers being clarity about patient charges; clarity about NHS availability; distinction between NHS and private treatment; and clarity about trust and accountability. Any replacement system must be easy to operate and avoid unnecessary bureaucracy.

The BDA believes patient charges are a matter for Government decision, but the Scottish Executive should clearly state the rationale behind applying patient charges. Currently, we conclude there is no such rationale and patient charges are inconsistent across the health service, leading to a lack of clarity with regard to NHS dental charges.

There is evidence to suggest that patient charges are a barrier to accessing dental care. Indeed, the introduction of patient charges for dental services in 1951 was undertaken in an attempt to suppress patient demand.

Separation of patient charges from, and simplification of the item of service feescale, should also help to address the “treadmill” effect referred to by the Scottish Executive in the Policy Memorandum and increase clarity and reduce bureaucracy.

NHS dental charges should be consistent with other NHS charges; they should also be consistent across a single primary care dental service. This would link in with the policy intention to integrate Salaried General Dental Services and Community Dental Services. However, this would raise questions over the infrastructure within the salaried services to collect patient charges and to process transactions.

We question whether it is right that general dental services dentists should carry bad debts if patients do not pay. It is more appropriate that Health Boards should assume debt recovery once general dental practitioners have made reasonable efforts to recover the debt.

Section 12 – Arrangements for provision of dental services

Response: The BDA recognises Scotland’s diverse oral health needs and believes it is not possible to have a successful, single system that will suit everyone in all parts of Scotland. It should also provide proper incentives for dentists and discourage the “treadmill” work pattern that is referred to in the Bill.

The BDA calls for voluntary entry and exit contractual arrangements, and supports the policy objective of the Bill to develop these on a national basis, but with flexibility to take account of local needs. The essential role of the profession in developing these contracts should not be overlooked and it is vital, therefore, that the BDA is fully involved in developing these agreements at both national and local level.

It is essential that Health Boards are fully engaged in the dental agenda and are held accountable for supportive service delivery. However, the BDA is concerned that the very recent research commissioned by the Health Committee highlights deficiencies in the availability of basic type
information at health board level. The type of data the BDA feels is required, but is not currently available at health board level, includes:

- Access levels for special needs patients
- Demand for access to general dental services
- Demand for access to hospital dental services
- Recruitment and retention levels of dental staff
- Availability of appointments
- Distances being travelled by patients

If the policy objective contained within the Bill is to be achieved, then devolving responsibilities to Health Board level will therefore require immediate development of comprehensive local databases to identify the oral health needs of the local community. The data should also inform the planning and delivery of services, by showing the level of available dental workforce, and identifying gaps in provision.

We support the extension to bodies corporate of the ability to provide general dental services and look forward to the necessary changes in the Dentists Act to allow for this.

Lastly under this section, in its response to the Review of Primary Care Salaried Dental Services, the BDA saw merit in the integration of the Salaried General Dental Services and the Community Dental Services, as is also outlined in the policy objective of the Bill. It should be noted, however, the Review’s remit did not include terms and conditions of service.

Section 13 – Assistance and support: General Dental Services (GDS)

Response: The BDA believes high quality oral healthcare should be provided in fit-for-purpose premises that would allow access to all members of the population, including those with special needs, to all NHS primary and consultant-led secondary and specialist care and emergency services. These clinics would be sited within the communities they serve.

Local funding by health boards to facilitate provision of these premises would be welcomed by the BDA. Such financial support might include, amongst other things:

- The provision and management of premises, with rent at lower rates to practitioners
- The continuation of practice improvement grants
- Direct funding provided in return for a level of NHS commitment
- Provision of funding to the dentist towards continuing professional development of the staff in their practice
- Support for equipment and materials

The current range of GDS allowances have been welcomed, but they do not address the fundamental problems of the current system. The research previously referred to (“Access to Dental Health Services in Scotland”) reported that no incentive to increase NHSScotland commitment was favoured by the vast majority of practitioners. The most frequently endorsed incentive was a significant increase in the fee per item of treatment (55% primary care dentists). Moves to a salaried contract or a capitation arrangement were far less popular. Only 3.5% of primary care dentists stated that they intended to increase the amount of time spent treating NHSScotland patients over the next two years.

Section 14 – Provision of certain dental services under NHS contracts

The BDA believes patients should be able to access high quality NHS oral healthcare in both the primary and secondary care sectors in all parts of the country. However, access to secondary care services in Scotland is patchy and throughout the country there are very long waiting lists to access secondary care.

In particular, problems exist in remote and rural areas, where consultant-led services are, firstly, limited and, secondly, patients have to travel long distances to access this care. The BDA has called for a substantial increase in the number of specialists, whether hospital- or practice-based, in
all the dental specialities. There are particularly acute problems in Highland, Grampian and Argyll where imminent retirements and actual resignations, together with failure to recruit have had a severe impact on services. We therefore see some merit in the Bill’s intention to allow health boards to make arrangements with dentists to undertake functions that will complement the work of hospital departments.

The BDA would support the development of properly funded systems that would encourage specialist services to be delivered more locally. The development of clinical networks utilising existing consultant services, together with “dentists with specialist interests” would be one way of providing such care. The use of clinical networks would support the provision of oral healthcare in the primary care sector, particularly in the remote & rural areas.

Dentists with special interests (DwSIs) already exist through the clinical assistant programmes within hospitals, but the provision of such posts is patchy throughout Scotland. The impact of dentists with special interests receiving adequate and focused training to complement their experience is of paramount importance to safeguard patient safety and the BDA would support moves to provide this.

Section 15 – Lists of persons undertaking to provide or approved to assist in the provision of general dental services

The BDA supports the listing of vocational trainees, assistant dentists and locums for the purpose of clinical governance and improving patient safety. Such listing should also allow for health boards locally to retain information on practitioner numbers, which, in turn will allow for better planning of delivery of local services. Some allowance needs to be made for patient care to continue in the case of illness or death of a single-handed practitioner.

Whilst the BDA recognises that it might not be appropriate to have an upper age limit for removal from a dental list, we do believe that greater emphasis must be placed on developing a service structure that does not encourage dentists to seek early retirement. In Professor Newton’s report it was stated that 62% of retired dentists could see no incentive to induce them to return to providing NHSScotland dental services and thus plans to increase provision of services by encouraging retired dentists to return to practice are unlikely to be successful. According to the findings of the “Toothousand Project”, a survey of General and Community Dental Practitioners carried out by the Scottish Council for Postgraduate Medical and Dental Education, two thirds of GDPs planned to retire early. Half of this group planned to reduce their clinical hours in the years before retirement. The “piecework” nature of the GDS was cited as one of the main reasons; furthermore, a third of GDPs identified stress as a reason for early retirement.

Section 16 – Lists of persons performing personal dental services under Section 17c arrangements or pilot schemes

We support the ability to develop Personal Dental Services in Scotland and agree the same conditions should apply for listing arrangements.

Are there any other comments you would like to make?

The BDA is concerned that the Bill has been announced without any response from the Scottish Executive to “Modernising NHS Dental Services in Scotland”. It is therefore almost impossible for the BDA to give an informed opinion on the dental section of the Bill without the availability of the Ministerial response. Because of this lack of detail, we are unable to provide comment on the Bill’s objective that it will improve the oral health of the Scottish population.

This lack of detailed policy intention is coupled with a lack of funding information. The BDA has been seeking for some time now details of the annual spending review and how it might relate to the modernisation of dental services in Scotland. This information is crucial in order to take forward this agenda. However, no such information has been published to date.

As we have stated earlier in our response to Sections 9-10 of the Bill, dental workforce shortages in Scotland will also affect the ability to deliver this initiative. Evidence to support this statement is

In the BDA’s response to “Modernising NHS Dental Services” we set out our recommendations for a way forward for improving oral health and a shift towards a preventive based service.

The funding of general dental practices is mostly from item of service fees. This system generates the “treadmill” effect which the Scottish Executive mentions in the Bill.

The BDA believes that if NHS dental services are to be truly modernised, then financial provision needs to be made to facilitate a preventive approach to dental care. This allows general dental practitioners to spend more time with patients discussing their oral health, their general health and agreeing individual management regimes. This increased time commitment must be recognised and appropriately remunerated. The current range of GDS allowances have been welcomed. However, the eligibility criteria of these are almost totally based on levels of GDS earnings, which is “output” based rather than “outcomes” based, thus compounding the “treadmill” effect.

As long as the current system does not recognise this time and focuses mainly on funding reparative and restorative work, modern dental services will not be delivered. Examples of where additional support might come from would be direct support for premises and infrastructure that would include things such as equipment and materials, as well as direct reimbursement for some staff costs.

The impact of the current NHS system requires dentists to work at a pace that is increasingly difficult to sustain in order to provide appropriate dental care. The result is that many dentists have had to withdraw from the NHS and seek support for running their practice through the provision of dental services on a private basis. In doing so, it also enables them to allocate greater time to their patients, which they are unable to do by working under the current NHS system.

The Scottish Executive has confirmed that since 1999, 93 practices in Scotland have ceased to provide general dental service, i.e. NHS treatment. In many cases, this has been as a result of dentists choosing to retire early.

Many dentists (practice owners) have found it difficult, if not impossible, to sell their practices as “going concerns”. The current criteria of the Scottish Dental Access Initiative does not allow for funding to be allocated towards the purchase of established practices. The BDA believes that if the criteria were expanded in this way, it would help address the problems associated with practice closures, not least continuation of care for patients.

SUBMISSION BY OPTOMETRY SCOTLAND

Smoking, Health and Social Care (Scotland) Bill – Stage 1 Consultation

Optometry Scotland (OS) is grateful for the opportunity to comment on this important legislation.

OS is the representative body for registered Optometrists and Dispensing Opticians in Scotland, and includes delegates from each of the Area Optometric Committees in Scotland, plus representatives from all the main national optical bodies, including The Association of British Dispensing Opticians, the Association of Optometrists, the College of Optometrists, the Federation of Ophthalmic and Dispensing Opticians, and the Scottish Committee of Optometrists. We are also an integral part of the Scottish Executive Health Department’s (SEHD) Review of Eyecare Services in Scotland that plans to report to Ministers on the optimum mechanisms for delivery of eyecare in Scotland in March this year. OS also has representation on the working group set up by the Centre for Change and Innovation (CCI) to establish model pathways in ophthalmology.

Our comments here relate to Section 10 of the draft Bill and those parts of the Financial Memorandum relating to ophthalmic services. In general terms, OS welcomes the long-overdue
consideration that is being given to eyecare in Scotland and is happy to support the general thrust of the move towards better delivery of service. What we do not welcome, however, is the simple widening of access to a GOS sight test, the so-called “free eye checks for all”. To put it bluntly, such a change would be seen as being implemented only for political purposes since it would confer no health gain on the people of Scotland and, therefore, OS could not endorse such a proposal.

It is important, therefore, that both the GOS sight test and eye examination referred to in the Bill should be defined at the earliest opportunity. If OS is to endorse the changes outlined in this Bill, it is also absolutely essential that, if access to GOS eyecare is to be granted to everyone, the Eye examination and Sight test should be inextricably linked, fully resourced and introduced together. Any proposal that does not actually produce a health benefit for the people of Scotland would not sit comfortably in a Health Bill.

To elaborate, in the absence of any agreed definition for the eye “examination” referred to in the draft Bill, we believe that merely extending the current NHS GOS Sight Test would be an ineffective and profligate exercise. Many sections of society receive a GOS sight test already though, due to its restrictive nature, it is not always appropriate to their needs and symptoms. To extend this facility to the other sections of the population that currently do not receive free eye care – those aged between 19-60 in work and in generally good health – will not make best use of limited resources.

Accordingly, we would suggest that negotiation on a new GOS contract with Optometry is started immediately. This will establish what is expected from a GOS eye examination, when a GOS sight test may be included in that examination, and when repeat procedures are advisable. This will open the door for more comprehensive and extended eyecare programmes such as those currently under consideration by the SEHD Review of Eyecare Services.

Our final major point at this stage regards the financial resources which the Financial Memorandum indicates will be required to extend the GOS Sight Test and Examination to all. We must point out that the sums detailed are wholly unrealistic and inadequate, a comment we have already made to both the Finance Committee and the SEHD. We do appreciate that the figures in the Bill were produced from out of date information and understand that the SEHD have informed the Health Committee that a new budget for Optometry services will be added to the Bill as figures become available. Until a new contract has been agreed it will be difficult to give an accurate estimate of costs.

At the request of the SEHD, The Review of Eyecare Services in Scotland is currently considering fundamental changes in the level of responsibility optometry should have for eyecare in the community. The Centre for Change and Innovation is designing new and innovative pathways for ophthalmology that will make extensive use of the services of optometrists at a level far in advance of that for which the current very limited GOS contract was designed. It is likely that the current fee structure for optometrists will change markedly in the light of recommendations expected from the Review.

We shall restrict our main comments to the above at this stage, conscious that further details can be provided when OS attends to give oral evidence to the Committee on 22nd February. We attach a list of more detailed points as an annex to this letter which the Committee may wish to consider now or at a later stage.

Suffice to say that OS’ aspiration is for the people of Scotland to enjoy a world-class, fully integrated and multi-disciplinary eyecare service, and we believe that this Bill, suitably amended, allied with professional developments elsewhere would go a considerable way to delivering it. The Scottish Parliament has, we believe, the opportunity here to reduce the incidence of preventable eye disease and take a significant step towards the elimination of avoidable visual impairment and blindness in Scotland. However, the Bill as presently drafted is unlikely to achieve this goal.

Hal Rollason
Summary of Additional and Supplementary Points

1. Optometry Scotland supports the opportunity this Bill affords to provide the people of Scotland with a high quality integrated community-based eye care service led by optometrists working in close conjunction with GPs and ophthalmologists. Simply widening access to the current GOS Sight Test would confer no health gain on the people of Scotland and OS could not endorse such a proposal.

2. This service can only be provided on the basis of a newly defined contract between the SEHD and optometry. This contract will allow for a “needs driven” service based on presenting signs and symptoms allowing optometrists to provide appropriate care and management. This contract must also allow for additional procedures to be carried out leading to refinement of diagnostic accuracy. The present GOS contract was introduced in 1948 for a different set of priorities to those we face today. The restrictive nature of this old arrangement does not fit with modern eye health issues faced by modern day optometrists.

3. OS accepts that private surcharges cannot be made for work contained in the new NHS contract. However, it would be sensible to accept that certain procedures might fall outwith the new contractual arrangement for the service that the NHS provides.

4. It is widely accepted that 5-7% of all GP visits are “eye related”. GPs generally welcome the support of optometry, recognising the optometric profession has the appropriate training and equipment to manage safely the many and varied eye problems regularly presenting in the community.

5. OS believes that this new contract must allow for an effective direct referral from optometry to the HES. Such efficient lines of communication will result in reduced time for the patient journey, avoid unnecessary GP consultations and reduce the administrative burden on primary care support staff.

6. Currently, 40% of patients presenting to a hospital eye outpatient clinic are discharged without treatment despite having waited up to 18 months for their consultation.

7. The proposals put forward by OS for the new contract will allow these patients rapid access to a competent clinician within their local community equipped to carry out accurate diagnosis and institute suitable management.

8. The new contract that this Bill facilitates should recognise optometrists as the principal providers of primary eyecare. The profession has just committed to compulsory CET and professional development. OS warmly welcomes the fact that this Bill enables an extension to the responsibility of optometry and we believe the profession has demonstrated it is prepared to accept the need to comply fully with the Code of Conduct and Clinical Guidelines laid down by the College of Optometrists and the enhanced clinical governance and audit which will follow.

9. OS believes the timing of this Bill is fortuitous:
   a) Optometry is the focus of the SEHD-led Review of Eyecare Services in Scotland.
   b) The Centre for Change and Innovation (CCI) will shortly conclude its deliberations on the pathways for ophthalmology and, in each of these, optometry acts as the core profession for patient management.
   c) Optometrists have just been granted additional exemptions under the Medicines Acts which will enable the profession to treat a range of external eye diseases. Supplementary prescribing rights have been agreed for optometrists and independent prescribing rights are expected to be granted within the next two years.
10. The aspiration of OS is that the convergence of the Bill and these ongoing developments will enable patients easy access to an expanded community-based primary eyecare service. This could lead to the establishment of a fully integrated multi-disciplinary eyecare service which would mean the Scottish Parliament had legislated for a world-class service, thereby reducing the incidence of preventable eye disease and taking a significant step towards the elimination of avoidable visual impairment and blindness in Scotland.

11. The uniform development of such a high quality eyecare service in every community would reduce the problems of health inequality and could only have a positive impact on hospital waiting times and lists.

12. OS is confident that MSPs recognise the benefits described above can only accrue to the people of Scotland if the implementation of these proposals is appropriately resourced and funded.

13. OS believes this Bill is the most exciting development in eyecare since the inception of the NHS in 1948 and looks forward to working with the SEHD to ensure this piece of legislation realises its full potential.

SUBMISSION BY THE SCOTTISH PHARMACEUTICAL GENERAL COUNCIL (SPGC)

SPGC is the body empowered by community pharmacy contractors to negotiate and make representation on their behalf with SEHD, on all matters of terms of service and remuneration for contractors’ NHS work. SPGC represents Scotland’s 1150 community pharmacies and 700 different community pharmacy contractors. SPGC also runs the central checking unit, providing the only independent audit of prescription pricing in Scotland. SPGC also answers queries from its members on all aspects of NHS services and works to increase the profile of community pharmacy with other stakeholders and political decision makers.

Part 3: Pharmaceutical Care Services (PCS)

Part 3 makes a series of provisions to support pharmaceutical care services. It places requirements on Health Boards to plan provision of pharmaceutical care services and deals with the contract for provision of such pharmaceutical care services. It also addresses the listing requirements for persons performing pharmaceutical care services and makes provision for assistance and support for pharmaceutical care services.

Main Objective: Giving Health Boards responsibility and powers to provide pharmacy services

Do you agree with the main objective of this part of the bill? Yes

SPGC supports the underlying policy intention to modernise the delivery of NHS community pharmacy pharmaceutical care services, as part of the wider process of implementation of new arrangements for modernising NHS Primary Care Services in Scotland.

SPGC agrees with the general intention of the Bill to allow for legislation to underpin the new pharmacy contract and legislation giving Health Boards increased powers and responsibilities in the provision of pharmaceutical care services, by making provisions for amendment of the National Health Service (Scotland) Act 1978 (the 1978 Act).

SPGC supports the Scottish Executive’s policy document “The Right Medicine”: a strategy for pharmaceutical care and the Scottish Health Plan “Our National Health: a plan for action a plan for change”.

SPGC agrees with the collective agenda for modernising and redesigning pharmacy services with the overarching aim of improving levels of patient care, through better use of the key skills of community pharmacists and their support staff but would like to stress that the dispensing and supply of medicines is still recognised as an important and valuable part of community pharmacy’s role.
However, while SPGC agrees in principle with the proposals contained within the Bill, there are a number of areas of concern on which we would like to make representation and seek further clarification.

As the accompanying Regulations, which contain the fine detail of the proposals, are not yet available for consideration, a number of concerns similar to those already raised and expressed within SPGC’s original response to the consultation paper, “Modernising NHS Community Pharmacy in Scotland”, still exist. SPGC does appreciate that these concerns may be allayed when the detailed regulations and accompanying directions are available.

If yes, why?

Smoking, Health and Social Care (Scotland) Bill

Part 3: Pharmaceutical Care Services

Section 18 Health Boards’ functions: provision and planning of pharmaceutical care services. This section inserts two new sections, 2CA and 2CB, into the 1978 Act.

Section 2CA Functions of Health Boards: pharmaceutical care services

Subsection 1 of the new 2CA requires Health Boards to provide pharmaceutical care services or to secure the services by others. This gives Health Boards a new obligation to provide service themselves, in contrast to current legislation that only permits them to secure provision by others.

Subsection 2 of this new section enables a Health Board to secure provision of pharmaceutical care services by others and to do so by means of such arrangements as they think fit. The main new arrangement is a pharmaceutical care services contract, which replaces the current Section 27 pharmaceutical services contract of the 1978 Act.

Subsection 3 places a duty on Health Boards to publish prescribed information about the pharmaceutical care services that they secure provision of by others, or provide themselves. This applies to Part 1 of the 1978 Act as well as section 2CA.

Subsection 4 creates an obligation on Health Boards to cooperate with each other in discharging their functions connected with every aspect of pharmaceutical care services.

SPGC supports the principle that Health Boards will be expected to meet all reasonable requirements as they see necessary to provide or secure the provision of pharmaceutical care services as respects their area. We understand that this requirement may extend to the area of another Health Board and may also be performed outside their area and that Health Boards will now have a new obligation to provide services themselves, if those services cannot be secured from others.

SPGC still has concerns as to the process and methodology whereby this might be achieved and would emphasise that any such process be fair, equitable and transparent. It is important that while Health Boards will be allowed to make pharmaceutical care service provision as they see fit and in particular make contractual arrangements with any person, they try first to secure any such service from within the Scottish community pharmacy network. There is a concern here that this allows for the possibility of some pharmaceutical care services being delivered by the ‘Managed Service’. SPGC believes there is a distinct danger in not being able to achieve the key principles of ‘The Right Medicine’ if delivery is attempted by a mixture of supported, salaried and managed service provision, which is left to the variable whim of a Health Board.

SPGC agrees with the requirement on Health Boards to publish prescribed information about pharmaceutical care services and sees that as being a vital part of an inclusive and engaging process.

SPGC agrees with the intention under Subsection 4 to create an obligation on Health Boards to cooperate with each other in discharging their functions in connection with every aspect of
pharmaceutical care services and sees that as reflecting the increased emphasis on patient care that is intrinsic within The Right Medicine and the New Pharmacy Contract.

Subsection 5 allows regulations to be made that will define “pharmaceutical care services” for the purposes of the 1978 Act. The regulation will set out types of services that are and are not pharmaceutical care services for this purpose.

Subsection (6), allows the regulations made and defined for the provision of pharmaceutical care services under Subsection 5 of the Act, to classify what services are to be defined as essential or additional pharmaceutical services.

SPGC believes that the approach to introduce a pharmaceutical care service contract in a planned and proactive manner can only benefit patient care in the longer term.

SPGC would like to emphasise that any regulations pursuant to the Bill should clearly detail and require that those pharmaceutical care service elements deemed core to the new pharmacy contract, classified essential and agreed nationally, are adopted, recognised and accepted by the Boards as being to national service frameworks, standards and tariffs. SPGC believes that any agreed core service elements of the new pharmacy contract must be delivered across all community pharmacies in Scotland to ensure consistency of quality pharmaceutical care thereby avoiding post-code inequality. This is in keeping with the Scottish Executive’s stated intention that the public should have full access to the full range of essential pharmaceutical care services irrespective of domiciled in Scotland or not. SPGC would suggest that it is not in the best interests of patients if sections of the “managed service” were allowed to provide a partial pharmaceutical care service within a PCS plan.

While SPGC agrees that Boards should be empowered to meet their local care requirements, it should not be at the diminution of the nationally agreed core contract services. Pharmacy is a small contractor profession and as such is concerned about the possibility of a nationally agreed pharmacy contract agenda being undermined in the desire to fulfil a local needs requirement. It is only through a consistent across the board introduction of core pharmaceutical care services that community pharmacy will succeed in delivering improved levels of quality care to patients as envisaged within “The Right Medicine”: a strategy for pharmaceutical care.

Subsection (7) provides that any directions to be issued by Scottish Ministers must be published in the Drug Tariff.

SPGC believes that there should be a full and comprehensive revision and updating of the Drug Tariff to reflect the changes to pharmaceutical care services within a modernising NHS in Scotland.

Subsection (8) makes it clear that arrangements, which a Health Board may make for the provision of pharmaceutical care services, may provide for the delivery of these services from a location outside of Scotland.

SPGC strongly suggests that any proposals allowing Health Boards to make provision for pharmaceutical care services to be performed outside Scotland, should involve a process whereby the procurement of that service is first sought from within the existing Scottish community pharmacy network. Any such procurement from outside Scotland should be a last resort to be pursued only after all other avenues have been exhausted.

SPGC however, does appreciate that there may be limited circumstances where it would be more convenient or practical for a patient to have services provided in this way.

SPGC would also make representation that in the circumstance where a Board sought to provide NHS pharmaceutical care services themselves, a fair and reasonable process of service procurement would be undertaken before any such stance was finally adopted and that this again would be a last resort approach to the procurement of such a service.
SPGC would urge that the community pharmacy network is recognised as the provider of choice. Community pharmacists in many ways already deliver added value. However in future there will be considerable opportunity to provide even more in terms of access and service delivery.

2CB  Functions of Health Boards: planning of pharmaceutical care services

Subsection 1 provides Ministers with the broad regulation and direction-making powers that will prescribe the arrangements by which Health Boards will prepare, publish and keep under review, plans that will enable them to discharge their duty under section 2CA(1).

Subsection 2 gives examples of what the regulations under Subsection 1 may cover and includes identification of what pharmaceutical care services are required in a Health Board’s area, whether there is convenient access and where provision of these services is considered inadequate. It also includes the periods in which Health Boards are to prepare, publish and review their pharmaceutical care services plan and the consultation process by which the PCS plan is prepared and made available to the public.

Subsection 3 gives the Scottish Ministers power to publish in directions what criteria ought to be considered in the identification by the Health Boards of the matters in subsection 2a in preparing a PCS plan e.g. the directions might require Health Boards to compare the location of NHS community pharmacies and GP surgeries relative to size and proximity of populations and their pharmaceutical care service needs.

SPGC supports the proposal to allow for regulations, which provide for the provision of a pharmaceutical care services plan. A more proactive approach to the provision of pharmaceutical care services can only ultimately be to the benefit of Scotland’s patients. The use of a planned holistic approach should make it possible to resolve objectively any specific local under-provision. Great care must be taken with reference to the setting of review and revision frequencies and to the duration of any such plan, so that as well as achieving the Health Board’s pharmaceutical care service requirement, nothing is done that could potentially reduce the current, well recognised benefits of the existing community pharmacy contractor network. It is extremely important that the regulations do not introduce anything, which will reduce the recognised benefits, effectiveness and stability of the current community pharmacy network. The use of the word convenient in relation to access as proposed in the Bill could be seen as potentially ill defined and open to conjecture, it would be better to consider the use of the word ‘adequacy’ within the PCS plan but with the use of a set of clearly defined criteria.

Point 1b implies continuous review. It is important that any agreed plan is reviewed with a sensible and realistic frequency.

SPGC supports the principle of moving towards a formal planning mechanism or framework to place the provision of pharmaceutical care services, as long as the benefits of the current control of entry regulations can be retained in line with the Scottish Executive’s response to the Office of Fair Trading report. SPGC does appreciate that a mechanism based on a response to clearly identified need rather than speculation can only be to the benefit of patient care.

With reference to the preparation of a pharmaceutical care services plan any consultation process should be involving, engaging and transparent, with all key stakeholders being allowed the opportunity to make positive contribution to the construction of the plan.

SPGC strongly suggests that clear guidelines, needs assessment criteria and preparation methodology for any such pharmaceutical care services plan should be clearly laid down on a national basis, so that each Health Board is required to take the same consistent approach in relation to service needs assessment. The regulations should clearly detail what PCS plans should provide and how they will be prepared, implemented and maintained. This should be done following a strict nationally agreed set of criteria.

There is a danger that too wide a set of criteria is introduced with reference to the definition of access to pharmaceutical services. It is extremely important that in any attempt to address
convenient access issues on a local basis, the attempt is not carried out in such a way that any items agreed nationally are devalued or lost.

The expertise and capacity within Boards is variable. Therefore it would be beneficial and indeed desirable that additional locally agreed services be defined through service specifications and tariffs benchmarked to a nationally agreed formula. Health Boards could then enhance those local services further, as and when required. Maintaining minimum local service specifications and tariffs to a national agreement would ensure consistency of pharmaceutical care across the whole of Scotland. Consideration should also be given to accompanying these changes with a national accreditation scheme for delivery of pharmaceutical care services.

Section 19 Pharmaceutical care services contract

The policy intention is to introduce the legislative changes required to allow the implementation of the new community pharmacy contract.

This part of the Bill inserts 2 new sections 17Q and 17V into the 1978 Act (in place of existing sections on pharmaceutical services). These new sections govern the terms and content of the new pharmaceutical care services contracts and who may provide or perform pharmaceutical care services under such contracts and contain regulation-making powers to set out the detail of the rights and obligations under the new contracts.

Section 17Q of the Bill refers to the general content of the contract.

Subsection 1 allows a Health Board to enter into a PCS contract with a contractor to provide pharmaceutical care services in accordance with the provisions of part 1 of the 1978 act.

Subsection 3 sets out the parameters for services to be provided under the contract, remuneration for their provision and other matters.

Subsection 4 allows the contract to cover a range of services such as those that are provided in other primary and acute care settings and for such services to be delivered at a location outside the Health Boards geographical area.

SPGC recognises that one of the main policy intentions proposed within the “Modernising NHS Community Pharmacy in Scotland” consultation document was a requirement to resolve instances of under-provision of pharmaceutical care services. SPGC would agree and fully support this policy intention.

SPGC seeks clarification that the previous proposal for the use holding contracts has been removed. SPGC remains concerned that the new process for the granting of any such contract for pharmaceutical care services is still not clear. Will the current criteria of “necessary and desirable” be replaced by a new set of criteria or will they remain in place but be more objective in nature? SPGC is concerned that a completely new process might be introduced for assessing the need to grant a new contract within a PCS plan, where instances of under-provision are identified. SPGC would strongly advocate that any new process for assessing the need for a new contract must be robust, transparent and unambiguous with a nationally agreed set of objective criteria and guidelines. Care must be taken to ensure that the key benefits of a system based on necessary and desirable criteria are not lost.

SPGC firmly believes that any pharmaceutical care services contract should encompass all four core essential elements (Chronic Medication Service, Acute Medication Service, Minor Ailments Service and Public Health Service) of the new contract without exception.

SPGC would be very concerned if any such new contract assessment process did not include provision for minor relocations. We maintain using the minor relocation facility allows for improved standards of premises and this can only ultimately benefit patient care.

Currently Health Boards and the NHS rely on pharmacy contractors investing their own money in premises, staffing, cost of stock etc. Therefore, careful thought must be given to appropriate
funding to encourage contractor investment when addressing any instances of under-provision in deprived and rural areas.

It is difficult for SPGC to make appropriate representation on this key issue, without having the detail of intent, which will be contained in the Regulations and supporting Directions. Until a draft of the actual Regulations is available, this whole issue around contracts remains a major concern for SPGC.

Within the Bill it is suggested that the National Appeals Panel would not have a remit in the future to make deliberations on contract disputes, which could infer that there is no expectation for any such contact disputes to arise. SPGC appreciates that any instances of under-provision will be identified within a pharmaceutical care services plan. However we are concerned that there may not be the opportunity for a contractor to apply for a new contract in an innovative and creative manner if the PCS planning process is too restrictive. It is essential that any PCS planning process will allow for community pharmacy contractors to fully participate and engage in a positive spirit of partnership working with Boards and other stakeholders.

A pharmaceutical care services contract may include services, which are not pharmaceutical care services. SPGC would have concerns that unless any such services are specifically confined within a healthcare remit, that this could pose contractual difficulties in the future. Point 4 provides for non-pharmaceutical services to be covered and allows all services covered to be provided in any suitable location, where it is to meet all reasonable needs. This may allow for pharmaceutical services being provided in GP’s surgeries or at Health Board clinics in rural areas or in areas of deprivation. SPGC would strongly advocate that this should only happen after every attempt to secure such services from community pharmacy contractors has been exhausted.

SPGC would make representation that any pharmaceutical care services contract, which will by definition be negotiated at a local Health Board level, should allow for the Executive’s intention that the new contract will be agreed at a national level.

A pharmaceutical services contract will require the contractor to provide pharmaceutical care services of such description as may be described. SPGC would seek confirmation that this applies only to the collective core essential components part of the contract.

The new section 17R makes it compulsory for a PCS contract to require the contractor to provide pharmaceutical care services of such description as may be in regulations under the section, the intention being to set out in regulations that providers must provide certain essential services.

SPGC agrees with this intention.

The new section 17S sets out the persons with whom a Health Board may enter into a PCS contract.

Subsection 1 allows a Health Board to enter into a PCS contract with a registered pharmacist or a person lawfully conducting a retail business in accordance with section 69 of the Medicines Act 1968.

Subsection 2 enables regulations to set out the effect on the contract of a change in the membership of a partnership contracted to provide pharmaceutical care services, the intention being to allow the membership of a partnership to change without requiring a new contract to be entered into merely because a change in partnership has taken place.

SPGC has concerns around how a Board will define practising and non-practising pharmacist status and would suggest that this should be done with due reference to RPSGB guidelines and thinking.

With reference to the proposed compliance with agreed standards, quality parameters and the achievement of benchmarked performance levels, SPGC is concerned that Health Boards will have such powers as to set their own at a local level rather than through an agreed national set of standards and performance criteria.
SPGC believes that the appliance supply and advice service sits naturally within a total package of pharmaceutical care and that this service should be incorporated within the essential core part of the new pharmacy contract. Recent definition suggests that Health Boards will not be able to enter into PCS contracts with businesses providing only appliance supply and this can only be to the benefit of patients, as supply should not be divorced from the provision of pharmaceutical care and advice.

Section 17T- deals with the payment to be made under PCS contracts.

Subsection 1 enables Ministers to give directions as to payments to be made under the contracts.

Subsection 2 makes it compulsory for a PCS contract to require payments to be made in accordance with the directions then in force.

Subsection 3 gives examples of the matters for which directions may provide and Subsection 4 requires Scottish Ministers to consult before giving any direction under Subsection 1.

SPGC seeks further detail about the process whereby global sum allocations will be based on a possible future weighted capitation.

It is extremely important that the essential core services are paid by the Health Boards to any nationally agree remuneration scale.

SPGC accepts that Scottish Ministers must consult with representatives of persons to whose remuneration the direction would relate. SPGC currently fulfils this role and looks forward to undertaking its new obligations arising from the legislation.

New section 17U allows regulations to be made identifying the requirements that must be included in all PCS contracts.

Subsection 2 gives examples of the issues that the regulations may cover e.g. manner in which and the standards to which services are provided, the persons who may perform services, contract variation and enforcement and the adjudication of disputes.

Subsection 3 provides for regulations made under subsection 2CA to set out prescribed circumstances in which a contractor must accept a person to whom services are to be provided and in which a contractor may decline to accept such a person or may terminate responsibility under the PCS contract for the person.

Subsection 4 provides that regulations varying the contract terms may include provision as to the circumstances in which a Health Board may so vary the terms or to suspend or terminate any duty under the contract to provide services of a prescribed description.

SPGC would like to emphasise the importance of clearly defining and detailing the premises standards that will be required within a PCS plan and it is vitally important that any premises standards criteria are set following national guidelines, which are not open to different interpretation across the Boards. The issue of premises being able to meet the required standard is extremely important and will potentially be one of the more difficult areas to address. Clarity is required as soon as possible in this key area so that when satisfying an identified patient need becomes the key driver, premises issues do not become the stumbling block to the delivery of new pharmaceutical care services.

SPGC is concerned that the monitoring of quality and standards and right of entry, premises inspection and enforcement by the Health Board could create cross responsibility issues with the Royal Pharmaceutical Society of Great Britain. SPGC questions whether or not this regulatory function should be shared in the future. Community pharmacy contractors could potentially become the victims of an unnecessarily bureaucratic system. There is concern around the regulations in relation to suspension and termination of a contract and clear definition of the circumstances under which this course of action might be taken is sought.
Under 4a, the Regulations may make provision as to the circumstances in which a Health Board may unilaterally vary the terms of the contract. The extent and meaning of the word unilateral in this circumstance requires further clarification. This could easily be taken out of context and applied more generally and SPGC has concerns around how any such unilateral decision would be reached and also about the rights and payments to the suspended person. The potential to allow for unilateral variations to any process is of grave concern to SPGC.

New Section 17V

Subsection 1 creates a regulation making power to set the national procedures for internal dispute resolution for the proposed PCS contracts. It may also provide for this to be referred to Scottish Ministers or a panel of persons appointed by them.

Subsection 2 creates a regulation making power to enable the parties to a PCS contract and parties who are already providing pharmaceutical services under a PCS contract to opt to be treated as a health services body for any purposes in the existing Section 17A of the 1978 Act. Section 17v instead provides for either party to an NHS contract to refer any matter in dispute to the Scottish Ministers for determination.

Subsection 3 provides that if a PCS contractor or potential provider elects to become a health service body under subsection 2, section 17a of the 1978 Act applies with appropriate modifications.

Where a business opts for its PCS contract to be an ordinary contract at law, it will have the option of asking the courts to resolve any resultant contract disputes.

Section 20 Persons performing pharmaceutical care services

This section insets a new section 17W into the 1978 Act.

Subsection 1 provides for regulation- making powers governing the ways in which persons performing pharmaceutical care services are listed. The regulations may prevent registered pharmacists from performing pharmaceutical care services for Health Boards unless their name appears on a list held by the Health Board.

An obligation to be on the list of a Health Board before performing services in that Health Boards area remains even if the services are carried out as a part of a contract with a neighbouring Health Board.

Section 17W ends the current arrangements whereby the Health Board’s pharmaceutical list contains the names of persons or businesses with whom the Health Board has made arrangement to provide pharmaceutical services and under which only the principal providers of those services are listed and thereby subject to terms of service requirements. The need to list contractors for “terms of service” requirement is no longer necessary as arrangements will be governed by the terms of arrangements which Health Boards enter into with persons to secure the provisions of pharmaceutical care services under Section 2CA.

The new listing requirements will apply to all registered pharmacists wishing to perform pharmaceutical care services i.e. whether contractors or employed or engaged by contractors.

Subsection 2 of Section 17W sets out particular issues that may be included in the regulations e.g. how the list will be drawn up and maintained, what criteria an individual will have to meet to qualify to be on the list, the process by which decision on applications will be made and mandatory grounds under which a Health Board would have to reject an application.

SPGC agrees that the intention of making non-principals accountable and principals more accountable for their actions is sound and improves clinical governance. The Health Board list therefore will be maintained as a control mechanism for all pharmacists undertaking PCS in the Board area and not for control of entry purposes as is the case now. This brings community pharmacists into line with the other healthcare professional groupings and ties in to part 4 of the Act (Discipline).
SPGC would stress that any proposed listing arrangement should incorporate a fast tracking registration facility to allow for sudden emergency situations such as absence or illness. It is vitally important that continuity of pharmaceutical care services is maintained.

SPGC is concerned how any selection or de-selection process sits with any RPSGB process and believes that there could be possible areas of conflict here in the future. SPGC would have extreme difficulty with any Health Board selection and de-selection process which might occur without due reference to the procedures and guidelines of the Royal Pharmaceutical Society of Great Britain. There needs to be clear demarcation with reference to responsibilities and remits between NHS Scotland and RPSGB, the regulatory body.

SPGC would advocate that there should be a registration process with one Board and then automatic adoption to other nominated Boards.

SPGC believes that in order to minimise bureaucracy there should be a facility to allow for the whole process to be administered through a national register. The use of National Services Scotland to maintain Scotland’s pharmaceutical list would make sense but more clarity is required around the process for Boards and Contractors access to check “PCS performer status”. The process must be made as simple as possible so as to avoid any potential resource and cost issues arising out of a system that could become over complex.

SPGC has concerns around selection criteria for entry to any such list and the possible methodology used for removal. Selection criteria must be agreed nationally to a set of robust and unambiguous guidelines. SPGC would maintain that even if a nationally agreed set of criteria were to be adopted then acceptance or otherwise of an individual may be subjective and the quality of decision-making may as a result still vary across the different Health Boards. This is of grave concern to SPGC.

Section 21 Assistance and Support: primary medical services and pharmaceutical care services.

This section inserts a new section 17X into the 1978 Act, making new provision to pharmaceutical care services and does this by replacing the existing 17Q which is an existing provision for primary medical services. The new section 17X extends the provision of assistance and support to the pharmaceutical care services.

The terms, on which such assistance and support are given, including terms as to payment, are a matter for the Health Board.

SPGC strongly suggests that a set of national guideline criteria is vital for ensuring equal opportunity in any assessment process for the allocation of assistance and support.

Within the regulations, this could make provision for replacement of the existing essential small pharmacy scheme with reference to instances of under-provision in rural or areas of social deprivation.

Final Statement

SPGC supports the key intentions proposed within the Bill. However we do have concerns regarding a number of issues, which can only adequately be answered within the fine detail of the Regulations and Directions.

SPGC would wish to be called to give oral evidence if the opportunity was forthcoming and would express a strong desire that Part 3 of the Bill, Pharmaceutical Care Services, be given due time and consideration as it paves the way for the future development of the community pharmacy profession in Scotland. Community pharmacists welcome the opportunity to deliver enhanced levels of pharmaceutical care to the patients of Scotland within a modernising Scottish NHS.
Acknowledgements

Fife Health Council would like to thank all those who assisted in this event, in particular, the participants themselves and Marjory Barquist and Lorraine Briggs from the Care Standards & Sponsorship Branch of the Scottish Executive Health Department (SEHD). Fife Health Council was also pleased to welcome Mr Neill O’Shaughnessy, NHS Quality Improvement Scotland, who attended as an observer of this “Raising the Issue...” event.

Summary

The issues discussed at this “Raising the Issue...” event were extremely wide ranging and interesting and much of the feedback provided a useful insight into the patient experience of dental services, for both NHS and private treatment. It was clear from the group discussions and the question and answer session which followed, that patients and the general public want to be involved in decisions about the planning and development of their NHS services.

In essence, participants welcomed the development of a set of standards which applied to both NHS and private dental services. From the discussion which took place, it was clear that, if regularly monitored, the standards would lead to an improved service and patient experience. Accreditation was an issue which came up on several occasions as an area which Participants felt worthy of promoting within the dental profession.

Identified throughout the group discussions were suggestions for improvements to access to information for patients. In this context, a significant number of participants mentioned the need to clearly explain the finer detail of de-registration rules and the procedure for agreeing a patient’s care and treatment. As could be expected, a significant part of the discussion covered dental costs and, in particular, what some participants considered to be confusing fee structures.

The care environment within dental practices generated significant debate, not only in terms of the difficulties associated with older style dental practice premises, but also the requirements of the new Disability Discrimination Act.

Finally, but by no means least, participants stressed the need to consider the dental standards from a children’s perspective. It was advocated by participants that training in how to deal with children and, more specifically, how to address their psychological needs within a dental setting was worthy of inclusion in the dental standards.

1 Introduction

Fife Health Council is the statutory representative of the general public in the NHS in the local area. One of its priorities is to represent the interests of the people of Fife, encourage public involvement in the planning and delivery of health services locally and support existing public involvement mechanisms.

Another area is to seek new and innovative ways of involving the public in the health service planning process and, in November 2001, Fife Health Council secured funding from the Scottish Executive to take forward a new initiative entitled “Raising the Issue...”. In essence, the overall aims of the project are to:

• create new and unique opportunities for public involvement via the establishment of a series of events where members of the public are invited for an in depth discussion on a chosen subject;
• promote public awareness of the role of Fife Health Council as an organisation tasked with promoting public involvement and a patient focussed NHS; and

• produce a detailed report of each event and take forward, wherever possible, issues raised by the public.

This ninth in the series of “Raising the Issue…” events sought to attract input from the public to discuss the draft National Standards for Dental Services developed jointly by the National Care Standards Committee (NCSC) on behalf of Scottish Ministers and by NHS Quality Improvement Scotland (NHS QIS).

2 Background

The Regulation of Care (Scotland) Act 2001 extended the scope of care services to be regulated. The Act also set up the Scottish Commission for the Regulation of Care to carry out the regulation of services. In carrying out its work, the Care Commission must take account of the relevant national care standards developed by the NCSC on behalf of Scottish Ministers. One of the new services to be regulated under the Act by the Care Commission is private dental services.

Dental services providing NHS care are already subject to regulation. The dental practice premises are inspected. In addition, checks are made on a sample of patients to make sure treatments have been carried out as claimed, and have been done satisfactorily. At the moment, there is no consistent monitoring of dental care provided in the Salaried Primary Care Dental Services. It has been recognised that there is a need for national standards and consistent monitoring of them across NHSScotland. Responsibility for developing the standards was given to NHS QIS.

Two different bodies therefore are responsible for setting standards: NHS QIS for the NHS and NCSC for the private sector. At first these two bodies worked separately and developed draft standards for dental services in their own sector. Most dental practices in Scotland provide both NHS and private dental services, so it was decided to develop a set of standards applying to both NHS and private dental services.

As firm believers and advocates of the view that involvement of service users is not just a regulatory obligation but should be part of every day good management and high quality service provision, Fife Health Council has always been keen to support public consultation and so we entered into this discussion with the enthusiasm which it rightly deserves. Fife Health Council is also of the view that consulting and involving service users and finding out what the general public want from their NHS services should not be seen as an extra chore for the service providers but as a means of carrying out their work efficiently and effectively.

Through this event, we asked participants to specifically consider the draft standards for dental services which had been issued for public consultation, from the point of view of the person using the service, in particular how the standards meet the common set of principles, namely:

• Dignity
• Privacy
• Choice
• Safety
• Realising potential
• Equality and diversity

3 Event Format

This “Raising the Issue…” event was advertised in local newspapers and publicised with a large poster campaign. People interested in taking part were invited to contact the Health Council via a freephone number. In addition, Fife Health Council specifically invited former “Raising the Issue…” participants and representatives from local voluntary organisations and specific interest groups. There was no set criterion for involvement and, for a variety of reasons, the maximum number of delegates had to be restricted.
The event, which was ultimately subscribed to by 45 individuals, took place in the Dean Park Hotel, Kirkcaldy on 14 September 2004 and was facilitated by representatives from Fife Health Council. Participants had benefit of a presentation from a representative from the Scottish Executive’s Care Standards and Sponsorship Branch. Participants were then invited to join one of three discussion groups. Each group was tasked with discussing five of the fifteen draft standards:

**Group A**

- Standard 1: Choosing your dental service
- Standard 2: Before your appointment
- Standard 3: Your visits
- Standard 4: Assessing your needs
- Standard 5: Deciding and agreeing your care and treatment

**Group B**

- Standard 6: Receiving your care and treatment
- Standard 7: The quality of your care and treatment
- Standard 8: Ongoing care
- Standard 9: Expressing your views
- Standard 10: Confidentiality and information held about you

**Group C**

- Standard 11: The dental team and service management
- Standard 12: Medical and other emergencies
- Standard 13: Control of infection
- Standard 14: Your care environment
- Standard 15: Children and young people

### 4 Results & Discussion

This section summarises the wide ranging factors found to be pertinent to those who took part in the discussion. Participants considered whether the draft standards were clear and easy to understand, and, more importantly, what, if anything, had not been covered.

**Standard 1: Choosing your dental service**

The group agreed how important it was that patients have a clear statement about accessing accurate, clear and easy-to-understand information. This draft standard detailed all information patients should have easy access to. It was, however, considered that some mention should be made of where this information should be available, i.e. GP surgeries, Libraries, etc. As the standard stood, participants felt that it could be interpreted that information would only be available at source, i.e. the dental surgery.

The general consensus was that this draft standard should also cover the de-registration of patients after a fifteen month period without treatment. It was agreed that dentists should ensure their patients are aware of the rules regarding de-registration, should be warned prior to de-registration and reminders of check-ups should be standard practice. Mention in this section could also be made of the obligation of dentists to inform patients when any service change is implemented, e.g. change of dentist or if a dentist decides only to take private patients.

**Standard 2: Before your appointment**

Members considered that some mention is made with regard to arrangements for emergency cover when a dentist is absent, on holiday or ill. Preparing for appointment should also include information on any allergies a patient may have, as well as any medications the patient is taking.
Standard 3: Your visits

Participants considered the nine points contained within this draft standard were to be commended. The group suggested the following amendments to aid readability:

- under item 7, the term “third person” is clarified – would this also cover an appointment with the hygienist?
- item 2 touches on inaccessible service for reasons of disability, however, it was felt that special mention should be made for the deaf and those patients with sight problems;
- one participant felt that footnote 3 should be incorporated within the text.

Standard 4: Assessing your needs

The group considered this standard should have more emphasis on patient’s allergies to medicines and how patients with, say, a heart murmur may require varied medicine dosages. Continuing with the health theme, it was felt that to ensure continuing care, patient’s dental records should follow the patient on a care pathway, including a change of dentist.

Participants wondered what the practicalities were of assessing the patient’s current state of health. For example, how time consuming was it for the practitioner and also whether a dentist was qualified to make what appears to be a medical assessment.

Two minor amendments were suggested:

- in 1, line 3, suggest adding “will” before “receive”, “you will receive help, if needed”;
- in 3, line 2, suggest changing “possibly” to “possible”, “signs of possible serious illness”.

Standard 5: Deciding and agreeing your care and treatment

It was agreed that this draft standard was comprehensive and covered all aspects of deciding and agreeing care and treatment. Notwithstanding, the group considered it should also include patient’s rights to access a second opinion.

Although this section covered adequately that patients should be provided with details of the cost of individual treatments, the group agreed that dental rates should be displayed somewhere in the premises.

Standard 6: Receiving your care and treatment

The group considered the first point to be confusing and wondered how a dentist could tell a patient what could happen without carrying out an examination first. This, therefore, requires clarity. If this means the patient will be told what will happen during the examination, then this should clearly say so. Some of the group felt the use of the word “told” was inappropriate and felt “advised” was more suitable.

Regarding codes of practice when a referral is required, the group felt this should include making it clear to patients that the arrangements could take time, i.e. patients should be advised of waiting times for referral to, for instance, a dental hospital.

The group considered the item relating to a patient having an acute condition or signs of serious disease that need urgent referral should contain more detail, with a clarification of what was considered “urgent”.

Standard 7: The quality of your care and treatment

“It is easy to say what should be done, to actually get that to happen is a very different matter” ….a participant
The group commends recommending a peer group review, however they felt there also should also be some kind of public involvement.

Regarding a patient’s right to request information about the review process and its results, the group felt it was highly unlikely that a patient would be aware that such a process existed. It was agreed how important it was that the information be displayed and updated as regularly as reviews are carried out, displaying information on changes of practice and improvements in the care and treatment.

Some participants considered the last item under this draft standard regarding laboratories used for diagnostic tests being accredited failed to get its message across adequately, with one participant suggested changing “makes sure” to “ensures”.

It was also considered helpful if mention was again made of the NHS Complaints procedures to re-affirm a patient’s right to complain if unhappy with treatment.

Standard 8: Ongoing care

The group felt that the expression “an explanation about what your responsibilities are”, in item two, sounded rather patronising. They felt this item should be removed altogether or replaced with one which mentions the provision of information on oral health.

Participants wished to see more information in item 5, i.e. “can you disagree with treatment?”, and “can you ask for a second opinion?”. An example was given as a patient being advised to have an offending tooth out if that patient was not convinced that this was the right treatment.

One participant felt that item 8 should not start with “You know that” and a phrase such as “You will be asked…” was more appropriate.

The group were in agreement that, in practice, item 9 was not possible and should be removed.

Standard 9: Expressing your views

The group felt that the term “opportunity” should be replaced with something more definitive, i.e. that there is a complaints/comments procedure in place and a standard form was available and easy to complete.

It was agreed that this Standard as a whole should put the onus firmly on the service to seek the patients’ view. It was not, however, considered to be “user friendly”. Most members of the public it seems are unaware of how to make a complaint, although service providers have a duty to inform their patients of their rights.

Standard 10: Confidentiality and information held about you

Hopefully one day we will carry a swipe card that will state our history, medication being taken etc.”…..a participant

The group agreed that the issue of confidentiality was already covered by current legislation, however, it was considered very important and merited reminding both patient and dentist about the finer detail.

Continuity of Care is stressed as important within the dental team, however, no mention is made of continuity within the draft standard if a patient changes dentists during a course of treatment.

One participant questioned whether this section should differentiate between electronic and paper records and if patients understood the difference. Equally, under the Data Protection Act 1988, patients have access to manual and electronic records and participants felt that this information should be included in this draft standard.

This section should highlight the point that patients have the right to access to their records.
One participant felt that footnote 6 describing patient care records should be incorporated in the text of the draft standard.

Standard 11: The dental team and service management

The group felt it would promote better communication and relationships between the dental team and patients if a board showing photographs and qualifications of the dental team was prominently displayed. It was felt that this would not only assist patients in identifying staff but also alleviate any doubts as to their ability to practice, particularly if their respective credentials were displayed. One member felt it would be embarrassing to ask about Disclosure Scotland checks, although having this information freely available within the practice would eliminate the need to ask for it.

Nonetheless, it was agreed how important the Disclosure Scotland checks were and some participants considered that this should be included in this draft standard under its own item number.

One participant considered that footnote 7 should be incorporated into the text as number 1, with subsequent items re-numbered accordingly. It was also suggested that item 6 be re-written to read “Your dental service should work effectively as a team. It should also communicate effectively with other professionals”.

Standard 12: Medical and other emergencies

“If you plan/organise for the worse scenario then you can cover everybody” ….a participant

As in standard 11, the group felt patients should be made aware of the protocol for dealing with emergencies, particularly that resuscitation equipment was available. They also felt that the Code of Practice including emergency care should be prominently displayed along with the details of the staff qualified to use the equipment and details of audits and equipment checks should also be freely available.

Whilst the evacuation of premises is included in this standard, it was felt that this should also stress the need for clear emergency exits and disabled access. Mention of the Disability Discrimination Act should also be included in this section. The group also felt there may be an issue around staff’s ability to move and handle people with a disability and suggested that the importance of training in this discipline should be included.

It is suggested that the safe storage of drugs is included in this draft standard.

One participant felt that footnote 9 should be incorporated in the text.

Standard 13: Control of infection

“You would expect the premises to be clean wouldn’t you?” ….a participant

The group was unsure of any incidence of MRSA infection within dentistry, however, with such an important issue within the NHS as a whole, all agreed that dental surgeries should follow the same rules and regulations that apply to hospital staff under any Infection Control Policy. Participants agreed that signs above sinks, “please wash your hands”, etc. should be standard policy and dentists should change gloves for every patient treated, with other comprehensive procedures in place to ensure a clean environment.

Standard 14: Your care environment

As mentioned previously, it is recommended that reference is made to the Disability Discrimination Act, particularly with access to toilet facilities and waiting areas.

The group discussed at some length the problems associated with inadequately sized waiting areas, particularly in older premises, again, this could be considered under the Disability Discrimination Act.
The risk management programme should stress the need to think about the “worst-case scenario” and then ensure the necessary equipment is in place.

The group considered that the suitability of access and equipment was paramount to ensure a comfortable, secure care environment for patients. Therefore, the importance of easily accessible premises with disabled car parking as a minimum requirement was considered worthy of mention.

Standard 15: Children and young people

“I think a child’s first visit to the dentist is crucial” ….a participant

The group considered this standard would benefit from including some recognition and understanding of how children view a dentist and how important it was to alleviate any fear from the time of a child’s first visit. The importance of talking to the children directly, not through the parent, to build a good relationship was seen as crucial and was advocated. Training in how to deal with children and young people should be undertaken by all the dental team as psychology plays such a large part in building a relationship.

It was also felt that the age of consent should be stated in the draft standard, not just a mention of the Age of Legal Capacity Act which could perhaps lead to complications.

One participant suggested the final item in this Standard should read “all team members with access to children must obtain an enhanced disclosure check from Disclosure Scotland. They may work with children under supervision until this check is completed. The situation of team members for whom disclosure checks have not been secured must be reviewed every six months”. If this final item was altered as suggested, or in a similar format, footnote 11 could be cancelled.

In general

All three groups wondered what kind of regulatory system would be checking these standards. Perhaps, accreditation should be promoted regularly and dental practices encouraged to apply.

Several participants mentioned the need for a glossary of abbreviations to be included in the standards. In addition, few questions also arose, such as:

• how will a patient be able to obtain this document? (Final Standards)
• are all dentists aware of the content of the document?
• who will monitor their response to this document?
• document doesn’t say it is available in other formats (Braille, etc.)?

One participant felt that the general information about dentistry could have been more comprehensive.

Most participants considered the draft standards well thought out and sensible, although it was felt that the document itself did not address the main issue of why most dentists were refusing adults NHS cover.

Several participants recommended that serious consideration be given to look into fee structures, particularly for initial consultations, which one participant described as “ludicrous”. This participant also felt that a patient’s major worry was cost of treatment and find it difficult to grasp the difference between NHS treatment and private, even though it was written down in black & white. The fact that NHS treatment charges of up to £372 for adults makes it at times impossible to differentiate. This participant stressed the importance of this aspect of the ethics of the standards to be set.

“Will the introduction of these Standards increase costs to NHS Patients or Patients?” ….a participant
One participant thought it was very important that the standard of dentistry remains at a high and safe level and acknowledged the difficulty remaining for some areas in getting NHS dentists to be available to the general public.

Another participant felt strongly that, because National Insurance contributions were set up to provide all aspects of healthcare, these National Standards should also include GPs, who were also beginning to close their lists.

Another participant felt that the section “Payment for dental care and treatment”(p5) needed to be re-written as the categories were not fully elaborated.

Another participant requested continuity, for instance, on page 30 the first bullet point, quite correctly refers to “her or him” whereas the fifth bullet point refers to “they have”, which preferably should read “he or she has”.

Finally, the majority of participants agreed that the draft Standards were on the whole clear and easy to understand. All participants were eager to contribute and offer suggestions for issues not covered in the draft Standards. However, it is acknowledged that there has to be a limit to the information contained within the final standards when produced to make it easily accessible and easily understood for both patients and dental staff alike.

This report will be shared with the participants themselves, senior officers within the Scottish Executive (Health Department & the Involving People Team), NHS Quality Improvement Scotland, Fife NHS Board, Fife Primary Care Operating Division, Fife Acute Hospitals Operating Division, Fife’s Local Health Care Co-operatives, Scottish Health Councils and the Scottish Association of Health Councils (SAHC).
On resuming—

Smoking, Health and Social Care (Scotland) Bill: Stage 1

The Convener: I thank everyone for coming along. I think that the witnesses realise that the committee is doing something a little different today in that we are having a round table discussion rather than our usual approach of having panels of witnesses slot in and out for questioning by members. This is the first time that the committee has tried such an approach and we are a little uncertain about how it will work. We hope that it works well and that everyone will join in the spirit of the approach, which is about engendering livelier cross-participation than can happen when members simply question witnesses.

The witnesses were sent a note that introduces the process with the papers for the meeting and I hope that they have had an opportunity to read the note and get their heads round the new way of working. The committee papers included background briefings from the Scottish Parliament information centre on parts 2 and 3 of the bill, along with submissions from a number of the witnesses—the committee has received other submissions, too.

I will ask the Executive officials to outline briefly—they must be really brief, because we are quite pressed for time—the main provisions of the parts of the bill with which we are dealing. I will then go through those parts of the bill section by section and invite people to comment. That will not preclude cross-discussion and at some point during the discussion on each section committee members will want to ask questions. We will try to get through the work as well as we can. It will not be necessary for every witness or committee member to comment on every section that we discuss; some sections might be completely uncontroversial, so people should comment only if there is something that they want to contribute. I invite the officials to refresh members’ memories about parts 2 and 3 of the bill and then I will start the process and see how we get on.

Dr Hamish Wilson (Scottish Executive Health Department): I will be as brief as I can be. Three main areas are covered by part 2. First, the implementation of the partnership agreement pledge to introduce free dental and eye checks for all before 2007 is covered by sections 9 and 10. The provisions also allow for more comprehensive oral health assessments and eye examinations than current legislation permits. The second main area is dental services and in that context the
main provisions relate to the dental charging regime and the opportunity that we have to separate the dental charge from how dentists are paid, which will allow us to make the charging system more flexible and transparent. Section 12 extends the arrangements for the provision of general dental services to include bodies corporate—currently, arrangements can be made only with individual dentists. Section 13 allows health boards to provide assistance, including financial assistance and support to persons who provide general dental services and section 14 allows health boards to make arrangements with general dental practitioners to enter into what we call co-management schemes in relation to functions that are complementary to the work of hospital departments.

The final sections of part 2 deal with the listing of dental and ophthalmic contractors. Currently only those whom we describe as “principals” are included on health boards’ lists, but in future it is intended to include in lists for dental and ophthalmic services people who assist with the provision of those services—so the bill extends the provisions for listing. That is a clinical governance issue for health boards. Those are the main provisions of part 2.

The Convener: Will you also describe part 3?

14:30

Dr Wilson: Part 3 relates to community pharmacy services in Scotland. In general, the provisions are intended to underpin the implementation of a new community pharmacy contract, which is currently under discussion with the profession in Scotland. Section 18 introduces a duty on health boards to plan and then provide or secure the pharmaceutical care services that are required for their areas. Section 19 describes the contractual arrangements under which pharmaceutical care services will be provided or secured. Section 20 strengthens the clinical governance arrangements in the community pharmacy sector, as I described in relation to dental and ophthalmic services, by extending the listing arrangements to encompass everyone who performs pharmaceutical care services. Section 21 empowers health boards to provide assistance and support to those who provide pharmaceutical care services. Finally, paragraphs 11 and 12 of schedule 2 provide powers to transfer resources for pharmaceutical care services to health boards’ unified budgets.

The Convener: Thank you. We will start by considering sections 9 and 10, which deal with free dental and eye checks. I invite the patients’ representatives to comment: they are Martyn Evans, from the Scottish Consumer Council; and Joyce Shearer, from Fife local health council.

Martyn Evans (Scottish Consumer Council): Should I be brief?

The Convener: Very brief.

Martyn Evans: We welcome the proposals, which will reduce the initial barrier to treatment for people. However, we have concerns about how the proposals can be implemented, which is not the direct concern of the committee. We would like there to be a greater emphasis on the use of professions complementary to dentistry in delivering the policy. In the context of the evidence of the Audit Commission, we are not convinced that six-monthly dental checks are universally necessary. We are concerned that aspects of the current process of dental checks, for example additional work such as scaling and polishing, which are not part of the dental check but form a significant part of a dentist’s income, should be clearly defined, so that users know what they will pay for and what will be free in future.

Joyce Shearer (Fife Local Health Council): In a nutshell, I will focus on four key areas. First, access must be based on need rather than the ability to pay—

The Convener: Could you ensure that you speak directly into the microphone? If you do not do so people will have difficulty hearing you.

Joyce Shearer: Secondly, and linked to access, accommodation, by which I mean the places in which checks are carried out, must be fit for purpose. Thirdly, patients are very much concerned with accountability and whether robust standards and procedures are in place in relation to assessment and treatment. Finally, in relation to credibility, the regulation of the professions is foremost. The professionals who carry out the examinations must be registered and have recognised qualifications.

The Convener: I invite comments from the witnesses from the professional bodies: the British Dental Association and Optometry Scotland.

Andrew Lamb (British Dental Association): On free dental checks, in our response to the consultation, “Modernising NHS Dental Services in Scotland”, we supported the principle of a properly funded oral health assessment as part of basic oral health care. We are pleased that the bill uses the words “oral health assessment”. It is important that we understand exactly what will be delivered as part of the pledge and that we fully define “oral health assessment”. It is also important that patients have access to a dentist who can deliver the assessment.

We also have concerns about funding. The properly funded health assessment will require more than just a quick look at a patient’s oral tissue; it will require an assessment of the
individual patient's needs, and the ability to talk through with the patient their particular problems and to focus on a preventive approach. The time that is required to allow dentists to take such an approach is not available in the current system. One of the reasons why dentists are moving into the private sector is so that they can deliver a preventive approach. Dentists need time to be able to do that. We are concerned that, given the continuing problems of access to dentistry, the bill might raise expectations in patients' minds that cannot be delivered.

It is important that the oral health assessment is not considered in isolation from the general overall principles of "Modernising NHS Dental Services in Scotland". Without a ministerial response to that, we are talking about the oral health assessment and free dental checks in a detailed policy vacuum. It is a bit unfortunate that we are in that position, because the oral health assessment cannot be taken in isolation and must be part of the overall package.

Three questions arise. What does the oral health assessment consist of? How will it be delivered by the workforce? How will it be funded?

The Convener: No members have questions on those specific issues, so we will go to Mr Rollason of Optometry Scotland.

Hal Rollason (Optometry Scotland): I thank the committee for the opportunity to address it. As chairman of Optometry Scotland, I state that we broadly support the bill. Press coverage last week, which might not have been entirely positive, highlighted our concerns. We understand that the terms “sight test” and “eye examination” are used in the bill to describe the same entity, but that must be clarified in the bill or to the committee to ensure that the proposed health gain becomes a reality.

An urgent need exists for a new contract that focuses on health issues rather than just the provision of spectacles. Funding and resources are another issue. However, we have a positive message about improving health care by enhancing the scope of optometric practice. We aim to deliver a world-class service by providing not just the general ophthalmic services sight test that is available at present, but a more relevant and appropriate eye examination, whose availability will subsequently be widened to all. That will produce considerable health gains to the nation by introducing improvements in the eye care that is available to the public; the earlier detection of more eye disorders; better preventive eye care, which leads to a reduction in visual impairment; and a meaningful step towards the long-term goal of eliminating avoidable blindness.

Those measures will provide immediate access to a health professional who can assess, diagnose and treat or refer as required, and that service will be available in every community in an easily accessible and convenient environment, which will ensure equality of eye care throughout the country. Such measures will also achieve a significant reduction in inappropriate referrals to hospital eye departments. The combination of enhanced community-based care and the reduction of inappropriate referrals to out-patient departments will have a considerable impact on the time that people wait for hospital appointments. The measures will also reduce hospital waiting lists and waiting times. They will produce substantial savings in real terms for secondary care by helping to ensure that only people who need to be in hospital eye departments are sent there and by reducing the number of wasted out-patient appointments. They will also help to eliminate most of the 5 per cent of GP appointments that eye-related issues take up.

I work in the east end of Glasgow, in an area that has major health problems, according to every report that is published. The people in the east end become quite upset when they read such reports. I admit that I have a passionate and personal interest in improving health care in my area. Procedures that can provide health benefits somewhere such as Shettleston can work throughout the country.

The Convener: Health boards are also represented. From Greater Glasgow NHS Board we have Dr Iain Wallace and Highland NHS Board is represented by Catherine Lush. I ask them to make opening remarks.

Dr Iain Wallace (Greater Glasgow NHS Board): Greater Glasgow NHS Board supports the principle behind the proposals. It is difficult to gauge the unmet need and therefore the demand that will result from the bill and to know how we will deliver the service by the due date in places with access difficulties. We need to be mindful of the costs that are associated with providing the service against those of existing and proposed commitments.

Catherine Lush (Highland NHS Board): NHS Highland also broadly supports the initiative, but the access difficulties that we in Highland are experiencing with dental services mean that the initiative must be taken in tandem with every opportunity to develop the team approach and to maximise the use of professionals who are complementary to dentistry. The initiative will compound demand when the service is creaking to meet existing demand.

The Convener: I will ask members for their questions. I believe that Mike Rumbles wants to ask about Optometry Scotland.
Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I welcome Optometry Scotland’s broad welcome for the bill. However, when I read some of its written submission, I was quite exercised. I will focus on one paragraph, which mentions the

“simple widening of access to a GOS sight test, the so-called ‘free eye checks for all’.

The submission continues:

“To put it bluntly, such a change would be seen as being implemented only for political purposes since it would confer no health gain on the people of Scotland and, therefore, OS could not endorse such a proposal.”

However, SPICe tells us that Optometry Scotland estimates that

“65% of patients are currently eligible to have GOS sight tests.”

Hal Rollason: That is correct.

Mike Rumbles: Is it the logic of the submission that if there is no health gain for 35 per cent of the population, there is obviously no health gain for 65 per cent of the population—because the only difference is that the individual pays for the test? I would like some clarification about that because the submission makes a stark point.

Hal Rollason: That is precisely the point. There would be no new tests done if people got them free rather than paying for them.

Mike Rumbles: That is not my question. Your submission says that there will be "no health gain".

Hal Rollason: That is because there will not be any more tests done. That is what is behind that statement.

Mike Rumbles: So you are not saying that there will be no health gain. Surely it does not matter whether an individual pays for the test or not. There is health gain with sight tests.

Hal Rollason: There is health gain with the sight test. At the moment, it tends to be opportunistic health screening that occurs within a sight test.

Mike Rumbles: So when the written submission says that there will be “no health gain”, it is not correct.

Hal Rollason: Our submission really says that there would be no health gain because there would be no new sight tests performed as the result of some people getting it free.

Mike Rumbles: But you are admitting that there would be health gain.

Hal Rollason: There is health gain in any sight test or eye examination.

Mike Rumbles: Right. Thank you. That is just what I wanted to hear.

Kate Maclean (Dundee West) (Lab): I did not see that article because I was otherwise engaged. However, my understanding is that even people who are currently eligible for free sight tests do not necessarily take them up. For instance, 20 per cent of school pupils have undetected levels of visual impairment.

The standard GOS sight test that is available at the moment is not a proper eye examination. If the bill introduced the right to such a test it would not necessarily lead to earlier detection of eye disorders or reduce future instances of visual impairment or blindness. Therefore, I conclude that unless the Executive ensures that the eye examination is a proper one, there will be limited health benefits for people. In that case, because there are people who currently do not take up the free eye tests to which they are entitled, it would be better for public health to target the money at those people, rather than to spread it so thinly that there is no significant health benefit. Is that correct?

Hal Rollason: There is a significant number of people in any category, such as drivers who do not pass the sight standard for the driving test, or people with diabetes who do not take up the diabetic check. There are all sorts of at-risk groups that do not currently have proper care. We are really promoting health care. The idea of the eye examination came about during discussions with the Scottish Executive. We could target a proper, health-based examination that is appropriate to the patient’s symptoms.

Kate Maclean: So in your opinion, the groups that are most likely to get a health benefit from having proper eye examinations are the very groups that would probably not take up sight tests. I do not think that anything in the bill suggests that the sight test is compulsory, so those groups would need more assistance than just the availability of free sight tests.

14:45

Hal Rollason: There is certainly an education message that we have to get across to the effect that when someone goes for a sight test, it is based on legislation that came along 60 years ago that was largely designed to get specs for people who had come out of the war and were starting to work in offices. That is what the legislation that we work with at present was designed for.

We need legislation that acknowledges the fact that eye problems and general health problems can be detected in a routine eye examination or health examination. Those are the most important issues that we must focus on. Every day, I see somebody who comes in complaining about flashes and floaters, which might mean a retinal
between the charges to the patient and the costs might get increased take-up. The relationship were, because they were not clearly displayed. People did not understand what the costs people thought that costs were higher than they became quite apparent through our talks that were relevant at the time. Dentistry has moved on and we must focus much more on the prevention of dental disease than on the management of the disease once it has occurred. Most of the problems that patients will encounter in the oral tissues—tooth decay, gum disease and oral cancer—are preventable. Time needs to be spent with the patient to identify the risk factors among individuals and to deliver a proper oral health assessment.

By and large, all the costs of running a dental practice come out of the dentist’s income. One or two allowances have been introduced in Scotland, which have been helpful, but most of the costs of running dental practices come out of the income that is derived from the patients or from the NHS. It costs about £120 an hour to run a dental practice, so you can see how much time can be spent for £7.08. It is that time that requires to be funded—it is that time that dentists are prepared to give to their patients, and they are prepared to move into the private sector to deliver that type of health care.

A simple dental check-up is not what is required. What is needed is a proper oral health assessment that takes into account the patient’s general health and matters such as their diet—including their intake of sugary foods and fizzy drinks—and whether they smoke. If they smoke, they should be provided with smoking cessation advice or passed on to someone who can deliver such advice. Like optometrists, dentists are in a good position to identify conditions such as diabetes. All such work is part of the general health game and dentists must be part of that process.

The Convener: I will allow Mike Rumbles to come back in briefly.

Mike Rumbles: The bill is enabling legislation—all that it will do is extend the scope for the provision of free dental checks and free eye tests. It is clear that that is the case and that, when the
bill has been passed, the Scottish Executive will produce proposals on dental checks and eye examinations. Is it the professional view of the witnesses, as representatives of professional bodies, that the more people who can take advantage of professional examinations in the fields of dental health and eye care, the better we will all be? Do they agree that if everyone could have such access, that would be a marked improvement?

The Convener: Please be brief.

Andrew Lamb: In our written submission, we said that the British Dental Association supports that. There is no question but that removing the barrier of a patient charge will help patients to access dental care, although the problem is whether there is dental care to be accessed. You are right about the bill being enabling legislation.

Hal Rollason: There is not an access problem in optometry, because there are enough optometrists. There are more than 1,000 optometrists—850 full-time equivalents in about 850 practices—working in Scotland, so there is plenty of access. I welcome the idea of a new eye examination that is appropriate to people's needs and symptoms.

Mike Rumbles: For everyone?

Hal Rollason: Yes.

The Convener: Shona Robison wants to take up some of the access issues.

Shona Robison (Dundee East) (SNP): I have two questions. In its submission, the BDA says that because of the lack of detail it is "unable to provide comment on the Bill's objective that it will improve the oral health of the Scottish population."

That is a powerful statement. It is unusual for the committee to receive evidence that strongly questions a bill's fundamental objective and its ability to deliver its intention. Do you think that the mistake has been that the lack of ministerial statements about the Executive's intention has left a policy vacuum that makes it difficult to assess whether the bill will achieve its objective? It would be interesting to hear the Executive's response on that general point.

I have a more specific question. You talk about access, funding and the workforce. As things stand, will the Executive be able to deliver free dental checks in any form, whether simple or comprehensive? Given the barriers that exist, do you think that that commitment can be met?

Andrew Lamb: I think that that commitment cannot be met. It is important that the oral health assessment—I am pleased that the phrase "oral health assessment" is in the bill—is part of the overall modernising NHS dental services package but, as yet, we are not clear about what the Executive will do in that regard.

Shona Robison: At the moment, you do not think that that objective can be met.

Andrew Lamb: The British Dental Association does not believe that that objective can be met.

Shona Robison: Can we hear from the Executive?

The Convener: Wait a second. Helen Eadie has a point on the issue in question.

Helen Eadie (Dunfermline East) (Lab): My point follows on from what you said about the existence of a policy vacuum. Will you expand on that and on how you would like dental policy to develop?

Andrew Lamb: There are several issues. First, we must keep dentists who are working in the NHS in the system. That requires a fundamental review of the way in which NHS dental services are configured and delivered. That is what we are waiting for from the Scottish Executive. I have already emphasised the need to take the preventive approach. There is certainly still a need for repair and replacement of missing teeth, but we need to emphasise the preventive approach. Access to a comprehensive oral health assessment will certainly help to improve the oral health of the people of Scotland, if they can get access to such a service. However, there are workforce shortages and there has been question after question in the Scottish Parliament about such shortages—I do not need to advise MSPs of that fact—and about difficulties in accessing NHS dentists. Indeed, in some parts of the country, it is difficult to access any dentist, so there is a serious problem, but it is a complex one.

We have heard about the role of PCDs. It is important to examine that role; that is all part of modernising NHS dental services. However, the comprehensive oral health assessment has to be delivered by the dentist. The dentist has to determine the treatment or management needs of the patient, but if some time can be freed up by the dentist not doing some of the other work that a PCD could do, that will improve the access problems significantly. That is one element of the issue.

We have already heard about the need for a six-monthly check-up. As part of an oral health assessment, it is important to determine the appropriate time to recall a patient. The appropriate time might be three months or it might be two years. If more patients move from six months to a year or two years, perhaps that will also free up some time. That is why we need to consider the whole package. Mr Rumbles asked a simple question, and if a patient can access an
oral health assessment, that will improve the oral health of that patient.

The Convener: Nanette Milne and Duncan McNeil want to ask questions, and Martyn Evans would also like to comment.

Mrs Milne: To some extent, my question has been answered already. Research has shown that the incentives that have been used so far to attract dentists back to the NHS or to keep them working in the NHS have not really worked. Do you agree with that research?

Andrew Lamb: Yes.

Mrs Milne: Have you anything to add to what you have already said about attracting dentists back in or keeping them in the health service?

Andrew Lamb: No. The incentives have worked spasmodically and only in some areas. The Scottish Executive has tried, but it recognises that they are short-term solutions—we call them sticking-plaster solutions. You have to look at the whole package. Rather than incentivising dentists with golden hellos, the whole package of the way in which NHS dentistry is delivered must be appropriate and must suit the needs of dentists and patients. It is the patients who come first, and the dentists want to deliver proper oral health care.

There is no doubt that if the system is right, dentists will stay in it. What concerns me is that many dentists are opting out of dentistry completely when they reach their 50s. Our written submission refers to the fact that two thirds of the dentists who have been committed to dentistry as part of the team and support the principle that they should be allowed to work in all areas of practice. As I have said, dentistry has changed since the 1940s—it has become much more complex. The dentist should be required to identify the patient’s oral health needs—which we have already discussed—and to carry out more complex procedures. More straightforward procedures can be undertaken by hygienists and therapists, and we would certainly welcome their inclusion in the dental team. However, dental teams should be led by dentists, who should determine patients’ needs. The nation’s oral health will certainly be improved by the provision of proper diagnosis and treatment planning and prescription to professionals complementary to dentistry.

I would like to pick up on the issue of the Scottish dental access initiative, which has made available funding to allow dentists to set up practices in Scotland. The problem with that initiative is that it has not supported existing practitioners—I think that Duncan McNeil alluded to that. Practitioners who have been committed to the NHS for some time have been unable to access funding, but somebody coming in from outside could set up a practice 200yd down the road and access up to £100,000. The problem with the initiative is that it requires people to commit themselves to substantial work in the NHS for seven years. It is not inappropriate for the NHS to want payback for investment, but in the vacuum of not knowing what the NHS will look like next week let alone in seven years’ time, it is not surprising that the initiative has not been taken up. However, the profession as a whole certainly supports moves towards team working that includes professionals complementary to dentistry and the use of hygienists and therapists in appropriate circumstances.

Mr McNeil: But you see dentists as being the gatekeepers to the whole process.

Andrew Lamb: Absolutely—they must be.

Mr McNeil: Dentists deciding what would be appropriate would be the ideal. From that point of
view and in the light of the massive problems that there are in getting access to a dentist, what has your professional organisation done in the past year or so with the Scottish Executive and others to develop from the basis of the dentist being key and the team concept?

Andrew Lamb: Some of the things that we would like to see happening require legislative changes. The section 60 order has been delayed by the Westminster Parliament for another six months and proposals that we would like to come into place cannot do so until that legislation has been enacted. However, we are certainly discussing the future of NHS dentistry with the Scottish Executive and we are considering how professionals complementary to dentistry can be included within the modernisation framework. It might be more appropriate to ask the Scottish Executive about that matter.

Mr McNeil: As a representative of a profession who has something to say about the roles that people will fulfil, you have some responsibility to develop such roles as well as the professional organisation. We all have the public’s interest at heart.

Andrew Lamb: We are in discussions with Governments throughout the United Kingdom on how professionals complementary to dentistry—

Mr McNeil: Is there anything specific that you have done to bring about team working?

The Convener: I remind Duncan McNeil that the committee has discussed the section 60 order that has been referred to. You might want to refer back to what was said, as some things cannot be done until it is brought into place. I say that as a matter of recollection.

Mr McNeil: I am making the point that the difference between the British Dental Association’s written submission and the other submissions that we are considering today is that the other submissions show development and a willingness to see things change and they give some vision of people’s future roles. Although the dentists’ submission dwells on a lot of the problems, I do not think that it goes beyond them to give a vision of what dentistry will be like in the future.

Andrew Lamb: I reassure you that we will discuss the matter when we enter into discussions with the Scottish Executive over the modernisation of NHS dental services. The profession is training dentists and PCDs in a common environment, and the training arrangements for PCDs are now much closer within the training institutions. Undergraduate dental students are being trained in the same environment as PCDs, so that the young graduate will understand what the PCD can do. We are also looking at how the PCDs can operate within the primary care sector. It is all part of the overall package and, I am afraid, it involves some changes through a section 60 order.

Martyn Evans: The question is whether there is a capacity to deliver, now that the commitment has been made. Mr McNeil made my first point about professionals complementary to dentistry, which is in Professor Tim Newton’s paper on access to dentistry. We made that point at the beginning and it is very important.

My second point is that there is a treadmill, at the moment. Because of the fee payment structure, dentists have to see their patients more often and have to do work that is not clinically necessary. The bill will alter that fee structure. We do not know what the structure will be, but it will be de-linked from patient charges. As we said at the beginning of our evidence, that is an important and progressive measure.

My third point concerns something that has not been mentioned—the local commissioning of services. Local commissioning, which is referred to in the bill, will allow a more flexible approach to be taken towards dental services and might well impact positively on the capacity to deliver. At the beginning of our submission, we say that we welcome the removal of the barrier of cost to looking at the initial inspection of teeth and eyes. We think that that is necessary but not sufficient to deliver access to services. There is a capacity issue, but we think that other things in the bill will help to create the capacity to deliver.

Kate Maclean: I have a brief question about the capacity to deliver. Andrew Lamb said earlier that, although under the current system everybody has a six-month check-up, that would not be necessary. People could have a three-month check-up or a two-year check-up, depending on circumstances. Would that be complicated to introduce? Would it affect the capacity to deliver the legislation?

Andrew Lamb: It is not complicated to introduce that; it requires the oral health assessment. It is a matter of identifying the risks to individual patients and determining, through consultation with the individual patient, when it is appropriate to recall them. As time goes on and a dentist gets to know the patient better, that period could be extended if the dentist knows that there are no risks involved—or it might have to be shortened. It is all part of the oral health assessment.

We will address in the next section the other issues that the patients’ representative has raised. However, dentists are not carrying out unnecessary treatments; there is plenty of treatment out there that needs to be done, without dentists carrying out unnecessary treatment. The problem is in providing the care that the patients need. If dentists could spend more time in
assessing the patients’ needs and perhaps preventing tooth decay by giving them dietary advice and so on, they might not take the current preventive approach, which is to cut a cavity because they are not sure whether something is going to become more significant if it is left for any length of time. If there was a proper review period, they would be able to decide whether a cavity needed to be cut. At the moment, the system does not allow dentists to take the preventive approach that is required. That situation needs to be changed, and we hope that the Scottish Executive will deliver that type of change in its programme.

The Convener: One or two questions have been indirectly put to the Executive official. Dr Wilson, I do not know whether you want to make any comment or whether you want to leave that until the final round-up session with the minister.

Dr Wilson: Certain points would be best dealt with in the final discussion with ministers. Nevertheless, I confirm that ministers have recently said that a response to the consultation on the modernisation of NHS dental services will be produced very shortly.

My only other point is that the bill’s provisions on oral health assessment and eye examinations were intended to underpin the discussions to which Andrew Lamb and Hal Rollason have referred. The intention behind the bill is to move us forward and not to leave us stuck in the NHS’s origins, as both representatives have said.

The Convener: We have covered many of the issues that I had expected would arise when we dealt with sections 12 to 14. As a result, instead of going through the whole process again, I ask whether anyone has any further comments on these sections, which deal with various changes to the provision of dental services.

Joyce Shearer: At the moment, parents are responsible for their children until they leave school. However, the number of people leaving school is huge. If, as one of the witnesses has said, those people had their dental assessment just after they left school and before they entered adulthood, dentists would be able to carry out more preventive work instead of having to deal with people who wait until much later in adulthood to visit them with problems that have arisen much earlier. The bill could target specific age groups. For example, university freshers weeks provide wonderful opportunities for examining young people’s oral health before they set out on a career pathway.

The Convener: Do the health board representatives want to comment on sections 12 to 14?

Dr Wallace: No.

The Convener: So you simply stand by your previous comments on targeting.

Dr Wallace indicated agreement.

Martyn Evans: We welcome the assistance and support that health boards will be able to give dentists. For example, in our study on access to primary care services, dentists were the least physically accessible. Indeed, 75 per cent of the dentists whom we reviewed were located up a flight of steps. The dental profession will have to address a whole raft of legislation. This particular provision will lead to a reasonable public investment in more accessible services. We are also in favour of co-locating services, but we think that the bill represents a significant start.

Andrew Lamb: We welcome the removal of the link between patient charges and payments to dentists. As a result of the proposed legislation, a greater percentage of practices’ income will not be derived from patient charges. We also welcome some direct reimbursement for premises, equipment, materials and so on.

Allowing health boards to determine the provision of oral health care services would provide a useful means of delivering that care to areas that suffer from such problems. In that respect, I hope that that there will be a Scotland-wide policy that can be locally implemented.

We have not yet mentioned access to secondary care, which is an area where local health boards could come into their own. One particular way of delivering specialist services could be extended into the primary care sector. The use of clinical networks and dentists with special interests in the primary care sector would benefit both patients, as it would give them access to services that they perhaps do not have at the moment, and dentists. One of the problems of recruiting particularly young dentists in so-called remote and rural areas is the sense of isolation and lack of support from their peers and the secondary care sector. As a result, working in a clinical network, which the local health board could set up, would be of benefit.

That said, Professor Tim Newton’s report has highlighted the lack of information that is held by health boards. If the proposed legislation is going to work, health board chief executives and chairpersons must be aware of the dental agenda and the strategic need to deliver dental services in their area. It is important that the Scottish Executive engage at a high level with health boards. Down the ladder, there is a problem with delivering dental services within the available funding. However, we must still engage with key people in health boards to ensure that they understand that dentistry is an important aspect of health care delivery in their area. That will be...
crucial if we are to deliver dental care in the so-called remote and rural areas. It will be helpful to allow health boards to support dental practices in some way other than through fees alone, and separating the dentist’s income from what the patient pays is another way to do that.

15:15

**Catherine Lush:** I support the concept of flexibility for boards. Within NHS Highland, we have already enjoyed an element of flexibility in contracting with general dental practitioners to provide emergency dental services, which has been beneficial for patients in that they have been able to access care locally. Some flexibility at board level will be an important catalyst for change in service delivery.

I flag up the issue of premises. My vision for the future modernisation of dentistry is that dental services will be delivered in much larger teams. I expect dentists to continue to head up the teams, but we will make much better use of professionals complementary to dentistry, who will need premises. The dental therapists and dental hygienists will need to work in surgeries, so the challenge is not only to create the workforce and skill it up, but to ensure that we have the premises for the workforce to work in. We in NHS Highland are beginning to look at that, because we consider it to be a major challenge for the next 10 years. We need to have a premises strategy to ensure the sustainability of services.

On access to secondary care dental services, if significant numbers of patients cannot access primary care dentistry, they also cannot access secondary care support and advice. Dentistry is different from medicine, in that most people have a general medical practitioner. General medical practitioners make some direct referrals to hospital dental services, but a huge group of patients cannot access secondary dental services, so the creation of an intermediate skill layer in primary dental care is essential, and I support the BDA in that.

**Dr Wallace:** I was not going to say anything, because I agree with all that, but the co-management schemes that section 14 allows and the flexibility to have personal dental services, community dental services and GDS working together with salaried GPs are important. Our experience in Glasgow with sedation services and services for the elderly is that such flexibility is beneficial in targeting particular groups.

**The Convener:** I see that Hal Rollason from Optometry Scotland wants to speak, but the sections that we are discussing are about dental services.

**Hal Rollason:** I was going to make some comments about access, which is highly important in optometry and dental services. We consider access all the time. It comes back to the idea of education and of advertising the fact that services are available.

**The Convener:** That exhausts our discussion on sections 9 to 14. We move on to sections 15 to 17, which extend the list of those covered by disciplinary procedures to other dental and ophthalmic service professions. I invite the patients’ representatives to comment at the start of the discussion.

**Martyn Evans:** The Scottish Consumer Council approves of the extension. We think that it is sensible to have provisions on fitness to practise and to have all those who are practising on a list. We approve of the idea that somebody who is debarred from practising locally should be barred from practising in other areas—if a practitioner is a danger to patients in one area, they might be a danger to patients in other areas. We also approve of the disclosure requirement for new entrants to the list and want to know why those who are on the list currently will not be subject to the same disclosure requirement, as it is in patients’ interest to know that there is nothing for them to be concerned about in relation to a person’s fitness to practise.

All in all, sections 15 to 17 make it clear who will be subject to the NHS disciplinary procedures. At the moment, only principals are on the list and so are subject to the disciplinary procedures, so extending the list makes great common sense.

**The Convener:** Ms Shearer, is there anything that you want to add?

**Joyce Shearer:** Not really, except that the length of time that disclosures take can disrupt services.

**The Convener:** What are the views of the professional bodies? Are you content with the proposals in the bill in this regard?

**Andrew Lamb:** You have our written submission and we are content with the proposals.

**Hal Rollason:** Our only comment was that the proposals should happen in the least bureaucratic way possible so that extra expense will not be incurred.

**The Convener:** Martyn Evans asked why the requirement does not extend to existing list members.

**Martyn Evans:** As I read it, there is a requirement for someone coming on to the list to make a disclosure, but that is not a requirement on someone who is already on the list.
The Convener: Will the Executive official clarify whether that is a fair reading of the bill? If so, why was the provision drawn up in that way?

Dr Wilson: I will come back to the committee on that.

The Convener: Thank you. Are the health boards happy that what is proposed is workable?

Dr Wallace: We certainly support the proposals because they introduce greater accountability for the professions. There will need to be a modest increase in administration to work the lists.

The Convener: Those sections appear to be relatively uncontroversial, with the single exception of the issue that Martyn Evans raised on which the Executive official has agreed to come back to the committee.

We move on to section 18, which deals with pharmaceutical care services. The representatives from the dental and optometry bodies can now leave and we will have a changeover of witnesses.

I welcome Mary Morton, the acting chief pharmacist in NHS Highland; Alex MacKinnon, who is the head of professional services development at the Scottish Pharmaceutical General Council; James Semple, the chairman of the Scottish Pharmaceutical Federation; and Chris Naldrett, team leader of the primary care division in the pharmacy issues team of the Scottish Executive Health Department. Eric Gray, also from the Scottish Executive, gets a bit of a break.

We will go through the process again. I invite the patients’ representatives to make any specific comments on section 18.

Joyce Shearer: I have one issue to raise about prescribing practices. A doctor can obviously prescribe—

The Convener: Mrs Shearer, you will really have to speak directly into the microphone because people are not picking up what you are saying. Try not to turn round and look at me; I know it is difficult because I am really easy to look at.

Joyce Shearer: The point I want to raise is about prescribing. If someone goes to an optician, the optician cannot prescribe an antibiotic. The patient has to go back to their GP, so their journey is disturbed. Equally, there seems to be a discrepancy between what a dentist and a doctor can prescribe. I would like to think the bill would address prescribing issues, to lessen the patient’s journey because of trips back to their GP, in particular from the optician.

The Convener: That will be difficult, because this section is to do with pharmaceutical care services. A question about prescribing perhaps ought to have been directed to the dentists and the optometrists, but they have gone now. I do not know whether others can comment, or whether we can find a way to return to the issue.

Martyn Evans: I have a comment on the more proactive role that health boards will now have in planning pharmacy provision in their areas. We were much more supportive of the Office of Fair Trading report “The control of entry regulations and retail pharmacy services in the UK” than were the pharmacy profession and others. It had some partial answers to the lack of competition and some of the access issues. We welcome the increase in planned provision that is in the bill.

We would like greater clarity on the national standards that might be applied possibly not in the bill, but in the regulations that follow. The first example that we gave in our written submission was services in supermarkets, which the Office of Fair Trading report found were open longer than community pharmacies—79 hours compared with 50 hours. We would also like clarity on national standards for pharmacy services in places such as railway stations and airports. Both those examples are being dealt with in the English context.

Overall, under the current system, provision is unplanned and is based on the existing services that pharmacies provide. The bill represents a move towards more planned provision, which is welcome. It perhaps does not go as far as we would like it to, but we welcome it.

The Convener: Does the Scottish Pharmaceutical Federation want to comment? Obviously, the issue is pretty important for your business.

James Semple (Scottish Pharmaceutical Federation): Sure. Would you like me to comment specifically on that point or generally on the bill?

The Convener: You can comment specifically on section 18, then pick up the point that Martyn Evans raised.

James Semple: On section 18, we broadly support the proposed legislation. We are happy that the Executive has not gone down the route
favoured by the National Consumer Council, which was the OFT route of having a free market. The best idea is for health boards to maintain the ability to plan services properly and to put them where they are needed, not just where the nearest honey pot is to which all contractors will rush to make money.

On services in supermarkets and railway stations, within a planned system there would be an ability to put services where there is an appropriate need, so that would not be a problem.

Alex MacKinnon (Scottish Pharmaceutical General Council): The Scottish Pharmaceutical General Council welcomes the opportunity to give oral evidence. As a member of the team that is negotiating the new contract, we fully support the policy intention of modernising NHS community pharmaceutical care services. We fully support "The Right Medicine: A strategy for pharmaceutical care in Scotland".

This is all about improving patient care. We fundamentally support the overarching aim of improving patient care through better use of pharmacists’ key skills. The proposals represent a major service redesign and a major change in the way in which community pharmacists work. They will move from providing pharmaceutical services to providing pharmaceutical care services. I fundamentally believe that we will reposition community pharmacy as an integral part of the modernising primary care team.

Because we do not have the detail of the regulations and directions, there are some concerns. Throughout our submission, we take the view that where something is agreed on a national basis according to national service frameworks and standards, that should not be diluted as it goes down through the boards. It is important that we have a national set of criteria and guidelines against which the pharmaceutical care services plan can be formulated. We stress that community pharmacy is involved in a participative and positive way, as one of the key stakeholders in the delivery of the plan.

Our other main concern centres on how a new contract will be granted in future, because it is highly likely that the current criterion, of assessing the need for a contract on the ground that such a contract is necessary or desirable, will go. Because we do not have the detail of the regulations, we are unsure what that will mean for community pharmacy. However, we fully support the need to address areas of underprovision throughout rural Scotland and in areas of extreme social deprivation.

We fully support the listing arrangements under which non-principals and principals will be fully accountable for their actions. In fact, such listing is best practice; it encourages best clinical governance.

Our colleague from the Scottish Consumer Council raised the subject of choice and also mentioned England. In rejecting the Office of Fair Trading recommendation, the Scottish ministers did not reject competition and choice. They made a pledge and commitment to the people of Scotland to improve patient care and access. The fact is that 85 to 95 per cent of community pharmacies’ work involves the NHS contract and not their retail business.

What does the word “choice” mean? In England, the word is used as a noun: choice probably means another 100 new pharmacies that could, I agree, sell paracetamol at a cheaper price. It will mean 302—or thereabouts—PCTs all having a different community pharmacy contract—

15:30

The Convener: Excuse me, but what is a PCT?

Alex MacKinnon: It is a primary care trust. There are more than 300 PCTs in England and part of the English contract will be left to the decision-making process in each primary care trust. Where does patient choice, post-code inequality and the need to get rid of such inequality fit in a system like that?

In Scotland, the word “choice” is used as an adjective. Choice means the delivery of quality and consistency. The new community pharmacy provision in Scotland will try to deliver core, essential services across every community pharmacy in Scotland. We want to make a fundamental difference to the health of the people of Scotland through their pharmaceutical care.

The Convener: We move on to the health boards. Given the specific issues that relate to the situation in remote and rural areas, I invite Highland NHS Board to go first.

Mary Morton (Highland NHS Board): NHS Highland broadly supports the policy of implementing pharmaceutical care plans and enabling boards to plan the delivery of pharmaceutical care services across their area. As Alex MacKinnon mentioned, it is extremely important that national guidelines are set so that all boards can consider the needs in their individual area in the same way. That is how we will develop a plan for the delivery of services in our area.

Obviously, given the issues of remoteness and rurality in the Highland area, we have a broader difficulty in providing services across our area. We welcome the opportunity to plan pharmaceutical services instead of being at the beck and call of
individuals who might or might not want to provide services in the area.

**Dr Wallace:** Pharmaceutical care services plans are a good thing. That said, it is inevitable that the plans will place an additional requirement on boards. Health boards should have the ability to provide or contract cost-effective services. That would give us choice about where we go for such services. It would also allow us to provide supplementary services in areas where there are gaps: methadone dispensing in Glasgow is one example of that. Greater Glasgow NHS Board believes that the plans are a good thing.

**The Convener:** Mr MacKinnon went on to talk about the pharmaceutical care services contracts in section 19 and the extension of the list in sections 20 to 21. Do you want to comment on those sections or to respond to what Mr MacKinnon had to say?

**Dr Wallace:** We support the amendment of the 1978 act that section 19 proposes, in particular proposed new section 17S(1). Some work is under way at the moment on a definition of "supervision" and we would like to see the conclusion of that work. We also welcome proposed new section 17T(3) of the 1978 act, under which we would see a move towards the incorporation of standards in contracts. As I mentioned, boards will require additional capacity to monitor aspects of the contract, but we support the proposed amendments to the 1978 act.

**The Convener:** Does Highland NHS Board want to say anything about the sections that deal with the pharmaceutical care services contracts and the pharmaceutical list? You might not have a comment—please do not feel obliged to make one.

**Mary Morton:** Broadly, NHS Highland supports all the comments that were made in the response from the Royal Pharmaceutical Society of Great Britain and the vast majority of those that came from the Scottish Pharmaceutical General Council. The bill will develop the ability of community pharmacy to provide the services that patients require by extending use of the workforce. I hope that that will give us the ability to provide the services that the public require.

**The Convener:** Mr Semple, you originally confined your comments to section 18. Given that we seem to have drifted on to the other sections, is there anything that you want to add in respect of the pharmaceutical care services contracts and the extension of the pharmaceutical list?

**James Semple:** I reiterate the point that Alex MacKinnon made. Although we completely support the thrust of the bill, the devil is in the detail. We need to wait until we see the regulations, as that is where the day-to-day problems might arise. We warn against the law of unintended consequences. Ideas that look good might in the long term affect the stability of what is currently a hugely effective network of pharmacies that dish out hundreds of thousands of prescriptions every day in a safe, effective manner. Representatives of the profession must be involved at all points in the process. Hopefully, at the end of the day we will get a new contract and make "The Right Medicine" work.

**The Convener:** Does Martyn Evans want to comment on the other sections of the bill?

**Martyn Evans:** We welcome and have no problems with the extension of the list. I would like at some point to comment on the planned provision of pharmacy services.

**The Convener:** Now would be a good time to do that.

**Martyn Evans:** I am concerned to make it as clear as possible that, although there are issues with the physical location of pharmacies in rural areas, there are competition issues in a range of other areas in Scotland, related to opening hours, quality of service and facilities. James Semple said that the devil is in the detail. The bill does not say how contracts will be arranged, and that affects a significant part of the service that pharmacies provide to the public. The Office of Fair Trading saw competition issues being raised, but planned service issues—how we plan for better service in local areas—are also raised. In its report, the OFT found that there were local pharmacy services monopolies whose delivery of services to the general public did not differ significantly. Where there were fewer pharmacies, especially in rural areas, the quality of service was lower. A smaller range of services was provided, because competition was not present.

The Office of Fair Trading saw competition as the solution to the problem. It argued that, if the control-of-entry requirements were removed, there would be greater competition. Despite what James Semple thinks, we did not fully support that approach. We said that there must be either more planned provision or more competition—the status quo would not work. We welcome what is planned, but we say that the devil is in the detail of how it will work.

We would like to see national standards. There are issues that cannot be decided in 15 different ways if there are not to be 15 different ways of providing the service. It is important that there should be national standards for supermarket services and for the provision of service at points of transition. Although we are generally in favour of competition, our research shows the value that is placed on pharmacy services. We support "The Right Medicine" as a way forward. There is much
support in community pharmacy for working within that agenda. However, we must bear in mind the fact that the current system of having a static market, which we are moving away from, has not helped to improve the quality of service that is delivered to the public.

The Convener: Janis Hughes has indicated that she would like to come in. One or two other members have also raised their hands. Before Janis asks her question, can Mr Naldrett say whether he has any indication of when the regulations will be available to us?

Chris Naldrett (Scottish Executive Health Department): We are working on the assumption that we will need something for stage 2. We are doing preparatory work on the regulations.

The Convener: So the regulations will be available at some time between now and our first stage 2 session.

Chris Naldrett: The regulations will be skeletal in parts and quite full in others. It will take a while to produce them, because we are still in the process of negotiation. The committee will appreciate that some contract conditions will still be the subject of negotiation in the summer.

Janis Hughes (Glasgow Rutherglen) (Lab): I have a question for the Scottish Pharmaceutical General Council, specifically on section 18 of the bill. In your submission, you say that you have grave concerns about

"The potential to allow for unilateral variations"

in the regulations, which at the moment say that a health board may unilaterally vary the terms of the contract. What kind of conditions do you think should be included in the contract, if you do not favour the use of the word "unilateral"?

Alex MacKinnon: The word "unilateral" has too broad a meaning and does not tie the matter down. We are working towards delivery of the four core service elements that we want to be present in every community pharmacy in Scotland. Could there be a way of changing the conditions or of tweaking them after they have been agreed? I cannot give a specific example, but I find that the broad meaning leaves too many openings for a contract to be changed at a later date, which worries me.

Janis Hughes: The alternative to using "unilateral" would be to be specific about what it is intended the legislation will allow health boards to do.

Alex MacKinnon: We are probably seeking engagement and collaboration with the profession in order to achieve a change in a service. There should be a negotiated change, if there has to be one, rather than a health board imposing change. The appropriate word is, perhaps, "engagement".

Janis Hughes: That is helpful. Thank you.

Mary Morton: I want to pick up on Martyn Evans’s point about extended hours. Currently, the contracted hours of community pharmacies tend to be 9 until half past 5, with an hour off at lunch time. The additional hour for which some stores are open is beyond the terms of their contracts with health boards. I would not like the committee to think that quality of service equates to the opening hours of the service. I hope that we will, in the new community pharmacy plan, be able to consider what out-of-hours services are required, and to ensure that they are available in appropriate places across the area, rather than stipulate that they should be in supermarkets or whatever.

Martyn Evans: I understand the issue about contracts, but there is some confusion in my mind. One route down which one goes to find better services is the competition route. A variety of competing organisations find out what the public want and what makes a successful business. As somebody said earlier, 80 per cent of pharmacies’ income is from the NHS; therefore, the pharmacies are a service of the NHS.

The other way to find better services is to have a centralised planning system. However, centralised planning has not worked well in Scotland; we do not have a good history of it, so we must be careful about how we plan services and ensure that they are not dominated by the professional interest. I acknowledge that the professional interest is important, but it is only one interest among a wide variety of interests in the community. This goes back to access to primary care services. One of the key criticisms came from working people who cannot access pharmacy services when they want them because of the lack of competition within pharmacy.

I support the move towards a more planned service; however, it should not just be about the physical location but about the quality of service. I agree with Mary Morton: the question is not just about opening hours, although opening hours and other services, such as home delivery, are important to patients. The evidence is that there has been less competition in those respects in the past, especially where small chains have a monopoly on local services. Increasingly, pharmacies are becoming expensive to buy. They cost about £500,000, and the only way someone can enter the profession is by buying a pharmacy. There is a capacity-to-deliver issue at the moment in dental services. Pharmacy may have a capacity issue in the future because more and more young pharmacists are unable to buy pharmacies. The pharmacies will be taken over by bigger
businesses which, as in the Office of Fair Trading’s report, buy locally and then have local monopolies.

**The Convener:** Two members are waiting to ask questions. I will bring you back in after them.

**Mr McNeil:** I am keen on developing the role of community pharmacists and getting them back into the communities of which they used to be an integral part. I accept the benefits of competition and the convenience of going to a supermarket, but supermarkets are for people who have cars. Some people are automatically excluded from that choice because they live on estates. I would like to be encouraged to think that pharmacists—or local chemists, as they would be known in my area—will return to such areas. What would encourage them to do that?

A wee bit of explanation of the top of page 3 of the Scottish Pharmaceutical General Council’s submission is needed, because it seems to describe a barrier. I need an explanation of the different methods of provision. The submission refers to the principles of “The Right Medicine: A strategy for pharmaceutical care in Scotland” and talks about delivery "by a mixture of supported, salaried and managed service provision".

What are the differences between such forms of provision? What are the pluses and minuses? What will encourage more re-engagement with marginalised communities and allow them the benefits of a local pharmacy?

15:45

**Alex MacKinnon:** I will go back one stage and touch on out-of-hours access, which is a big issue that we intend to address in the new pharmacy contract and will be part of the planning process of a pharmaceutical care services plan. Some health boards are already piloting creative and innovative ways to improve access and out-of-hours access to pharmaceutical care, which will all be part of the process.

The key strengths of community pharmacy at present are its position in the community, its accessibility and the fact that people do not have to make an appointment with a pharmacist, who can probably be accessed for advice within five or 10 minutes maximum. I have been a pharmacist for 30 years. We truly believe that the only way to make a significant difference to the nation’s health from a pharmaceutical care point of view is to have some services agreed and delivered in every community pharmacy.

I suggest that if we are 100 per cent committed to resolving under-provision in an area, that should not involve a partial contract; the people in such an area deserve more than just part of a service. The point that I have tried to make is that there is concern that if we use different bits of the service to deliver different bits of an overall service package, the people in a deprived area might not receive the full spectrum of pharmaceutical care services. Services such as management, a chronic medication service, a public health service with advice and even diagnostic testing must be delivered where any pharmaceutical care services are provided. We must provide all the services if we want to get rid of postcode inequality in pharmaceutical care for the patients of Scotland.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** The questions that arise in my head about competition and the health boards taking over supply of pharmaceutical services relate to the British Medical Association’s concerns about doctors dispensing. Dispensing by doctors is an advantage to patients in rural areas, but the situation is a worry for doctors, who receive an extra fee for dispensing, which is an enhancement that encourages doctors to work in areas to which it is difficult to attract them. I ask somebody to comment on how the proposal will affect dispensing practices.

I also wonder about security. When I started to work in general practice, chemists’ shops were open late, but as security became a problem, fewer chemists have opened late, so people have had to travel considerable distances to obtain prescriptions after a certain hour. That is difficult for people who have no car.

Another advantage to patients relates to prescribing. Some pharmacists are allowed to prescribe in line with protocols and agreements with doctors. I think that some dentists, orthoptists and what have you might also be able to prescribe, but I certainly know that some pharmacists, especially those in rural areas, can already do so. The proposed changes might be a good idea, but what will happen when the pharmacist goes on holiday? Will the service still be provided to the community if the doctor is not available? Will the locum pharmacist be able to prescribe? Has that been considered?

**Dr Wallace:** I defer to Mary Morton on rural issues.

On access, I hope that opening hours and locations of pharmacies will be considered in the pharmaceutical care services plans. We will need public involvement and engagement in developing those plans; community health partnerships’ patient participation forums could be one of the main ways of engaging with the public on that.

Clearly, more work needs to be done on the core elements of the pharmacy contract and I do not want to second-guess what those should be.
However, as I said, I think that health boards will want a narrow remit for provision of services such as methadone dispensing. We will not want to be constrained to provide the whole service, but we will want to be able to provide a niche service in areas where a contractor cannot meet demand.

Mary Morton: I agree with Iain Wallace’s point about services such as methadone dispensing. My understanding is that, if a dispensing practice can meet the pharmaceutical care needs that have been identified in a rural NHS board’s area, the NHS board would use that practice for provision of those services. I expect that practices that currently provide such services will continue to do so, but the process of deciding who should provide which service will need to be very open. There will need to be a level playing field for all, whether or not that causes discomfort to various individuals. It would certainly cause discomfort to community pharmacists if they felt that a new entrant could threaten their patch, so I can quite understand that there might be some discomfort for dispensing practices. However, we do not yet know the detail of how it all will work. I welcome the flexibility that the new system will provide.

James Semple: I want to reply to Martyn Evans, who made a good point about how local monopolies might previously have resulted in poor service by failing, for example, to provide home deliveries and all the other things that people tend to do when they are competing against each other. However, he has missed the point about the new contract’s fundamental change, which is that we will no longer be paid a piece rate for sticking labels on boxes. Once we start to be paid for delivering quality services, the driver will not be not so much to do things better than the guy down the road but to get paid, because we will no longer be paid simply for sticking labels on boxes. That is why I think that the issue he highlighted will not be a problem any longer.

Alex MacKinnon: On prescribing, I think that pharmaceutical prescribing will be key to the success of the new pharmacy contract. Under the new contract, it is intended that the minor ailments service that has been piloted by Ayrshire and Arran NHS Board and Tayside NHS Board will be rolled out across Scotland. By enabling pharmacists to write prescriptions for products from a national formulary for the treatment of minor ailments of exempt patients, access to medicines for such patients will be improved. We now have more than 200 qualified supplementary prescribers who can work with GPs on certain conditions by amending doses and so on. Supplementary prescribing will also be key to the planned chronic medication service, which will incorporate the model schemes of pharmaceutical care. Our vision for community pharmacy is that, further down the line, we will have independent prescribing pharmacists. That will only enhance pharmaceutical care for the people of Scotland.

Dr Turner: What will happen when pharmacists are on holiday? Has that been worked out—

The Convener: I remind Jean Turner that she is supposed to direct her questions through the chair. She must ask her question in a way that allows the rest of us to hear it.

Dr Turner: Sorry. My question is about what will happen with locums. The prescribing pharmacist might provide a good and effective service on which the community depends but, if the service is specific to a pharmacist, will there be difficulties when he goes on holiday if the locum is not a prescriber? Has thought been given to that issue?

James Semple: That is a good question, which goes back to what we said about national standards. We have to upskill everybody. At the moment, people might have done emergency hormonal contraception training, for example, in one health board, but not in another. Once we get national standards—I speak also as an owner of a locum agency—the locums will have to show what they have done and will be sent only to places where it is suitable for them to work. That can be handled easily.

Martyn Evans: I want to make a point about pharmacies in areas of multiple deprivation and low-income areas. The most important aspect of pharmacies is their convenience. At the moment, pharmacies tend to cluster around general practices, because that is where people get their prescriptions and they want to have them dispensed fairly quickly. We do not believe that having more choice of pharmacies in supermarkets and travel stations will reduce the convenience of pharmacies near general practices; they will still be attractive. The issue is that sometimes a local pharmacy will move out of an area because the GP moves out of the area. Co-location and planning of services are important to us.

Secondly, there are provisions in the bill to relax the requirement for a pharmacist to be present on a variety of occasions, which we think is a more modern approach to pharmacy provision. We accept that there was sense in the pharmacist’s being present in the place where pills were dispensed when, as in the old days, the pharmacist physically made up pills. Now sometimes, if a pharmacist goes away and conducts a short consultation in a private room, dispensing cannot take place, so we think that the bill makes more modern provisions in that respect. Although patient safety will be maintained, the bill will allow greater flexibility in delivery of a modern pharmacy service.
Alex MacKinnon: The new pharmacy contract in Scotland is different from that in the rest of the UK, because it could involve patient registration. The issue of clustering around health centres will not be so important in the future in that the patient will register with the pharmacy of their choice to receive a package of pharmaceutical care.

The Convener: We have heard frequently this afternoon that the devil is in the detail. I do not know whether the devil’s representative wants to make a final comment.

Dr Wilson: You have heard from Chris Naldrett about the regulations and we accept that more detailed work needs to be done. On planning, which was mentioned a number of times, the intention is to produce national guidance on the local planning process. Boards also have a responsibility to plan for primary medical services, so there is therefore the opportunity to ensure complementarity, which is relevant to the point about dispensing doctors, who are not covered formally by the bill but by the Primary Medical Services (Scotland) Act 2004. That has not changed and it is not intended that provision of those services will be affected directly. Indeed, there is an opportunity for the two professions to work together more closely than they have done in some areas in the past.

On supervision, the Medicines Act 1968 determines the nature of, and requirements for, supervision by pharmacists; we are partly dependent on that. On prescribing, the number of healthcare professionals who can prescribe either independently or in a supplementary sense is increasing, which will add to the complexity of the relationships within primary care between community pharmacists and those who are prescribing. The detail must take account of that.

The Convener: I thank all the witnesses for coming and everybody else for participating. That ends our public businesses.

15:59

Meeting continued in private until 16:27.
1st March 2005 (6th Meeting, Session 2 (2005)), Written Evidence

SUBMISSION BY FORTH VALLEY LOCAL HEALTH COUNCIL – MRS MARGO BIGGS

Part of Bill: Part 4
Main Objective: Strengthening disciplinary powers over health professionals

Do you agree with the main objective of this part of the bill? YES

If yes, why?
This strengthening of disciplinary powers is necessary in view of recent events in the NHS (not only Shipman). There is a need to get away from the “old boy network” – patient safety should be the main concern. If something which raises suspicion is noticed by anyone from domestic staff to consultant that person should feel able to report it, therefore a culture of “whistle blowing” should be encouraged.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY THE BRITISH DENTAL ASSOCIATION

Part of Bill: Part 4
Main Objective: Strengthening disciplinary powers over health professionals

Do you agree with the main objective of this part of the bill? Yes

If yes, why?
The BDA supports the roles proposed for the NHS Tribunal and NHS Boards in the Bill, subject to the comments below.

If not, why not?

Not applicable

Are there any other comments you would like to make?

The BDA has no objection to standardising NHS disciplinary procedures, but the legislation does not address how they will relate to the role of the General Dental Council and its Professional Conduct Committee, nor of other professional regulatory bodies. We would be keen to avoid the situation where FHS practitioners might be undergoing at the same time more than one set of disciplinary procedures for the same case. The BDA believes any decisions by NHS Boards or the NHS Tribunal should not prejudice or contradict the role of the Professional Conduct Committee of the General Dental Council.

NHS Boards’ general dental services lists also include Salaried General Dental Practitioners (SGDPs) as well as independent contractor general dental practitioners. SGDPs, whilst covered by the General Dental Service Regulations, are also covered by local disciplinary procedures through their employers. It is imperative this arrangement, and how the two disciplinary procedures will interface, are acknowledged to ensure salaried dentists do not have to undergo more than one procedure.

The BDA hopes the legislative changes would eliminate all the serious shortcomings of the present system and facilitate efficient and expeditious resolution of all disciplinary cases, in the best interests of patients and of practitioners.
Whilst recognising the need to protect patients it is also important that the legislation recognises the rights of practitioners and their rights to appeal.

We feel it is important to emphasise the importance of the responsibility for maintaining the accuracy and confidentiality of any information submitted to NHS Boards and for ensuring the grounds for disclosure of such information are clearly defined.

We feel it is necessary for a legal definition for the new ground for suspension “of protection of the public interest”

SUBMISSION BY BMA SCOTLAND

Smoking, Health & Social Care Bill: Part 4: Discipline

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

Introduction
The BMA welcomes the general principles of Part 4 of the Smoking, Health and Social Care (Scotland) Bill which aims to harmonise aspects of the disciplinary procedures of family health service practitioners and introduce greater measures to protect patients.

Professional regulation
The BMA is concerned that there is no recognition within the Bill, explanatory notes or policy memorandum of the role of professional regulatory bodies such as the General Medical Council (GMC). The BMA continues to work closely with the GMC to create efficient, safe and fair disciplinary procedures for the profession and we would urge the Health Committee to seek assurances that any changes to NHS Tribunals as a result of this Bill will be consistent and compatible with existing regulatory procedures for all of the professions falling under the remit of the NHS Tribunal.

Changes to the NHS Tribunal
The BMA has no objection to extending the remit of the NHS Tribunal to cover all independent contractor health care professions and to introduce procedures that ensure the public interest is protected.

The BMA also accepts the need for the additional ground of disqualification – unsuitability by reason of professional or personal conduct. However, there is a lack of detail on the definition of these new grounds and we would wish to see this clarified within the legislation. The GMC (and other professional regulatory bodies) has clear definitions for such conduct and these could be adapted for use by the NHS Tribunal.

Removing the sanction of local disqualification by the NHS Tribunal would seem sensible in protecting the public interest, and national disqualification would ensure that a family health service practitioner who is unsuitable to practice in one area is unable to practice elsewhere in Scotland.

Summary
This Bill creates an additional ground for disqualification by NHS Tribunals and removes their ability to suspend practitioners locally.

While we support the general principles underlining Section 4 of the Smoking, Health and Social Care (Scotland) Bill, the BMA would like to see greater clarity on the definition of what constitutes “personal conduct” (e.g. conduct which might reasonably demonstrate material harm or threat to patients).
SUBMISSION BY ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN SCOTTISH EXECUTIVE

Part of Bill: Part 4

Main Objective: Strengthening disciplinary powers over health professionals

Do you agree with the main objective of this part of the bill?

The Society is totally supportive of the intention to protect patients from health care professionals who are unfit to practice.

If yes, why?

The Society is the regulatory body for all pharmacists throughout Great Britain and has extensive experience of investigating complaints about individuals and pharmacy companies, and taking appropriate action to protect the public. It fully endorses the functions and responsibilities of a Modern Regulator as set out in the Kennedy Report and is in the process of modernising its disciplinary processes through a Section 60 Order under the Health Act 1999. The extension to the NHS disciplinary processes outlined in the Bill will be complementary to those exercised by the Society, but we have some concerns about their effectiveness, which are outlined below.

If not, why not?

The Bill considerably extends the disciplinary roles and responsibilities of Health Boards and the NHS Tribunal. It is essential that these duties are discharged equitably, efficiently and effectively, and that there are clear links with the disciplinary processes of the professional regulatory bodies including the Royal Pharmaceutical Society of Great Britain. We appreciate that much of the detail will be contained in regulations and guidance, but wish to be assured that the following issues will be addressed.

• Investigation of complaints. The Fifth Report of the Shipman Inquiry was critical of the lack of investigation of complaints against doctors. The Society has a team of 18 Inspectors who regularly inspect community pharmacies and investigate complaints relating to pharmacists and pharmacy services, taking evidence to legal standards. This is an essential component of an effective disciplinary process, but there is no reference to it in the Bill or accompanying documents.

• Timescales for the process. It is important that the stages of the disciplinary process are undertaken within reasonable periods of time, both to ensure prompt action to protect the public and to respect the rights of the health care professional subject to the process. The latter aspect is important given the new power of Health Boards to suspend practitioners pending application to the NHS Tribunal. (Incidentally, paragraph 107 of the Policy Memorandum states, ‘Any practitioner subject to suspension proceedings will have the right to a hearing and, if suspended, will continue to be paid.’ As the majority of pharmacists subject to this process are employees of pharmacy companies or self-employed locums it is not clear who will be responsible for paying them when they are unable to provide NHS services.)

• Consistency of approach. Health Boards will be able to suspend practitioners from their own lists on the existing ground of patient protection and on a new ground of protection of the public interest. The NHS Tribunal will be able to inquire into cases referred under a new ground of unsuitability by reason of professional or personal conduct. These new grounds are very broad and open to wide interpretation. It is essential that clear and specific guidance on these terms is provided to avoid inconsistent application of the process, resulting in inequitable treatment of practitioners and inevitable legal challenge.

• Available sanctions. It is proposed that the NHS Tribunal will have two sanctions available to it: substantive or conditional national disqualification. We suggest that these two alternatives may not be adequate to deal appropriately with the considerably extended range of cases that the Tribunal will have to consider. Cases where a practitioner’s ability is impaired by health problems need particular consideration.
• Linkage with regulatory bodies. Neither the Bill nor the accompanying documents make any reference to the role of the professional regulatory bodies or their disciplinary processes. The existence of two parallel but unconnected systems creates possibilities for confusion and delay and consequent risk to the public. As the regulatory body for pharmacists who will be subject to the revised NHS disciplinary processes in Scotland the Royal Pharmaceutical Society of Great Britain is keen to ensure that this does not occur and that the two systems are complementary. This can be secured through development and implementation of formal Concordats or a Memorandum of Understanding between the Society and NHSScotland. This would set out arrangements for co-operation on disciplinary matters concerning pharmacists, including mutual exchange of information and evidence, and we request that this becomes a statutory obligation through the regulations.

• Cross-border information exchange. We have previously referred to the need for a consistent approach across Scotland and this applies equally to national boundaries. It is particularly important for patient protection that there is an effective mechanism for sharing essential information about the conduct of a health care professional between UK NHS services to prevent individuals disqualified in one country from providing services in another.

Are there any other comments you would like to make?
No

SUBMISSION BY SCOTTISH HAEMOPHILIA FORUM

The Skipton Fund arose only as the result of the campaigning in Scotland by the Scottish Haemophilia Forum, the Motion supported by 80 MSPs from all parties, the unanimous support of the 1999-2003 Health Committee of the Scottish Parliament and the decision of the then Health Minister Malcolm Chisholm who announced to Parliament in January 2003 that he was thinking making payments of £20,000 to those infected with Hepatitis C as the result of Blood Products or Transfusions.

Sadly since then, the work of the Scottish Parliament appears to have been hi-jacked by Westminster. On the 29th August 2003 Malcolm Chisholm announce that he would be making ex-gratia payment of £20,000 and a short time after this John Reid Health Minister announced that the Westminster Parliament would follow Scotland’s example. Regrettably this announcement stated that the dependants of those who had died prior to 29th August 2003 would be excluded.

Following the announcement three meeting were held in London the first on the 14th October 2003 at the Department of Health Offices in Skipton House (thus the Fund has been named after a building rather than acknowledge the role of Scotland). These meeting consisted of a senior civil servant from each of the four countries of United Kingdom, the Chief Executive of the Haemophilia Society and myself as Chairman of the Scottish Forum, the Chief Executive of the MacFarlane Trust and representatives from two other organisations.

At this first meeting despite requests that a minute of the meeting be taken this was resisted by the civil servant from the Department of Health who undemocratically took the role of chairman.

From the onset it was apparent that there had been a dialogue prior to the meeting between the civil servants from the Department of Health and the Chairman and Chief Executive of the MacFarlane Trust thus the meeting was faced with a fait accompli that the MacFarlane Trust take on the responsibility of administering the now to be known as the Skipton Fund. At this meeting about two hours were spent on draft application forms that had been prepared by the MacFarlane Trust!

Prior to the next meeting which was held on the 26th March 2004 the Skipton Fund had been registered as a private company and without consultation had appointed four directors all who were trustees of the MacFarlane Trust. At this meeting there again was a request that minutes be taken given that there was a need of a record and an understanding how decisions would affect applicants.
The final meeting to my knowledge was held on the 17th May 2004. At this meeting notes relating to the meeting of the 26th March 2004 were circulated but the chairman was not open to questions regarding inaccuracies. It is our opinion that these notes were only made available as the result of a question raised by a MSP in the Scottish Parliament. Unfortunately no notes have been circulated in respect of this meeting.

It is our understanding that other meetings took place during the same period these consisted of Hepatologists (liver specialists) the Haemophilia Society at short notice was asked to nominate a Haematologist (blood specialist) it is uncertain whether this consultant attended more than the first meeting. We are uncertain whether there has been any meaningful consultation with the United Kingdom Haemophilia Centre Directors Organisation (UKHCDO) and the Government Departments drawing up the proposals for Skipton.

Issues of Concern
We have grave concerns regard the proposals regarding the “Appeal Panels”.

It is uncertain whether the proposal in the next paragraph, regards Appeal Panels, announced had been made by Government or the Skipton Fund!

“The Appeals Panel would be constituted and convened consistently on each occasion that it met or deliberated on cases. The Panel would be Chaired by a legal professional such as a QC, and consist of lay representatives, a lawyer, a GP and a hepatologist. We expect the Appeals Panel to meet on a quarterly basis (at least for the first year or two) before a review of how the process has been working is carried out.”

1) Why is there a need to set up a private Company limited by guarantee given that its function will only be to administer the Fund by sending out application forms, making payments based on a set criteria and rejecting others?
2) Given that Skipton will be funded by public finance, why is it not part of a Government Department thus ensuring that a Minister be politically responsible and answerable to elected members?
3) As a Private Company funded by public finance, how and who will monitor the Fund?
4) Why has the money provided as an ex gratia payment, to people infected with Hepatitis C through NHS Blood, being used to pay the staff of Skipton?
5) In the event of an Appeal Panel being set up how will the panel members be funded?
6) In other situations where a person has been refused a payment by for instance Disability Living Allowance by the Department of Works and Pensions, the Appeals Panel are appointed independently by the Department for Constitutional Affairs and funded by the Appeals Service.
7) Membership of the Panel, why a GP rather than a haematologist, given that most of the appellants will have been recipients of blood transfusions or products.
8) Generally the majority of patients, seen by hepatologists involved in the field of Hepatitis C are due to a choice of life style. (Scottish Executives statistic state that there are 568 people in Scotland infected with Hepatitis C as the result of Blood) Therefore some concern has been voiced.
9) Will all members of the Appeals Panel be recruited in the same way?
10) Will the legal members be recruited acknowledging different legal systems in the UK?
11) Will there be recognition that lay member should have an understanding of the issues and experience of Hepatitis c. Rather than paid professional staff?
12) Where will Hearings take place?
13) Will the appellant be able to attend?
14) If the Hearings are being held for instance in London will appellants have their expenses met?
15) Will the appellant be able to have legal representation and who will meet the cost?
16) What expenses will be paid to Panel members and who will meet the cost?
17) How will appellants obtain expert opinion to challenge the decision of the medical panel?
18) Will all the documents used by the Skipton Fund in reaching a decision be made available to the appellant?

We note that within Part 5 of the “Bill” Section 24 sub section 5 “The Scottish Ministers may revoke or amend a scheme under this section” We would urge the Committee to recommend to the
Minister that the proposed figure of £50,000 recommended by the Scottish Executive’s Expert Group chaired by Lord Ross should substitute the proposal of £20,000 by Skipton.

We would urge the Committee to amend the “Bill” and remove the discrimination refusing payments to the dependants of those who have died prior to the 29th August 2003.

There are several concerns regards how different Consultants may deal with application to Skipton resulting in long delays for those who have applied.

We also are aware that some of the tests proposed to determine whether an individual meets the criteria for the second stage are flawed.

As previously mentioned we believe that the medical membership of the Appeals Panel should be a haematologist rather than a GP.

Philip Dolan
Chairman – Scottish Haemophilia Forum

SUBMISSION BY SKIPTON FUND

Skipton Fund is the company that has been established to administer the hepatitis C ex gratia payments scheme (“the scheme”) on behalf of the four health administrations.

The company was set up under the auspices of The Macfarlane Trust (“MFT”), which is a charity that was founded in 1987, funded by the Department of Health, to provide support to people with haemophilia who were infected with HIV through their treatment by the National Health Service. Some time after the announcement on 29 August 2003 of the scheme, MFT were asked by the Department of Health (“DoH”) whether they would be prepared to administer the scheme. In December 2003 the Trustees of MFT agreed to do so, subject to certain conditions, and proceeded during the early months of 2004 to work closely with officials from the DoH and the devolved administrations to design both the operating procedures of the scheme and the administrative vehicle.

Because the scheme was not a charitable activity, MFT could not directly undertake the task. A company limited by guarantee, Skipton Fund Limited (“Skipton”), was, therefore, set up as the most appropriate entity. In the interests of speed of implementation and, subsequently, of operation, and in order to make best use of the expertise of MFT in handling such a task, four directors were appointed who were Trustees of MFT, two of whom were appointed as such by DoH and two by the Haemophilia Society.

Following protracted development with the four health administrations of operating procedures, in particular the criteria for determining eligibility for receiving payment and an application form to ascertain for each applicant whether these criteria had been met, Skipton started operations on 5 July 2004. The choice of this date shortly before the summer holiday season led to some early operational difficulties, which were overcome in the autumn. Activity in Skipton is now running at a low rate.

Skipton is now staffed by an Administrator, Keith Foster, and one other staff member. All Skipton’s payments are made through the finance department of MFT, using proven systems. Frequent progress reports, of which the attached is the latest, are supplied to the officials of the four health administrations.

The scheme provides for payments of £20,000 (Stage 1) to those who meet the medical criteria that show infection through NHS treatment, and for subsequent payments of £25,000 (Stage 2) to those who infection has led to serious liver disease. The statistics show that there have been a small number of Stage 1 applications declined, some (137) because they do not fall within the scope of the scheme (and are not, therefore, eligible for appeal) and some (45) because of doubts that the medical eligibility criteria have been met (as when, for example, an applicant has a history of intra-venous drug abuse that might have been a source of hepatitis C infection).
very small number of Stage 2 applications has been deferred because the existence of serious liver disease cannot yet be proven; such applications can be re-submitted when further evidence of such disease is found.

An Agency Agreement is close to completion which will formalise the contractual arrangement between Skipton and the DoH (on behalf of the devolved administrations). An appeals process is also being developed.

Skipton Fund Position 14/2/05 (4/2/05)

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<tr>
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<th>Stage 1</th>
<th>Stage 2</th>
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<tbody>
<tr>
<td>Application forms dispatched</td>
<td>4,435 (4,433)</td>
<td>558 (533)</td>
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<tr>
<td>Paid</td>
<td>2,905 (2,880)</td>
<td>224 (218)</td>
</tr>
<tr>
<td>England</td>
<td>2,228 (2,190)</td>
<td>165 (149)</td>
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<td>172 (170)</td>
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<td>412 (405)</td>
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<tr>
<td>N Ireland</td>
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<td>6 (6)</td>
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<tr>
<td>and including MFT</td>
<td>347 (347)</td>
<td>16 (16)</td>
</tr>
<tr>
<td>Declined (Stage 2 deferred)</td>
<td>182 (189)</td>
<td>14 (14)</td>
</tr>
<tr>
<td>natural clearers</td>
<td>137 (142)</td>
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<tr>
<td>on medical criteria or infection date</td>
<td>45 (47)</td>
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<tr>
<td>Applications with queries</td>
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<td>9 (13)</td>
</tr>
<tr>
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<td>(Applications received as % of forms posted)</td>
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<tr>
<td>(Declined/deferred as % of forms received)</td>
<td>6% (6%)</td>
<td>6% (6%)</td>
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<tr>
<td>Stage 2 application forms despatched as % of Stage 1 forms received</td>
<td>17% (16%)</td>
<td></td>
</tr>
</tbody>
</table>

We continue to issue about 7 registration forms and about 20 Stage 2 application forms per week.

KJF 14/2/05
Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:04

The Convener: Item 3 on the agenda is continuation of our evidence taking on the Smoking, Health and Social Care (Scotland) Bill. Today we will hear oral evidence on two aspects of the bill. We will consider part 4, which deals with discipline, using the same round-table format as we used last week. When we take evidence on part 5, which deals with infection with hepatitis C as a result of national health service treatment, we will use the standard format of witness panels to which we are more accustomed.

The witnesses for part 4 are already at the table with us. At the outset, I inform them that witnesses who are called to give evidence by a committee are entitled to claim travel expenses. Does the committee agree to delegate to me authority for deciding whether any claims that arise from stage 1 consideration of the bill should be paid?

Members indicated agreement.

The Convener: As I said, the first session today will be in round-table format. I thank all the witnesses in advance for participating. I draw everyone’s attention to the paper that introduces the round-table approach and sets out how it will work. Members saw it at work in practice last week. The committee papers include background papers from the Scottish Parliament information centre on part 4 and all the written submissions, both from people who are present and people who are not here.

I invite the Executive officials to outline briefly the main provisions in part 4. Dr Hamish Wilson is head of the primary care division and John Davidson is from the workforce and policy division’s general medical services team.

Dr Hamish Wilson (Scottish Executive Health Department): At the moment, the National Health Service tribunal is the ultimate disciplinary body within the national health service for general practitioners, dentists, pharmacists and opticians. The tribunal’s main sanction is to disqualify a practitioner from membership of the list that the health board holds for his or her profession. It also has a power of suspension, pending the outcome of any case.

I will outline the main changes. The bill introduces a third ground for disqualification, in addition to those relating to efficiency and fraud—namely, unsuitability by reason of professional or personal conduct. Section 22 brings within the tribunal’s jurisdiction additional categories of persons, in particular those who assist with the provision of general dental services and general ophthalmic services, dental corporations, persons who perform personal dental services and registered pharmacists. That change follows on from the changes to listing, which were discussed a week ago.

Section 22 also removes the sanction of local disqualification and leaves only national disqualification at the hand of the tribunal. At present, the tribunal can only disqualify someone locally. The view was taken that that was inappropriate and that, if a disqualification were necessary locally, it would also be necessary on a Scotland-wide basis.

Section 22(7) introduces a new ground for suspension, when it is “otherwise in the public interest”.

Section 23 updates the provisions by allowing decisions that are taken elsewhere in the UK to be applied to Scotland.

The Convener: I ask the two patient representatives to comment specifically on part 4. Stewart Scott is the chair of Borders local health council and Margo Biggs is a member of Forth valley local health council.

Margo Biggs (Forth Valley Local Health Council): We welcome the new ground for disqualification. Our primary concern has always been about the linkage of information, so that incidents can be reported timeously and dealt with accordingly. That is my main comment.

Stewart Scott (Borders Local Health Council): We have heard what Dr Wilson said. We are talking about practising 21st century health care. There is no doubt that we need to match that with 21st century legislation that enables clear and unambiguous approaches to dealing with issues of suspension and discipline of all professional groups that are involved in health care. The public expect no less.

The proposals in part 4 provide a good basis for proceeding to amend and strengthen the disciplinary powers of boards and tribunals. Gone are the days when the majority of patients were passive recipients of health care, and there is a need for more active involvement of the public in decisions about disciplinary matters. I do not come from a medical background, but I wonder whether appraisals of general practitioners and others might be a good way of highlighting any shortcomings in their clinical skills or methods of practise. I do not see any mention of appraisals in the papers, but GPs are taking on board that new approach and they might well be a useful way of picking up on problems much earlier and allowing earlier progress to be made, rather than picking up on them later, when the damage has
been done. We all know the benefits of that.

The Convener: We move on to the witnesses from the various professional bodies. Dr Love might be the appropriate person to respond to Mr Scott’s comment on appraisals. With us are Alex Matthewson, who is north branch representative from the British Dental Association Scottish council; Dr David Love, who is deputy chair of the British Medical Association Scotland; Hal Rollason, who is chairman of Optometry Scotland; and Angela Timoney, who is chairman of the Scottish executive of the Royal Pharmaceutical Society of Great Britain.

I ask the four professional representatives to make specific comment on the bill, and I ask Dr Love to address Mr Scott’s specific concern.

Dr David Love (British Medical Association Scotland): Generally, the BMA has no objections to the Smoking, Health and Social Care (Scotland) Bill. We acknowledge the need for the new category of professional or personal conduct to be introduced. There have been instances in which persons who were clearly unfit to practise were not covered by the existing categories, so we accept the need for the new category. We also accept that it is common sense to drop the option of local disqualification and to ensure that disqualification applies nationally.

We have only one major concern, and that is the lack of a definition of professional or personal conduct. The policy memorandum states that the ground will apply if “a practitioner has been convicted of an offence, the nature of which suggests he or she no longer deserves the trust which is necessary”.

That is quite right, but the way in which the bill is written makes the ground a wide-ranging catch-all that could be abused and misinterpreted. It is terribly important for subsequent regulations and guidance to make it clear to both the profession and the tribunal what sort of professional or personal conduct could lead to disqualification of a GP’s right to earn a living, which is a severe sanction.

We also note that there is no reference to the professional regulatory body of GPs, which is the General Medical Council. It would be sensible for subsequent regulations and guidance to be compatible with current GMC guidance on what constitutes unsatisfactory professional or personal conduct, which I realise might change in the light of the review that is taking place following Dame Janet Smith’s inquiry into Shipman.

In response to Mr Scott’s particular question, GP appraisal as it is currently modelled and practised in Scotland is a formative educational exercise between the appraiser and the appraisee in which a doctor identifies priorities for learning in the following year and the appraiser assesses progress and compliance with that learning plan in succeeding years. It is not primarily a method of detecting poor performance or underperformance. If poor performance is thought to be an issue during appraisal, the appraisal process stops and the GP concerned is referred to the performance procedures that are in place at health board level, which might lead to referral to the tribunal. Therefore, appraisal is not the vehicle for instigating disciplinary procedures.

I say that with the large proviso that the whole business of appraisal and revalidation is being re-examined on a United Kingdom basis. The chief medical officer is examining the matter in England, as a result of the Shipman inquiry, so the GMC might change its position on the requirements for appraisal and revalidation in future.

The Convener: Mr Scott will have an opportunity to respond, but first we will hear from the other three professional representatives.

Hal Rollason (Optometry Scotland): I apologise for not submitting comments on tribunals earlier. I submitted a response from Optometry Scotland yesterday, but I understand that the committee will not have had a chance to consider it yet.

Optometry Scotland and the General Optical Council replied to the Scottish Executive consultation last June and broadly supported the Executive’s proposals. In the response that we submitted yesterday, we state:

“Optometry Scotland welcomes the harmonisation of disciplinary procedures of family health service practitioners, and as you would expect, we are firmly committed to the concepts of improving patient protection and optimizing NHS resources.

In general OS supports the future role envisaged for the NHS Tribunal but thinks that the policing of these proposals may be difficult. Consideration must also be given to the place of trainees and students since these people also have close patient contact.

OS does agree that all the primary care professions should be included in whatever scheme for fitness is produced, but there should be a realistic assessment of a practitioner’s risk profile. The various family health service practitioners will have very different degrees of patient contact and opportunity to cause harm to those patients. The Tribunal when assessing any one practitioner’s risk to the patient or the NHS must take this into consideration.”

The Health Committee might want a copy of the submission that the GOC made to the Scottish Executive consultation. Yesterday I was in contact with the registrar, who has sent a note to the Scottish Executive that it will pass on to the committee shortly.

In our response to the committee, we also say:
“It might be extremely difficult to decide whether a person is a fit person following a conviction that does not result in a successful prosecution. It may be more appropriate for the National Regulatory bodies to be the arbiter and take responsibility for the character of their registrants. It may be more appropriate for Health Boards to refer suspected people to the regulatory body rather than to a whole new system of investigation. This would give a consistency of approach throughout the UK.”

We have some specific reservations. One relates to paragraph 107 of the policy memorandum, which suggests that, while a practitioner is suspended, they will continue to be paid. However, if an optometrist is unable to work, he cannot generate any income and so cannot be paid. That is a slight difficulty.

Another reservation concerns paragraph 114 of the explanatory notes, which states that a body corporate may be suspended or disqualified on the grounds of fraud or unsuitability. I understand that that is already the case, but we think that it is slightly unfair. In our response to the committee, we disagree with the proposal and argue:

“Each situation would need careful investigation before making a decision, as it would be unfair to punish an entire organisation for the act of a single individual”

in that organisation. The submission continues:

“A corporate body may have a large number of practices”

and a few directors,

“but could be disqualified in total, based on the actions of one or two people. The actions of one individual may be unknown to anyone else in the company

“or may be malicious in their intent.”

In conclusion, we state:

“OS would not support an extra layer of administration if it duplicates tasks already performed by the National Regulatory Bodies, or which such bodies could easily assimilate.”

However, we understand that the tribunal is concerned specifically with NHS issues and that the regulatory bodies deal with all issues.

As Margo Biggs said, there need to be clear lines of communication between the national regulatory bodies and the NHS tribunal. We think that it is important and advisable that the family health service practitioner groups are closely involved in any policy development or review that follows on from this.

Angela Timoney (Royal Pharmaceutical Society of Great Britain): This is a good time for pharmacy. A lot of changes are happening in the profession. “The Right Medicine: A strategy for pharmaceutical care in Scotland” has been in place since 2002 and the profession supports that strategic direction and the new services that are now being delivered.

It is the view of the Royal Pharmaceutical Society of Great Britain that parts 3 and 4 of the Smoking, Health and Social Care (Scotland) Bill are inextricably linked.

The society is the professional and regulatory body for pharmacists. That dual role is unique in the health care profession. It means that we have responsibility for pharmacists’ undergraduate training, their entry onto the register, standards of practice and assessment of competence. If things go wrong, we are able to identify that at an early stage and provide support, which picks up on the point that the Borders local health council representative made. Where that is not successful, disciplinary proceedings and the ultimate sanction of removal from the register might result. The society has more than 150 years’ experience of providing both regulatory and professional input.

As I have said, our view is that parts 3 and 4 of the bill are linked. Last week, when the committee discussed part 3, which deals with pharmaceutical care services, many people around the table stated that there is a need for nationally agreed standards to ensure that there is not inequity in the provision of services across Scotland. The society has extensive experience of setting standards and of developing practice guidance, and we would like to be involved in that and in developing and commenting on the regulations. It is our view that the next stage is then assessing competence against those standards. Part 4 would apply where there are problems with monitoring those standards, as it relates to the disciplinary proceedings that might be invoked.

The society is totally supportive of the intention to protect patients from health care professionals who are unfit to practise. We endorse the functions and responsibilities of a modern regulator that are set out in the Kennedy report and are modernising our disciplinary processes through a section 60 order under the Health Act 1999. The Kennedy report talks about the functions of a modern regulator as being not simply to deal with discipline and sanctions but to deal with proceedings from undergraduate training right through, to ensure that, at every stage, people are fit to practise and that, when things go amiss, corrective action is taken at an early stage.

We feel that the NHS disciplinary procedures that are outlined in part 4 will be complementary to those exercised by the society and that there should be clear links between the NHS tribunals and the regulatory bodies so that those duties can be discharged effectively and efficiently. We have an inspectorate within the society that inspects community pharmacies and checks to ensure that they meet professional standards and have safe systems of work. It also responds to complaints, so we are both proactive and reactive in our responses to problems in the profession.
In undertaking that work, inspectors know at an early stage when something is amiss and can intervene on behalf of patients and pharmacists. It is our view that the regulations that follow the bill will need to ensure that there are two-way links between the NHS and the society, so that we can deal appropriately with professionals.

The timescales involved in such processes are another reason why that is important. It is necessary to have streamlined and efficient processes to ensure patient safety and to protect professionals. The committee might be aware that, last week, the English Minister of State for Health announced plans to tackle the cost of long, drawn-out disciplinary procedures for doctors and dentists in England, following a Public Accounts Committee report that suggested that the cost was around £40 million, because of the costs of legal fees and of paying people when they are suspended. It is important that the detailed and complex disciplinary systems and procedures are effective and efficient.

We have a busy agenda so I will conclude. We express our support for taking forward NHS tribunals, but the society wants to work with the committee on parts 3 and 4 of the bill to ensure that the regulations work effectively for patient safety.

Alex Matthewson (British Dental Association Scottish Council): I promise members that there has been no collusion with the other people at the table, but the committee will see from the British Dental Association’s submission that we also agree with the general principles of the bill and the part about discipline. There is no harm in going over the issues again. The reason why we like the bill is that it will strengthen the disciplinary powers, because we have no truck with underperforming dentists or people who are a disgrace to our profession. We realise that there are some anomalies just now that the bill will iron out.

We are unhappy about one or two things. The professional conduct committee of the General Dental Council is already looking into areas where discipline is necessary. There should be some mechanism whereby the tribunal and our professional bodies can work together in harmony.

We are pleased about the removal of local disqualification. We feel that disqualification should be national.

The power of suspension is an interesting one. The policy memorandum refers to

“protection of the public interest”.

There is a need for a definition to go along with that. We know that the General Dental Council has a strong definition on that area of indiscretion and malpractice. Some extra words are necessary in the bill.

One or two witnesses have referred to the fact that, according to the policy memorandum,

“Any practitioner subject to suspension proceedings will have the right to a hearing”—

which is fair—

“and, if suspended, will continue to be paid.”

General dental practitioners are paid on an item-of-service basis. If they do not work, they do not earn, so that has to be clarified.

We understand the measures on removal from dental board lists. However, we are concerned that the confidentiality and accuracy of reports should be maintained and ensured in case of innocence. We are almost talking about people already being guilty. We want to ensure that when a spurious allegation is made against a doctor or a dentist and the matter is all cleared up, no aura of suspicion hangs over them.

The Convener: Before we move on to the open session, I ask Mr Davidson whether he has anything to say about the payment of opticians and dentists while suspended because, clearly, both professions have an interest.

John Davidson (Scottish Executive Health Department): Suspension was introduced for doctors, dentists and so on in about 1996. At that time, we introduced the principle that, if a practitioner was suspended, he would continue to receive his net income from the health board. The provisions for that applied only to the classic example of a principal GP but, clearly, we can build on that principle and try to ensure that anyone who is suspended receives their net income. We will consider that.

The Convener: The issue comes down to who pays the net income.

Hal Rollason: There is no net income if we do not work. There are no capitation fees or anything like that for optometrists.

John Davidson: We stated that a GP’s income would be preserved as far as possible. We would take into account the fact that he did not have any practice expenses during the time he was suspended. That is why we used the expression “net income”. We consider that the health board will ultimately pick up the cost, because it is the health board that decides to suspend.

The Convener: Does that clarify things for the dentists and opticians?

Alex Matthewson: Not really, because “net income” does not carry much meaning for me. As a general dental practitioner, I have vast expenses that I have to continue to pay, even though I am not working.
Hal Rollason: The same applies to me. I work with a pre-registration trainee optician—if I do not work, they do not work and nor do any of the other practice staff.

14:30

Dr Wilson: There is no disagreement about the principle that while somebody is suspended, they should continue to receive an income. The practical problem that we face with some contractors is determining what exactly the income should be, because normally they earn their income in a particular way. One can consider a practitioner's historical earnings to determine their average earnings. As with some other issues, practical work needs to be done to follow up the matter. We need to work out with the individual professions a fair way of remunerating suspended practitioners.

Angela Timoney: I am pleased to hear what Dr Wilson says because pharmacy has a particular problem. As the committee discussed at its previous meeting, we have pharmacists who are contractors, but who employ pharmacists within a pharmacy. For instance, Boots has employee pharmacists. If an employee is suspended by the pharmacy, for instance, Boots has employee pharmacists. If an employee is suspended by the NHS, it would not seem reasonable in many situations for Boots to pay. We need discussions about appropriate remuneration for such people.

The Convener: Clearly, the issue needs to be resolved.

Members have more general questions. Shona Robison wanted to ask about professional conduct.

Shona Robison (Dundee East) (SNP): I am particularly interested in the comments from Margo Biggs of the Forth valley local health council, who is sitting beside me. Her written evidence mentions the "need to get away from the 'old boy network'" and states that "patient safety should be the main concern." I am sure that we all agree with that.

Margo Biggs continues: "If something which raises suspicion is noticed by anyone from domestic staff to consultant that person should feel able to report it, therefore a culture of 'whistle blowing' should be encouraged." Obviously, the bill has limits and it may not achieve that culture, but will it go some way towards allaying those fears? More generally, what needs to happen beyond the bill to achieve that aim?

Margo Biggs: The bill will improve matters by helping to create a culture in which causes for concern are shared and in which it is not felt that, by bringing concerns to public attention, a person is in some way being disloyal to their profession. Dr Love mentioned Dame Janet Smith's Shipman inquiry. One of her suggestions was that patients should be asked to comment on their level of satisfaction at various stages of their treatment. That would improve matters further. It is all very well with hindsight after Shipman to raise issues such as the concerns that relatives may have felt at the time, but patients and carers must be more involved throughout treatment.

We also need more robust record keeping, to which I alluded previously. Another suggestion in Dame Janet Smith's findings was that health boards should have robust databases through which people, including patients, would be able to access practitioners' track records. That sets alarm bells ringing because it is similar to league tables in education and because people may make judgments on false bases, but we must have more transparency and more of a culture in which concerns are not seen as a betrayal of colleagues.

Shona Robison: What do the representatives of the Executive say on the general point about how patients and the public fit into disciplinary matters? I know that it is a difficult area, and that there is a balance to be struck, but the same point was made earlier by the representative from Borders local health council, who was talking about the involvement of the public in disciplinary procedures. Is that something that the Executive has considered? If so, what form could that take?

Dr Wilson: I would separate complaints from discipline as the two procedures are separate in Scotland. You will be aware that a revision of the complaints procedure in Scotland is already under way, which would strengthen the role of organisations such as the successors to health councils in the investigation and pursuit of complaints. That may itself be subject to review, depending on the outcome of Shipman 5. Work is already under way on modernising and making more effective the complaints procedure.

If a case comes to discipline at health board level, the discipline committee that hears the case—which will be heard at a health board that is not the health board where the offence may have taken place—will consist of lay people as well as professional people. There is already involvement there. On an NHS tribunal, one of the three members is a lay person: its chairman is a legally qualified individual, there is a member of the profession and there is a lay member. Lay members are actively involved in the formal procedures. As Margo Biggs and Stewart Scott said, significant effort is made at local level to catch problems early, so that we avoid going down the discipline route wherever possible.
As Dr Love will know, work was carried out two or three years ago on poorly performing doctors, which resulted in a procedure that allowed for earlier identification of problems, much of which comes from information provided by patients. That procedure is implemented in such a way as to avoid going down the discipline route and to provide help and support to the individual practitioner, so that problems do not escalate and become disciplinary matters.

**Shona Robison:** Does that happen routinely, or were you referring to a specific case?

**Dr Wilson:** A procedure is now in place.

**Shona Robison:** Will that be applied consistently in every case?

**Dr Wilson:** Yes—where poor performance is identified. Dr Love referred to that in his remarks on the appraisal system, which is separate but parallel.

**Hal Rollason:** Optometrists probably work at the most retail-oriented end of the health service. Many optometry companies send out questionnaires in which one is asked to gauge on a 1-to-10 basis how good the test was, what explanations were given, what happened and what the handover to the dispensing optician was like. We might not want to go down a wholly formal, league-table version of that with information being collated by the health board, but I see no reason why doctors, dentists or other health professionals could not do the same.

**The Convener:** Surprise, surprise—Dr Love wishes to come in at this point.

**Dr Love:** One of the major requirements under the new GP contract is to carry out a patient survey, part of which involves feedback on the doctor’s performance. The surveys solicit feedback from, on average, 50 randomly selected patients who are seen in normal surgeries. A validated questionnaire is used—it is independently analysed—which is retained by the GP and put in the revalidation folder, after which it will be examined as part of the appraisal and revalidation procedures. It is all beginning to happen.

A point was made about information on individual doctors being more readily accessible. That recommendation was about the General Medical Council’s database, not health board databases. It was felt that the GMC should make it much clearer what doctors’ past records were and what information the GMC holds on them.

**Alex Matthewson:** To put Mr Scott’s mind at least partially at rest, there are already two routes to looking after the concerns of the patient as far as the dental profession is concerned. One is through health boards, which have dental practice advisers who do practice inspections, which could involve an assessment of cross-infection control, of the premises or of record keeping. In other words, anything that “would seriously compromise or disrupt the efficient delivery of local health care” could be looked into at local level.

Secondly, the dental part of the practitioner services division has district reference officers who assess five cases on the basis of the quality of the work that was delivered. Put very simply, patients are asked how the dentist did. If the dentist’s work does not pass muster or if there is one bad reference, that triggers a series of five or so inspections. I should point out that the references are graded 1 to 4, where 4 is the worst. If there is a 4, the matter could be referred to the General Dental Council and disciplinary action could result.

**Mrs Nanette Milne (North East Scotland) (Con):** If I have understood things properly, the witnesses believe that the NHS tribunal and the professional regulatory bodies need to work together in a complementary way instead of duplicating one another’s work. In its submission, the Royal Pharmaceutical Society of Great Britain says that such an approach “can be secured through development and implementation of formal Concordats or a Memorandum of Understanding between the Society and NHSScotland.”

I wonder whether Ms Timoney would care to elaborate on that statement, and whether other witnesses think that that would be the way forward.

**Angela Timoney:** In my introduction, I mentioned that our inspectors visit every community pharmacy and check the premises and professional standards. That enables us to identify at an early stage whether there are problems.

A memorandum of understanding between the society and the NHS would allow us to have an agreement about what information could be exchanged when moving from a support function to concerns and disciplinary issues. Such an approach would protect patients and allow us to have more efficient processes. Because NHS tribunals rely on patient complaints, other concerns might not come to the surface or result in a complaint. For example, when we investigate certain matters, on the one hand we need to find an appropriate way of feeding into systems and, on the other, the NHS must give us certain information. After all, as other witnesses have pointed out, we are dealing with people outside the NHS as well as people within it.

**Mrs Milne:** How does that fit with the thinking of the other professional bodies?
Dr Love: I am not certain that most cases will reach tribunals via complaints. Although that might happen, many cases could arise as a result of court convictions. However, the anxiety is that no one knows what is meant by the phrase “by virtue of professional or personal conduct” in the bill. The tribunal and practitioners have to know what it means, and we are simply flagging up that most of the professional regulatory bodies already have fairly copious guidance on what constitutes satisfactory and unsatisfactory professional and, indeed, personal conduct. In fact, the GMC produces a constant stream of booklets that we are all meant to read. They are usually very helpful and set out a clear framework of what is or is not acceptable. We need to link that guidance with the regulations that will guide tribunals.

The Convener: Perhaps the Executive officials can tell us about the definitions of misconduct.

Dr Wilson: I confirm Dr Love’s point that we see the need to be more specific in guidance about some of the words that are used in the bill. That said, I must point out that some of those words are consistent with the text of legislation south of the border. No definitions have been needed in that regard; moreover, professional regulatory bodies also provide a good deal of background information. We intend to produce guidance that will follow through the bill’s enactment and provide clear examples of professional and personal misconduct, public interest and so on.

14:45

Mrs Milne: I would have thought that the last thing that we need is duplication of all the books that the British Medical Association brings out. It will be good if the regulations make the system simpler so that there is clear understanding and no duplication. Have the other witnesses anything to say?

Hal Rollason: I agree. We want to avoid duplication of tasks, and it is important to share information. Optometrists think that they are onerously dealt with by their regulatory body, compared to some of the other professions. That is just a personal opinion, which the body knows about. The most important things are sharing of information and protection of the public.

Alex Matthewson: There is a burgeoning industry in all things concerned with standards: NHS Quality Improvement Scotland has just brought out a draft standard of dental practice. The re-accreditation and revalidation that is required every year to be a practising dentist is getting more and more onerous. Various amounts of postgraduate work—far more than used to be the case—must be done every year and we still have practice inspections that examine everything from our hepatitis B status to the nature of our toilets. We are being examined all the time and, a bit like the optometrists, we feel that we are being spied on every corner and that it is not possible to get away with anything nowadays, although that is as it should be.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): There is a crossover in what you were talking about. I was going to go into the details of the provisions on unsuitability by virtue of professional or personal conduct, but we have discussed that. The Scottish Pharmaceutical General Council suggests in its submission that “unsuitable to be on the list” would be a better phrase. In some ways, that seems to me to be vague as well, although the SPGC’s criticism of the other wording was that it was too broad and open to interpretation.

How much are the witnesses worried about the workforce? Perhaps enough optometrists are working to cover all the hoops that they have to go through nowadays. How concerned are you about having sufficient people to cover all the extra postgraduate work that has to be, and is, done and about the fact that young doctors and pharmacists who are in training will be open to disciplinary proceedings and might be making mistakes? Will you elaborate on that? It has a bearing on future recruitment, because people might be scared to work in a profession that is unclear about how it labels people as being unsuitable. How would that work out?

Hal Rollason: There is no workforce problem with optometry, which is attracting a good number of entrants to all the universities that provide the course. Optometry Scotland has felt for some time that students and pre-registration trainees should be covered for their own and patients’ protection as much as anything else, so we have no issue with that. We are pretty well regulated. Optometric advisers—who do regulatory work on the submissions that we make for payment—work locally for health boards and NHS National Services Scotland, which used to be called the Common Services Agency. Workforce and regulation are not problems.

Angela Timoney: I will speak on behalf of pharmacists. We do not have a problem with people being interested in becoming pharmacists or with recruiting to the profession, and the calibre of people that we want to recruit should want to be regulated and to practise to the highest possible standards. I have no concern about that, but the RPSGB has codes of ethics and practice, and I would be concerned about duplication. I would like it to be the case that what the RPSGB considers
to be appropriate personal and professional conduct meets the standards that the NHS tribunal sets so that pharmacists do not have to go down parallel tracks and so that there is no dubiety between the two sets of standards. Therefore, we need to work together on developing the regulations to make them efficient.

**Dr Love:** Can I comment on doctors and training? There is an issue about the regulatory process in respect of weeding out unsuitable people before they do damage. There is also a debate about whether the GMC should extend its remit to undergraduates; however, clearly that is nothing to do with the bill. There is a workforce issue about increasing appraisal procedures, which involves a large number of doctors taking time away from patient contact and carrying out appraisals on another large number of doctors who also have to take time out from patient contact. Appraisals are worthwhile exercises, but there is a service delivery problem that has not been played into the workforce calculations—certainly not for GPs.

**The Convener:** There has been quite a lot of discussion about the existing regulatory bodies and the new system. I wonder whether Dr Wilson or Mr Davidson can tell us what are the links between the new system and the regulatory bodies.

**Dr Wilson:** It is an opportune time to consider the matter. All the national regulatory bodies have been reviewing their own procedures and how they operate—not just because of Shipman, but because of a series of other factors. We want to ensure that the system is fair to patients and to practitioners, so the proposals that have come from all the professional bodies for harmonising procedures and making them complementary to one another are important. We will want to pursue those proposals, following the passing of the bill.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** We have concentrated on discipline and referral not being specific, and we have heard it conceded that referral will be more specific when the time comes. What concerns me is the vulnerability of patients in relation to some of the thought processes that were engendered by discussion made me wonder about the SPGC's written submission states:

“SPGC suggests that only those carrying a six-month prison sentence i.e. those offences of a serious nature should be reported.”

Does that mean that it is okay for a drunk driver, someone who beats his wife or someone who abuses a child to be a family health service practitioner? What does that mean? Would that power be triggered only by a six-month jail sentence?

**Angela Timoney:** Those comments were made by the Scottish Pharmaceutical General Council, which is a separate body from the Royal Pharmaceutical Society of Great Britain.

**Mr McNeil:** Oh. I am sorry. It was not you.

**Angela Timoney:** As a regulatory body, we may take a different view from that.

**Mr McNeil:** Nobody supports that view.

**The Convener:** Ms Timoney is saying that the regulatory body takes a different view.

**Mr McNeil:** It is here, in the evidence that is in front of us.

**The Convener:** I appreciate that. Unfortunately, we do not have somebody from that organisation present.

**Mr McNeil:** What a pity.

**The Convener:** Perhaps that is something that we could explore in writing. Do members have any more questions for the witnesses, or do the witnesses feel that anything has been missed out?

**Margo Biggs:** This is possibly not totally relevant to today’s meeting. In general discussion, possibly because of the last week's media coverage, particularly the campaign in *The Herald*, the regulation of NHS 24 sprang to mind. I wonder how it feeds into the system whereby people are acting in some ways independently. I do not know whether that is relevant.

**The Convener:** It is quite a good question.

**Dr Wilson:** NHS 24 is not covered by the provisions that we are talking about. I am unable to comment further on the issues surrounding NHS 24; all I can say is that the provisions we are talking about refer to those who are on the list to provide medical, dental, pharmaceutical and optical services.

**Margo Biggs:** I realise that. However, the thought processes that were engendered by discussion made me wonder about the vulnerability of patients in relation to some of the concerns that have been raised over NHS 24. Perhaps that could be considered in another forum.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** That is a legitimate question and I am glad that it has been raised. NHS 24 does provide a medical service in the form of advice, which may be wrong or damaging, so perhaps it should be included. Would the Scottish Executive consider bringing it in at a future stage?

**The Convener:** Why was it not considered appropriate to bring NHS 24 into the ambit of the bill?

**Dr Wilson:** If we may, we shall take that question away and write to the committee about it.
The Convener: That was a nice late lob from Forth Valley local health council, but that is the beauty of sessions such as this.

Alex Matthewson: As a matter of interest, I have been in the dental profession for 40-odd years, and I can remember only two tribunals during that time. Could the Executive give us an estimate for how often a tribunal would sit? Two in 40 years does not seem to be an awful lot from a dental point of view. Does it happen more often with the other professions?

John Davidson: Until 1996, there was a long period without any tribunal cases and then there was a case concerning a dentist. I think that the last case before then was in 1984. Since 1996, we have had about one case each year. Recently, we have had two cases running at the same time, so there is an indication that the workload has increased.

Alex Matthewson: Is that to do with dentistry or with other areas of medicine?

John Davidson: It is spread across the professions.

Mr McNeil: We need to understand what is going through the system and how that case load compares with official complaints to give us some balance in understanding which complaints arrive at a tribunal and which are settled through the process.

The Convener: Perhaps we could get some information from the Executive about tribunal history, so that we know what that position is. We shall also endeavour to get information about the complaints.

Alex Matthewson: It seems that complaints progress far down the line before tribunals kick in. I just wanted to know what the importance of the tribunal was, because many matters are sorted out before a complaint reaches that stage, although perhaps not to the satisfaction of patient representatives. It would be good to find out.

Hal Rollason: I have some paper copies of our submission if you would like me to leave them for members.

The Convener: That would be helpful. Thank you.

Mrs Milne: As the question has been asked about how many tribunal cases take place, I just wondered how many cases, by comparison, had been dealt with by the professional disciplinary bodies in the same 20-year span.

The Convener: No doubt the clerk can contact the appropriate regulatory bodies and get some background information on that.

14:58

Meeting suspended.

15:01

On resuming—

The Convener: Part 5 of the bill deals with infection with hepatitis C as a result of NHS treatment. In taking evidence this afternoon, our focus is on the bill, which proposes a legal basis for the existing system of ex gratia payments. The committee will hold a further separate evidence session to examine the case for a public inquiry; that session, of course, will involve representatives of the Scottish haemophilia forum and the Minister for Health and Community Care. I remind witnesses and members not to stray into that area today, because we are dealing specifically with what is in the bill.

I welcome Philip Dolan, chairman, and Dave Bissett, vice-chairman, of the Scottish haemophilia forum and Frank Maguire, who is the legal adviser to the forum. I invite Philip Dolan to make a brief introductory statement, which I ask him to confine to five minutes.

Philip Dolan (Scottish Haemophilia Forum): Thank you for the opportunity to speak to the committee. This is the first forum at which we have been able to discuss our concerns about the Skipton Fund. The committee has received our submission, which I do not intend to go over, other than to highlight a few points. We have concerns about the Skipton Fund.

Frank Maguire will speak on the legal aspects of our concerns about the bill, of which you have given us a copy. He is much better equipped to deal with the legal aspects than we are.

It seems that the minister will have the opportunity to lodge amendments. Perhaps I am misreading the information that I have—no doubt you will put me right about that. We have always expressed our concern that the Skipton Fund seems to discriminate against the dependants of the people who died prior to 29 August 2003. We think that that is unfair and we do not know why the decision on it was reached. I am the only person here who attended all three of the meetings about Skipton that were held in London and there are no minutes of the meetings. We are concerned about how a record is held of how Skipton has come to decisions.

We have concerns about the fact that the appeals panel will lack any involvement from haematologists, who are the people who have been most involved with all those who have developed hepatitis C as a result of receiving blood products or blood transfusions. That is a concern, especially given the fact that the Skipton
Fund deals only with those who acquired hepatitis C through NHS blood products or transfusions.

That is all that I will say at this stage, but I am happy to answer questions. Mr Maguire will be able to deal with the legal aspects.

The Convener: I do not want extensive or lengthy opening statements. If Mr Maguire can restrict his statement to no more than a minute or two, we can bring out the other issues in questioning.

Frank Maguire (Scottish Haemophilia Forum): As a general point, let me state that we welcome section 24 of the bill, which will give Scottish ministers the scope and power to provide for a scheme that is more amenable to people in Scotland. I have a lot of experience of how the Skipton Fund has operated for people in Scotland since it started in July last year. First, the scheme is based very much on written applications. Many people, including many of my clients, find the forms intimidating and difficult to complete, which is a big disincentive. However, I think that section 24 will give Scottish ministers the scope to provide for claims to be presented orally. It should also mean that the scheme can have a presence in Scotland so that people can have a face-to-face discussion if they want to inquire what they should do with their form and what information they need to provide on it, or if they do not understand the scheme’s requirements. At the moment, the fact that the Skipton Fund is based in London makes things extremely difficult.

Secondly, no appeals procedure has yet been put in place for the scheme. Applications have been refused, but there is no mechanism whereby my clients and others can appeal those decisions. Another problem with the appeals system concerns the question whether lawyers and others will need to travel to London to make their case or whether the appeals panel will sit in Scotland. Either way, there is a difficulty. Obviously, it would be difficult and impractical—and, indeed, costly—for many of my clients to travel down to London for an appeal, but requiring all those lawyers to come up here will also have a cost implication. However, there is something to be said for having an appeals procedure in Scotland. Section 24 will give Scottish ministers scope to do that.

As well as those general points about section 24, I hope to be able to highlight, in response to questioning, some specific points about the terms in the bill, some of which are contradictory, inconsistent and inaccurate. I will go through those issues as and when we are asked questions.

Janis Hughes (Glasgow Rutherglen) (Lab): The appeals panel is dealt with in some detail in the Scottish haemophilia forum’s submission, which highlights a concern about the absence of a requirement for a haematologist on the appeals panel. I think that the stipulation is that the panel must have a GP and a hepatologist. Given the issue with blood transfusions, I can understand why people might see a need for a haematologist to play an important role on the appeals panel, but could not a GP play that role, given that GPs look after patients throughout their illness?

Philip Dolan: Very few GPs have had direct involvement with hepatitis C. Some GPs will have been involved, but that is not true of the majority. For most people with haemophilia, their first application form to the Skipton Fund will have been filled in by the United Kingdom Haemophilia Centre Directors Organisation. Often, a haematologist will have been involved in that process, because virtually everyone who has developed hepatitis C got it through a blood transfusion. Therefore, the process generally involves some contact with a haematologist.

There is a question over whether a GP could deal with stage 2 applications to the Skipton Fund, because even haematologists find it difficult to work out the equation that determines whether someone reaches that stage. Therefore, there is a role for haematologists. One GP to whom I spoke recently was completely at a loss when they were asked by a patient to fill out the form.

The United Kingdom Haemophilia Centre Directors Organisation says that it has been involved in little or no discussion during the process even though it is the main organisation and most people who have developed hepatitis C are people with haemophilia. We have no idea why a GP was put on the appeals panel; I have also raised questions about how the other members of the board are recruited.

Dave Bissett (Scottish Haemophilia Forum): As haemophiliacs, we do not have a lot of contact with our GPs. We go straight to a centre for treatment. When I go to see my GP about anything we usually have a discussion about how things are, but GPs are not really up to speed on what is going on.

Shona Robison: The first of my two questions is on the point that is made in your evidence, and the evidence from the Royal College of Nursing, that the committee should examine section 24(1)(c) of the bill, which refers to those who “did not die before 29th August 2003.”

You suggest that that cut-off date disadvantages families and partners, who have no access to compensatory payments from any fund or legal process. Will you confirm that the Scottish haemophilia forum is calling for that provision to be amended or deleted from the bill to avoid the arbitrary cut-off date for those relatives who will miss out because the person who died of hepatitis C happened to die before 29 August 2003?
Has the Scottish haemophilia forum done any work on the number of families who are concerned about or caught up by that arbitrary date and who have therefore missed out on payments? Have any costings been done on what it would cost to include those people? That is my first question.

The Convener: We will deal with that question first.

Philip Dolan: We do not know the figures because of the need for confidentiality and so on, but hepatitis C has been an issue since the birth of the Scottish Parliament in 1999. Why choose 2003 and not 1999? Why discriminate, given that there are only a limited number of cases? It is complete discrimination against us.

Perhaps I am just a maverick, but I have not registered with the Skipton Fund. I hope that a public inquiry will address the issues at a later date. If I walked out of the Parliament today and got knocked down, my dependants would get nothing because I am not registered with the Skipton Fund. The fact that one has to be registered is another example of discrimination against us.

Initially the forum was concerned only with haemophilia, but in the course of our work we have taken on board other people who contracted hepatitis C through blood transfusions, who do not have an umbrella organisation to represent them. Frank Maguire has had more dealings with that group.

Frank Maguire: I will give an example. I have two death certificates here. On the first, the cause of death is hepatic failure and septic shock and the date of death is 7 May 2003. On the other, the cause of death is hepatitis C-related liver disease and the date of death is 4 September 2003. I see no difference between those cases. The date of death is pure chance and nobody has any control over it, but in one case the payment was made and in the other it was not. That puts the matter in stark contrast.

I have handled nine fatal cases; four of the people in those cases died in the period before 29 August 2003. It is quite hard for some of my clients to accept that they have gone through all the suffering because they were infected by the hepatitis C virus through a blood product or a blood transfusion and that because Parliament has only just got round to dealing with the issue, they are disadvantaged even though their pain and suffering are exactly the same as someone else’s. That is the injustice. If we are dealing with numbers, and I have nine fatal cases out of 130 cases, and four of those people died before the date, we are not talking about an awful lot of money.

Shona Robison: The evidence from the Skipton Fund says:

“Activity in Skipton is now running at a low rate.”

Mr Maguire said in his opening remarks that there was a disincentive because the scheme was based on written applications and the form was long. Do you think that the low rate of activity—I assume that that means a low rate of applications—relates directly to the amount of paperwork that a person has to fill out? Are your clients telling you that the process is preventing them from applying? Is the situation as stark as that?

Frank Maguire: I cannot deal with statistics, but I can tell you my experience. My impression is that although a lawyer is helping people, they are still having difficulty with the process. We are helping them with that. A vast number of people out there do not have a lawyer. The Skipton Fund does not like lawyers; it will not correspond with me. It will write to my client and my client has to come to me. I do not understand the reason for that, but that is what the Skipton Fund does. That is a disincentive, even for my clients who are using a lawyer. There is almost a disincentive to use a lawyer, because the Skipton Fund will not correspond with me.

There are several people out there who are struggling and trying as hard as they can to deal with the form. Not only do they have to fill in the form, they have to go and see someone and ask them to do something with the form. A lot of activity is required of the client.

There is a lack of information on the Skipton Fund. Where do people find out about it? How do they know what to do with the long form that they have to fill in? People sometimes find that their GP or medical adviser does not know about the fund either. I have a case in which it has taken from August last year until now to get the form filled in because the GP did not understand it and the consultant refused to deal with it because he was not getting paid; the form then went backwards and forwards to the Skipton Fund. We went to the fund and said that the consultant would not sign the form because he was not getting paid, and the fund said, “That’s not our problem. You will have to pay for it.” The client had no money to pay for it, so I wrote to the minister and he got involved. There are many bureaucratic systems in place that are potential disincentives.

Philip Dolan: This point might come up later, but I will mention it just now. Paragraph 3 of the Skipton Fund’s submission is very misleading. First reading of that paragraph might give the impression that, of the four directors who were appointed to Skipton, two were from the
Department of Health and two were the result of nominations from the Haemophilia Society. I have received an e-mail from the chief executive of the Haemophilia Society who assures members that the UK society was never asked to nominate persons to be appointed as directors.

We have grave reservations about the closeness of the Skipton Fund, the Macfarlane Trust and the Department of Health. The chairman of the Skipton Fund, Peter Stevens, is one of the nominees of the Haemophilia Society to the Macfarlane Trust, but we certainly did not nominate him or any other person to the Skipton Fund. That raises questions about relationships. Mr Steven’s term of office as a representative of the Haemophilia Society on Skipton finishes in July this year. A lot of things are going on. I want to be clear on the point that we were neither asked nor invited to make nominations to Skipton.

Dr Turner: I have two questions on the matter of filling in the form: one is on the form itself and the other is on the private nature of the company. I know of at least one person who is having great difficulty with filling in the form. How many consultant haematologists have said that they did not have time to fill in the forms? I understand that, in this case, they pleaded that the problem was one of workforce issues.

We heard earlier about someone who filled in the form as a private service and, because he was paid £200 to do it, the form was filled in a little bit more quickly. Consultants in the NHS do not seem to have the time to do that. From what you said, it seems that the length and complexity of the forms mean that it is not appropriate for GPs to complete them.

Frank Maguire: The consultants have to set aside time to fill in the forms. First, they have to see the person who has brought in the form to have it completed. They then have to set aside time to get out and look at the patient’s notes, some of which are quite large. The consultant might then have to go back and talk to the person about their case. Consultants have to go through that procedure before they get down to filling in the form. If they are diligent, they want to get it right; they know how important that is to the patient. All of that has to be fitted into the work of a busy practice.

No one is saying to the consultant, “We will set aside time for you”, or “We will pay for you to do this.” Some consultants find the lack of payment quite galling. They are doing the work of filling in the forms, yet who gains a saving as a result? It is probably the private company. Skipton wants to keep down costs by making the process simple and by putting the burden of completing the report on to the consultant, who has to do it gratis. That saves the private company money and, in turn, makes it more profitable. That is the dynamic of what is going on.

I agree that the form is difficult to complete. There is also an issue for consultants in terms of the time that they have to take to complete the forms and the fact that they have to make themselves available to do so. I emphasise again the fact that medical records are very large.

Philip Dolan: The haemophilia directors have been fairly helpful in relation to helping people to fill in the forms at stage 1. That said, it depends on the part of Scotland in which people reside. Some directors are pedantic about how they fill in the forms. We know of cases, certainly in this part of the world, in which people’s forms went backwards and forwards between the consultant and Skipton and, at the end of it, people got no money. However, because the haemophilia director in another part of Scotland knows the patients, they can say that someone needs a payment and the payment is made.

Greater complications are involved in stage 2 payment applications. As I said earlier, I know from conversations that I have had with the haemophilia directors in Scotland that some of them have a great deal of difficulty in completing the second part of the application process, partly as a result of their trying to get meetings with hepatologists. I know of one case in which both the professionals work in the same hospital and yet an e-mail that was sent in November says that one can meet the other to discuss the filling in of the forms in February. I am talking about people who walk by each other in the link corridor of the hospital in question.

Dr Turner: I am concerned about the fact that a private company should have been formed in order to distribute the fund. I think that it was the Scottish haemophilia forum that went into detail about the private nature of the company. I do not understand why that had to happen. My understanding is that, under the Freedom of Information (Scotland) Act 2002, it is very difficult for a private company to give out information.

The Convener: Perhaps Mr Maguire can respond in respect of the difficulties that arise simply because Skipton Fund Ltd is a private company.

Frank Maguire: Questions arise because of the fact that it is a private company. What is in it for the private company? We do not know how much the directors are paid, how profit oriented they are or what their profit motive is, and whether they are being efficient because the company provides a public service or because they want to save money.

If I were to be cynical, I would say that—given the requirement for written applications, the
practice of batting everything back to the patient, the avoidance of lawyers and the avoidance of other costs—Skipton is keeping the costs down so that its profit is higher. If the company gets involved in such things, its expenditure goes up, so its profit is obviously less. Whether I can get into that, or whether the company can reveal that, is a different matter altogether. The company keeps talking about judicial review, but such a review is normally conducted on an administrative body such as a local authority or a public body. There is a question mark over whether I could judicially review the actions of a private company, if only the private company and not the minister were involved. There is an obstacle involved when the Skipton Fund talks about judicial review.

Dr Turner: That is what I thought.

The Convener: Witnesses from the Skipton Fund are coming later this afternoon. We hope that they will be here by 4.15, although there have been difficulties with their flight. I understand that they have now arrived, so we will be able to put some of those questions directly to the Skipton Fund representatives.

Mr McNeil: I am shocked to hear that consultants are being obstructive and that they are not being helpful. We know that, in other areas, consultants are an essential part of the network to get people who are suffering from certain conditions through the system and referred to self-help groups. I am really shocked and disappointed that that delay has arisen. I do not know whether the committee can do something about that with the minister to clear away some of those problems. It may be useful for us to get some more information about the form. How long does it take for the consultant and the person together to fill out the relevant part of the form?

Dave Bissett: Often they do not have to be together. The consultant has the information.

When I filled out the stage 1 application form, there was one page that the applicant had to fill in and the consultant filled in the rest. For the record, I would like to say that we have had no problems at Ninewells hospital in Dundee. The consultants there have been first class at getting the forms filled in.

Mr McNeil: Can you be more specific about where the problems lie? Which health boards are affected?

Dave Bissett: I believe that there is a problem in Edinburgh.

Mr McNeil: Where else?

Frank Maguire: There is a case in Glasgow.

Mr McNeil: There is one case in Glasgow. How many are there in Edinburgh?

Dave Bissett: I do not have a figure, but I know that there is a problem.

Mr McNeil: It would be useful if we could get some of those figures.

The Convener: Could you do some digging around and get some further information to the committee on that aspect of the issue?

Philip Dolan: Yes. There have certainly been individuals in Edinburgh who have had difficulty with the forms being batted backwards and forwards. We know that, in some instances, consultants took one and a half minutes to complete the stage 1 application form. In other cases, the process has taken months, because the consultants have wanted to go into greater detail. I can talk about individuals but, as you will appreciate, most people who have been involved have wanted to keep away because of the stigma that is attached to their condition.

The Convener: I appreciate that there is a difficulty, but it helps the committee if we can get as much information as possible about what is happening.

I would say the same to Mr Maguire. If you know of specific areas of Scotland or situations in which that specific problem has arisen, could you ferry that information to us? It would be gratefully received.

Frank Maguire: To be clear, I raised the matter with the minister and he took action on a specific case. However, it is a bit silly to have to go to the minister to get a form filled in.

Mr McNeil: The situation that you have described is shocking and not acceptable. We want to have an understanding of the extent of that situation so that we can put it right. Thankfully, we do not need to write to Dundee, because the consultants there may represent best practice, but we need to identify why that is not happening in other areas.

I presume that you have a copy of the submission from the Skipton Fund. Your own submission has been helpful to us in considering the evidence. You say that the two representatives from the Haemophilia Society who are directors were not nominated by the Haemophilia Society to the Skipton Fund. Do you have good links with them? Have they been able to raise and address some of the issues? Or is it the case that they have been of no effect and that you have had no contact with them?

Philip Dolan: I am a trustee of the Haemophilia Society and the matter has been discussed with the trustees.

The concerns about the appointment of the directors, which was done without consultation,
have been discussed with the trustees of the Haemophilia Society. For the benefit of the representatives of the Skipton Fund, who have probably now arrived, I repeat what I said earlier: we have an e-mail from the chief executive of the Haemophilia Society—I will make the e-mail available—in which he confirms that the society was not consulted and did not make any appointment. We believe that the Haemophilia Society is having on-going conversation on the issue, but, unfortunately, the chief executive of the society could not be with us today to answer questions. We do not know why the Skipton Fund was set up—whether it was for reasons of speed or for some other reason—but we should have been consulted and had a say.

Mr McNeil: Is there any reason why you would not have nominated the two people concerned? Do you have objections to them? Do they have any association with the Haemophilia Society?

15:30

Philip Dolan: The Haemophilia Society nominated both of them for the Macfarlane Trust, on which people serve for a period of time. However, the Haemophilia Society might not wish to reappoint those people to the Macfarlane Trust in the future and may have preferred to appoint other persons to the Skipton Fund. The chief executive and chairman of the Macfarlane Trust were initially appointed to set up the Skipton Fund. The chairman of the Macfarlane Trust, who is with us today, is also the chairman of the Skipton Fund. Given the procedures in Scotland to ensure that everything is visible and up front, that relationship is rather close.

Mr McNeil: Given that we will question representatives of the Skipton Fund later on, and that you may not do so at this stage, do any other points jump out of the Skipton Fund submission, including the figures that have been provided, with which you disagree or to which you object?

Frank Maguire: My problem with the Skipton Fund is how it conducts itself. We have discussed the difficulty with forms and how the burden is put on to the patient. It would be of great assistance if something—the initial £80-worth or whatever—but if more work needs to be done, the Scottish Legal Aid Board just says that the Skipton Fund deals with the matter and that is the end of the story. There is a constant struggle with the Scottish Legal Aid Board to get it to authorise increased expenditure to cover more work on accessing medical records and assisting clients. That goes right through the system.

Philip Dolan: To answer Mr McNeil, the concern is why we need the Skipton Fund. Why could the function not have been carried out at arm’s length from, or within, the Department for Work and Pensions? Only a limited time is available. Once all the applicants for the first and second phases have been dealt with, there will be only a trickle of people applying, as their condition worsens from chronic hepatitis into cirrhosis and cancer. The Skipton Fund seems to be an organisation that deals with paper—sending out forms, receiving them, sending out money and coming to decisions based on criteria that are not known to me or other people.

In two years’ time, instead of having a large office in Westminster—the most expensive part of London—a confessional box in a church will be sufficient, because the body will need only a part-time worker. As Mr Maguire pointed out, we do not know how much of the money that the Skipton Fund was set up to pay to patients is being spent on administrative costs and rent. I do not know whether you are planning to consider the appeals system, which is one of our major concerns.

The Convener: You have made that point already. Mr Maguire mentioned specific issues that he wanted to raise. I invite him to take the opportunity to do so now.

Frank Maguire: With regard to compensation, we must consider what is best for people in Scotland. The system is not ideal, but we must be practical about it. It should be possible to access the system both in writing and face to face. There should be face-to-face access to advice. People should be able to go to an office in Scotland to ask someone questions, or another person should be able to do that for them. The face-to-face dimension is completely missing because the fund is based in England. It does not matter whether the system is run by the Skipton Fund or another body.

When people’s claims are rejected, they must be given clear reasons, with appropriate reference to the evidence, for why that has happened. We do not get reasons—we are just given a little one-liner that says “refused”. Why?

The Convener: That is similar to the way in which the Crown Office indicates that it is refusing to proceed.

Frank Maguire: Yes. I am concerned that, if we have an appeals procedure that is London focused, it will be based more on written communication and there will be an attempt to avoid oral representation. Oral representation is essential in any appeals procedure. A face-to-face
question and answer session reveals much more than is contained in written documents and allows people to get right to the nub of the problem, without being misdirected in various ways. With face-to-face meetings, people understand why their important application has been turned down.

The system that we seek would ensure accessibility to both advice and decisions. Reasons for decisions and access to information would be provided. It would be helpful if that information were held here. There would also be an appeals procedure that was Scotland focused and accessible in Scotland. If the Skipton Fund can provide what we are seeking, that is fine. If it cannot, we must have our own system. If the number of applicants is declining, as has been indicated, such a system would not be very expensive. However, the benefits to people in Scotland would be great.

Dave Bissett: The Skipton Fund submission refers to payments of £20,000 and a further £25,000. No one has ever told us how those figures were calculated. Where did they come from? What do they mean? The Skipton Fund’s advisers came up with an equation, based on liver tests, to work out whether someone should receive a second-phase payment. Any liver specialist will tell you that those tests do not necessarily mean that someone does not have cirrhosis or cancer—they are only a guide. Even if a good part of the liver is taken in a biopsy, it cannot provide 100 per cent certainty.

I qualify for the first section of payments, but not for the second. Although some of my readings are high, they do not fit into that category. I have probably had hep C for about 30 years. From the symptoms that I experience, I know that I have some sort of liver damage, but the tests do not show it. The equation that has been developed does not mean much to me. Over the years, even before hep C came into being, we were told that the tests were guides and that there were no guarantees. The fund intended to come up with a non-invasive test, but it was not able to do so. However, if it worked out an equation to determine who should get the second payment, could it not have worked out an equation to calculate what people were losing through ill health and stress?

I have a brother who is seriously ill and cannot work. He had his own business and is probably losing about £50,000 a year in earnings. He qualifies for the second payment, so he gets £45,000. The chap who runs the Skipton Fund probably gets more in his salary than my brother gets in compensation. Where do the figures come from? Did someone just decide that the figures sounded good and that by giving people £20,000 they could get rid of them? That is not satisfactory.

The Convener: We have a few minutes left in this session. I do not want to move off this topic if people want to raise issues. I remind witnesses that we have the written submissions, so it is not necessary to repeat everything that is in them. Committee members have no more questions. Do you have any final comments on the bill?

Frank Maguire: I wish to address an important point on section 24, concerning eligibility. Section 24(2)(b) states that a person will not qualify if their sole or main residence was not Scotland when they applied for a payment or if, in the case of someone who died, their sole or main residence was not Scotland when they died. I cannot see the logic of that. The issue should be that the conduct complained of happened in Scotland. No matter where you live after that, you should be paid if the NHS in Scotland infected you with hepatitis C.

Let us consider the practicalities if we keep that provision. I have cases the length and breadth of Scotland. Take the example of a baby in Shetland who was infected with hepatitis C virus. If as a teenager that person goes to England to get a job, their sole or main residence will be in England. In that instance, they will be disqualified. Why should that be? At the other end of the age spectrum, an elderly person might go to live with or near their children in England, France or elsewhere. By that fact, they will be disqualified. It is illogical that when making an application a person’s sole or main residence must be in Scotland. That has no connection to what we are talking about. All that they should be required to prove is that, wherever they live, they were given a product or transfusion in Scotland and that it was administered by the NHS. Section 24(2)(b) should be removed from the bill.

In addition, there is a contradiction between what the Skipton Fund says and what section 24 says about people who receive money by way of another scheme or litigation—cases are proceeding on negligence grounds. Guidance from the Skipton Fund asks:

“Will any payments I have received from other schemes, or as a result of litigation, be deducted from the payments made to me by the Skipton Fund?”

to which the answer is, “No.” However, section 24(3)(b) states that a scheme may

“provide that the making of a claim, or the receipt of a payment, under the scheme is not to prejudice the right of any person to institute or carry on proceedings … (but may also provide for the taking account of payments under the scheme in such proceedings).”

That seems to say something different from the Skipton Fund. Perhaps section 24(3)(b) should be examined closely and amended.

Why was the cut-off date of 1 September 1991 picked? I cannot explain that. If it was chosen because it is believed that no infected blood was in the system, I would like to see the evidence. We
have never had an inquiry—we will not talk about that today—but because the issue has never been fully explored, how can we be satisfied that 1 September 1991 is the correct date? Where is the incontrovertible evidence? I have indications from clients that they were infected after that date. In any event, why not leave the question of whether you received hepatitis C from infected blood as the matter of proof? Whether you were infected in December 1991 or in 1993, you would still have to prove it. Leave it open and do not prejudge the issue.

I can submit those points in written form.

**The Convener:** You do not need to now, because you have put them on the record, unless you want to follow up with more detail. We have two minutes left. Do committee members want to ask questions on the last points that were raised?

**Shona Robison:** That is important evidence. I was aware of the issue around the date of 29 August 2003, but the important points that you make require further explanation, which I hope we will receive.

**Helen Eadie (Dunfermline East) (Lab):** Is the £15 million that the Executive has set aside adequate?

**Frank Maguire:** That is very hard to forecast. There are people in the system who do not know that they have hepatitis C. That is another problem, and it is why there is a problem with application. People cannot make an application if they do not know that they have the condition, but they still get disqualified for not making one. Those people in the system who do not know that they have hepatitis C are being discovered as and when they return for treatment, or if they die. The number of people concerned is unknown. We also do not know how many people will die of hepatitis C. Judging from the cases that I have dealt with, deaths have occurred in 2003 and 2004, and there will be some in 2005 and into the future, no doubt. That is difficult to assess.

£15 million may be set aside, but I hope that the Scottish ministers will recognise that there would need to be more if that fund were exhausted. I would not like ministers to keep within that £15 million by trying to keep expenditure down and doing various sorts of cost-cutting exercises. That would only go against the people who are trying to make a claim.

15:45

**The Convener:** I will allow Mr Dolan to come in very briefly, as we need to move on.

**Philip Dolan:** Dave Bissett raised the question of the £20,000 payments. The Scottish Parliament set up an expert group under Lord Ross, which recommended a minimum sum of £50,000. We do not understand why that has not been implemented. Perhaps the committee is in a position to review that during its consideration of the bill. The concerns that we have expressed about the appeals system are important, and I know that you will be taking those concerns and our submission into account.

**The Convener:** I thank the three witnesses for coming along. Witnesses from the Skipton Fund will give evidence later. We now have to move into private session, as previously agreed. We have had to rejig our agenda because of late planes and so on. I will first suspend the meeting for a couple of minutes to allow the room to be cleared.

15:46

Meeting suspended until 15:49 and continued in private thereafter.

16:27

Meeting continued in public.

**The Convener:** I reconvene the meeting in public and welcome Peter Stevens, the chairman of the Skipton Fund, and Keith Foster, scheme administrator of the Skipton Fund. We have heard evidence from representatives of the Scottish haemophilia forum. Mr Foster did not hear all of that evidence, but he heard a significant portion of it. I suspect that committee members will have questions arising out of that evidence. I ask one or other of the witnesses to make a brief statement about the Skipton Fund in connection with the legislative proposals that we are considering.

**Peter Stevens (Skipton Fund Ltd):** I apologise for delaying your proceedings, convener. The matter was out of my control.

**The Convener:** We understand.

**Peter Stevens:** The Skipton Fund began operations on 5 July last year, having been set up earlier in the year following discussions that have been going on since the announcement of the hepatitis C ex gratia payment scheme at the end of August 2003. Everything that has been done in setting up the scheme and in staffing it has been done in the interests of getting the payments made as quickly and efficiently as possible.

There are four directors of the fund who were all trustees of the Macfarlane Trust, which was invited by the Department of Health, on behalf of the health departments in the four Administrations, to put its resources, expertise and experience at the disposal of the departments to run the scheme. The directors have a job to do in signing off payments and I believe that we have already made well in excess of 80 per cent of the
payments that the scheme will ever be required to make. That is all I wish to say at the moment.

16:30

The Convener: I thank you for being commendably brief.

Does Mr Foster want to add anything, or shall we go straight to questions?

Keith Foster (Skipton Fund Ltd): It is probably best to go straight to questions, but I will first explain my role. I came in as administrator at the start of the scheme, so questions on procedures are probably best directed to me, whereas questions on policy can be directed to Peter Stevens.

Shona Robison: My first questions relate to the status of the Skipton Fund. Will you confirm whether it is a private company? Concerns were raised earlier—you might have heard them—about whether, as a private company, you make a profit through the operation of the fund. Will you clarify that and whether the directors are paid or unpaid? Further to that, I ask you to tell me the breakdown of finances for the Skipton Fund—for example, administrative costs, office costs, the payments and the costs of appeal. I do not necessarily expect you to be able to answer that today, but you might be able to provide the information in writing, as it would be useful to have a breakdown of the fund's finances for those elements.

Secondly, I have questions about your written evidence. You say:

“Activity in Skipton is now running at a low rate.”

We heard earlier that there are concerns about the length and complexity of the fund’s application forms, which might put potential applicants off applying in the first place and might be one of the reasons for that low rate of activity. What is your view on that? Has that concern been raised with you?

Mr Stevens, you just said that 80 per cent of the payments that the scheme will be required to make have been made. Do you mean by that that you think that 80 per cent of the payments that you will ever make have been made or are you referring to 80 per cent of the payments that have been applied for to date? Will you clarify that point?

The Convener: The witnesses can decide between themselves who should answer which questions.

Peter Stevens: The Skipton Fund is a company limited by guarantee. It is our intention to minimise the profits and to make them as close to zero as possible so that we do not have to concern ourselves with profit distribution or tax. If there is a profit, it will be carried forward from one year to the next to pay for the following year’s expenses and, in the long run, I anticipate that the company will be totally non-profit making.

At the moment, there is a slight uncertainty in everything to do with operating costs, because some VAT might be involved in services that the Macfarlane Trust supplies to the Skipton Fund, but HM Customs and Excise is taking a considerable amount of time to analyse the nature of the two operations and whether VAT payments will be required.

The directors give their services for free; there are no directors’ fees. We have considered that directors might deserve a fee for the amount of time that they spend not performing directors’ functions but coming into the office to process and sign off application forms, but no one has booked one yet.

Shona Robison asked me to amplify my statement that we have made more than 80 per cent of the payments that we will ever make—I emphasise “ever”. Roughly 4,400 application forms have been sent out to people who have completed their registration. We are registering people at a rate of about seven a week—one a day—so it will be a long time before the initial estimates of between 6,000 and 8,000 applications are received. Indeed, I do not think that those figures will ever be reached.

When people register, they have no idea whether the application form will be complex. The registration form is very simple and the application form is even simpler for applicants. The bulk of the application form must be filled in by the claimant’s clinician, because it is concerned with medical evidence; there is no other complexity in the form. The application process is simple and the form was designed so that it would not put anyone off applying.

That is all the information that I can give in answering the member’s questions. Mr Foster will add something.

Keith Foster: I will leave a couple of spare forms with the clerk so that members can see them. The witnesses from the Scottish haemophilia forum made the point that the forms are complex and Shona Robison asked about that. However, the forms are not complicated for claimants, who need only fill in their name, address and national insurance number, sign the form and send it to us in a pre-paid envelope. All the work that needs to be done is then undertaken by the claimant’s clinician.

The witnesses also expressed concern that there were difficulties in getting the forms completed. However, such cases tend to be isolated. I administer the scheme for the whole of
the UK, so I can say clearly that the number of problems is small in relation to the number of claims that are being processed. Although such cases obviously present a big problem for individual claimants, the problem is not regarded as large globally. The chief medical officer has written to all consultants in a bulletin, to advise them of the existence of the Skipton Fund and to ask them to consider forms in that light.

Members might have encountered constituents who are having difficulties because GPs are being asked to fill in forms. We suggest that a consultant fill in the form whenever that is practical, but that does not always happen. Because of GPs’ terms and conditions and their contracts with health authorities, fees might be charged. Also, GPs are not necessarily au fait with the details of the disease.

**Shona Robison:** Are you saying that you do not expect the £15 million that the Scottish Executive set aside to be claimed? You seem to be indicating that fewer applications than you expected have been made to date. How much of the £15 million has been claimed so far? What figure is represented by the 80 per cent of payments that you say that you have made?

**Peter Stevens:** Currently, Scottish stage 1 and 2 payments total roughly £8 million. If we were going to reach the figure of £15 million, which would be consistent with the entire scheme having around 8,000 applications, I would have expected that by now we would have heard from more than 6,000 people. However, we have heard from 4,500 people. I do not see where the other 3,500 applicants are. The scheme has been running for several months and has received quite a lot of publicity through the chief medical officer's circulars. We receive requests for new registrations at a rate of seven per week, as I said, and the figure has been falling gradually for about three or four months. I do not know where the other 3,500 applications would come from.

**Shona Robison:** Unless eligibility for payments is widened.

**Kate Maclean (Dundee West) (Lab):** I was not clear about Peter Stevens’s response to Shona Robison’s question about the fund’s running costs. You said that the VAT issue is being sorted out, but notwithstanding that, what percentage of your budget goes on ex gratia payments and what percentage do you budget for running costs? You must have an idea of the approximate percentages. It would be interesting to know what they are, because there seems to be concern about the matter.

**Peter Stevens:** So far, we have paid out about £65 million in ex gratia payments. The fund’s running costs to date are less than a quarter of 1 per cent of the total figure.
hands of officials from the four Administrations, rather than in our hands. We do not have access to the process of sending circulars to doctors or consultants; that is a matter for the health departments of the four Administrations.

Mr McNeil: Is the 80 per cent achievement rate a UK figure? What is the figure in Scotland?

Keith Foster: That is an overall figure. I would have to calculate the Scottish figure. I will give some statistics that I prepared before I came here. Your paperwork talks about 581—

Mr McNeil: I have seen that somewhere.

Keith Foster: I am talking about the Smoking, Health and Social Care (Scotland) Bill and the related documentation, which says that Scotland has 581 hepatitis C sufferers. I do not know where you took that figure from, but at our last count, we had received 461 applications.

16:45

The Convener: That is not our figure; it is the Scottish Executive’s. Any discrepancy is between the Executive and you.

Keith Foster: I was just making a comparison. The documentation talks about 580 people and 460 payments have been made.

Mr McNeil: There have been 460 claims.

Keith Foster: Yes. We have gone through those who knew about the scheme fairly quickly. The fund’s concern, which Mr Stevens just touched on and Frank Maguire talked about, is about reaching people who were affected many years ago and do not necessarily know about the scheme, although it is hep C awareness year. The Skipton Fund has asked the Department of Health how it will promote the scheme to the wider public. We would like the devolved Assemblies to think about that, too.

It is vital not to miss people. The Haemophilia Society and the haemophilia world are close and have good contacts, but one of my big worries as an administrator is that people who were affected many years ago and are probably becoming elderly may not know about the scheme, so we need people to be advised of it by their GPs and others.

Mr McNeil: That information about the figures was useful. Will you provide us with figures for Scotland and the achievement rate here?

Keith Foster: As I said, we have processed claims from people who are aware of the scheme. We must try to quantify who else out there should benefit from the scheme. We are beginning to see many claimants who are different from those who claimed at the start. Many now are elderly and have heard of the scheme only through word of mouth. Their infection dates are much earlier than the peak times of the 1970s and 80s. That is why those people’s claims are appearing more slowly.

Mr McNeil: Have you no feel for the additional number?

Keith Foster: Mr Stevens said that when the fund started, the top figure that was talked about was 8,000 for the UK. That is probably too high. If we can have not so much a relaunch but the right emphasis in the medical world, the global figure might reach about 6,000 to 6,500.

Mr McNeil: That leads me to another line of questioning that I might as well run with. Have you allocated some of your budget to targeting those people and raising awareness? How will you fund that process?

Keith Foster: Unfortunately, our hands are tied. We have no budget for marketing, if that is the right word. We must approach the Department of Health for what we need. We are involved in the hepatitis C awareness programme, which is widely available through the internet. Only a week or so ago, we talked to the department about raising our profile again in the press, so that people more widely are aware of what we are doing.

Mr McNeil: I have a question about clinicians and medical evidence that I was going to skip but will not. How long does an average Scottish claim take?

Keith Foster: The question, “How long is a piece of string?” comes to mind. The whole process can take seven to 14 days, or it can take many months if the clinician spins it out. With regard to what was said earlier, it is true that applications come back much more quickly from certain pockets. Much depends on an individual’s viewpoint on filling in the forms. As was highlighted earlier, there have been cases in which the Parliament had to step in to say to consultants, “This is part of your doctor-patient relationship. The forms need to be completed.”

Mr McNeil: The earlier evidence about certain areas can be substantiated. Can you provide us with some of your information?

Keith Foster: No, I would not wish to do that.

Mr McNeil: Why not?

Keith Foster: That would isolate people who do not need to be isolated, because the problem has been solved.
Mr McNeil: So there are no current problems. The issue has been resolved.

Keith Foster: As far as I am aware, we have no outstanding applications from Scotland that are causing us problems.

Peter Stevens: We use the same form for people with haemophilia and people without haemophilia. Consultants who have to complete the application form on behalf of somebody with haemophilia—who will be somebody about whom they are well informed; they will know him or her quite well—say that it takes two or three minutes. However, it will take some time to complete the form for somebody without haemophilia who is rarely seen, whose hepatitis C is not active and who was infected through some form of hospital process perhaps 30 years ago. The issue is not the form itself, but digging out the paperwork and finding the records that will demonstrate the source, date and route of infection. The form itself is simple.

Mr McNeil: But there is a problem with people in some areas not prioritising the completion of the form. Is the fee a problem? It was suggested that because consultants are not given an appropriate fee, or if there is a dispute, the form is at the bottom of their list. A clinician can obstruct the whole process, which can prevent people who need the money from quickly receiving payouts. Where are those people?

Keith Foster: We know of a few, but they are not all in Scotland. There have been some in Scotland—

Mr McNeil: But not now.

Keith Foster: Not that I am aware of. There have been problems, but as far as I am aware they have been resolved. I do not know whether you have information that I do not have.

Mr McNeil: We may be able to give it to you.

Keith Foster: We always have a number of forms that are out being filled in and of course I do not know where all those forms are, but our overall impression is that there is no huge problem. There have been isolated pockets, not only in Scotland, where consultants have said, “I’ve got too many to do,” which is a problem. There may be a problem with GPs completing forms if they are not happy to do so. That may be another area about which we are not entirely aware.

The Convener: You heard the end of Mr Maguire’s evidence. Can I confirm from what you are saying that the decision on the 1991 cut-off was not taken by you?

Keith Foster: Correct.

The Convener: Mr Maguire also raised questions in respect of the appeal procedure. Was it set up by—

Keith Foster: The appeals process is still being set up by the Department of Health.

The Convener: Right. So it is outwith your bailiwick.

Keith Foster: We will administrate it once it is in place.

The Convener: But you do not make decisions about it.

Keith Foster: No.

The Convener: I am trying to address the points that were raised. I am beginning to get a clear understanding of your role. Effectively, all policy decisions are made elsewhere. You simply administer them.

Keith Foster: We do what we are told.

Mike Rumbles: When do you envisage the appeals process being in operation?

Keith Foster: We would like it to be in operation as soon as possible but, unfortunately, we are in the hands of other people.

Mike Rumbles: Have you been given any indication?

Keith Foster: No.

Peter Stevens: I understand that there was a meeting yesterday between officials from the Scottish Executive Health Department and the Department of Health at which reference was made to the appeals process. I am told that the meeting was useful, but I have not yet received a report on it—I will get that tomorrow.

The Convener: Helen Eadie has a question. Is it one that these witnesses can answer?

Helen Eadie: My question is on a point that was raised by Frank Maguire. I do not know whether these witnesses can answer it. Can the Skipton Trust be judicially reviewed?

Peter Stevens: Presumably.

The Convener: But that has not happened.

Shona Robison: I have a point of information. In a letter to me dated 21 December, Andy Kerr, the Minister for Health and Community Care, stated that the employment of the appeals panel would be done through the public appointments process and would take a few months to complete. We may want to tie him down on that.
I have a more direct question on an issue that I pursued earlier, although I do not know whether the witnesses will be able to answer it. As a manager and an administrator of the system, they are indicating that there may be money left in the system after everybody is paid. I am interested in that on behalf of those who are excluded from the scheme because their relatives did not die before 29 August 2003. As things stand, will there be enough money left in the system to widen the eligibility criteria to include those people?

Peter Stevens: If my view is right that we are heading towards—as Keith Foster said—6,000 to 6,500 eligible claimants rather than 8,000, the fact that the departments have put aside money based on 8,000 claimants would suggest that there will be unspent funds at some time. However, I do not know when it might be decided that progression from stage 1 to stage 2 has gone as expected and will not require a greater proportion of the budget than was originally estimated. That will be up to the health departments.

The Convener: There are no further questions. The session has been helpful, although there have been many questions that you cannot answer. The fact that you are not in a position to answer them is in itself helpful to us. I am sorry that you had such a hard time getting here today.

Peter Stevens: It has been a pleasure.

The Convener: It must seem like an awful long journey for such a short time. Nevertheless, your attendance has been valuable and I thank you very much.

I ask for the room to be cleared as we move back into private session.

16:58

Meeting continued in private until 17:10.
SUPPLEMENTARY EVIDENCE BY THE SKIPTON FUND

Further to the recent committee meeting and request for further information please find enclosed within this note the figures requested.

The fund has dispatched in excess of 4500 claim forms throughout the UK. For operational reasons the “regionalisation” of forms only occurs on receipt back of a completed application to the fund office.

In this respect for Scottish Registrants we have paid:

- 428 Stage 1 application (also known as the basic application) £8.56m
- 50 Stage 2 applications (also known as the advanced application) £1.25m

Total 478 £9.81m

In respect to the percentage of paid applications that have been processed by the fund in relation to received completed application forms, this currently stands at 89.5%. (This percentage does not include any form that is still to be received by the fund which is still being completed by doctors and specialists.)

Please do not hesitate to contact me further clarification is required.

Keith Foster
Scheme Administrator

SUPPLEMENTARY SUBMISSION BY SCOTTISH HAEMOPHILIA FORUM

I thank your good self and Members of the Committee for the opportunity to provide evidence and views on Section 24 of the Bill concerned with infection with Hepatitis C as a result of NHS treatment.

In the interest of time there were two other matters which I did not raise and which hopefully I can now by way of written submissions.

The first of these is related to Section 24 (1)(c) and Section 24 (2) (b) which concern eligibility. I attach a document entitled “The Skipton Fund – What it is and how it works” and would refer you to section 3(g) of the document. It states that no payments will be made in respect of those who have died before 29th August 2003. It then states that in the case of eligible persons who died between 29th August 2003 and 5th July 2004 payments will be made to their estate. However it then goes on to say where eligible persons die after 5th July 2004, payments will only be made to their estate if the eligible person has applied to the Skipton Fund whilst they were still alive.

The Scottish Haemophilia Groups Forum object to this further condition of the eligible person having to apply whilst they were alive in order for their relatives being able to claim.

Firstly we cannot see any reason why as between deaths 29th August 2003 and 5th July 2004 payments cannot simply be made to the estates of a person who has died from Hepatitis C infection arising out of NHS treatment.

There is no explanation as to why this additional rule is inserted. There is nothing wrong surely in a relative applying after someone has died where the person who has died has not applied.

Secondly there might be good reason why someone has not applied while they were alive. It may not be discovered that they were suffering from Hepatitis C until after their death e.g. when a post
They may not have been in a fit state, coping with their injury, to making the application. Indeed the requirement to make an application may have occurred at one of the hardest points in their condition. There are also a number of social reasons why someone would not apply given the prejudices which attend Hepatitis C and they may have still been in the process of deciding whether or not to make an application.

The second submission relates to paragraph 24 (2) (a) where it says that the question as to whether a person became infected with Hepatitis C as a result of treatment needs to be determined on the balance of probabilities. This is a somewhat technical term and I have reservations as to whether those who administer the Skipton Fund understand the concept. It is a question of weighing up all the factors and evidence and coming to a decision whether it is more likely than not that the treatment was so caused. I would be concerned if there is an automatic reaction from the Skipton Fund to dismiss an application where there were suggestions of alcohol, tattoo, drugs as well as transfusion or administrative blood products. That would not be a proper application of the test. A fund which is administered with a view to not only efficiency but keeping expenditure down may tend towards automatic dismissal rather than the fuller proper consideration on the balance of probabilities.

Given that the proposed Bill has a considerable impact on death cases by way of eligibility or application, and these can also be the most serious and distressing cases the Fund has to deal with, I respectfully suggest that the Committee hears the evidence from a family or families whose loved one has died from the Hepatitis C virus and questions of exclusion or access seen from their perspective.

Yours faithfully

THOMPSONS

SS

Note referred to:-

1. The Skipton Fund – What it is and how it works
THE SKIPTON FUND - What it is and how it works

1. WHAT IS THE SKIPTON FUND?
(a) It is a scheme for making lump sum payments to certain people who became chronically infected with Hepatitis C as a result of receiving NHS treatment with blood or blood products.
(b) It operates throughout the UK – making payments to people who were infected in England, Northern Ireland, Scotland and Wales.
(c) The money paid out by the Fund is provided by the 4 UK Government administrations on a compassionate basis – the payments are not an admission of legal liability.

2. WHO CAN APPLY?
(a) People who have contracted Hepatitis C as a result of receiving blood or blood products from the NHS prior to September 1991.
(b) Those representing the estates of people who would have qualified for payments from the scheme had they not died between 29 August 2003 and 5 July 2004.
(c) Those infected with Hepatitis C as a result of the virus being transmitted from someone else who was themselves infected as a result of receiving blood or blood products from the NHS prior to September 1991 (eg someone who was infected at birth by a mother who had been previously infected through NHS treatment).

3. HOW DOES THE SCHEME WORK?
(a) The scheme will make a lump sum payment of £20,000 to any person who now has Hepatitis C as a result of receiving blood, blood products or tissue from the NHS prior to September 1991.
(b) People who had Hepatitis C in the past as a result of receiving blood or blood products from the NHS prior to September 1991, but who have cleared the virus as a result of treatment, will also receive £20,000 lump sum payment.
(c) People who have cleared the virus as a result of treatment or who have cleared it spontaneously after a period of chronic infection will also be eligible for payments from the scheme.
(d) People entitled to the basic £20,000 payment as described above will receive an additional £5,000 payment if they develop or have developed a cirrhosis or liver cancer, or have had a liver transplant or are on a transplant waiting list.
(e) People who have been infected with HIV through blood or blood products in the past, and have in addition contracted Hepatitis C in the same way, will be eligible for payments from the scheme in the same way as those who have only been infected with Hepatitis C.
(f) It will be assumed that people who have developed Hepatitis C after being treated with Factor VIII or Factor IX blood clotting factor concentrates were infected as a result of that treatment. Virtually all haemophiliacs will fall into this category.
(g) No payments will be made in respect of those who have died before 29 August 2003 or to people who have cleared the virus spontaneously in the acute phase of the disease. In the case of eligible people who die between 29 August 2003 and 5 July 2004, the payments will be made to their estate. Where eligible persons die after 5 July 2004, payments will only be made to their estate if the eligible person had applied to the Skipton Fund whilst they were still alive.
(h) The scheme will not pay any legal costs that people incur in preparing a claim for payment from the Skipton Fund.

If you have further queries after having read this guidance – contact the Skipton Fund Helpline 020 7808 1160. If you phone the Skipton Fund Helpline it may be busy and your call will be recorded so please be ready to leave a telephone number to which it will be possible to return your call. Or if you can e-mail the Skipton Fund at apply@skiptonfund.org.
THE SKIPTON FUND – APPLYING FOR A PAYMENT

1. HOW DO I APPLY?
(a) If you want to apply for a payment you can do so by completing the online registration form (available at www.skiptonfund.org), or by applying direct to the Skipton Fund. They can be contacted by telephone or email, details of which appear above. If you would prefer to write to the Fund, their address is PO Box 50107, London, SW1H 0YE. Once your registration form has been received, the Skipton Fund will enter your personal details on a database and allocate you a unique reference number.
(b) The Skipton Fund will then send you an application form, bearing your reference number, together with comprehensive guidance on how to use the form. After answering a few questions concerning your application and signing the form, you should then pass it to your doctor – who will answer the questions that relate to your illness and how you might have been infected.
(c) We suggest that if you are being treated for a bleeding disorder you ask your consultant haematologist to complete these sections of the form. We suggest other applicants ask the consultant who is dealing with the treatment of their Hepatitis C to do this. If these doctors do not have access to all the necessary information, they may advise you to take the form to your GP or to another specialist doctor.
(d) The application form you will receive initially only covers applications for the basic payment of £20,000. Once the Skipton Fund has checked that you are entitled to the basic payment then it will be open to you to apply for the additional £25,000 payment. You are entitled to this additional payment if your condition has progressed to the stage where cirrhosis is present, or you have been diagnosed with liver cancer, or have undergone a liver transplant. You will need a separate form to apply for the additional payment which you will be able to obtain from the Skipton Fund on request. There is no time limit to eligibility for this additional payment so if you are not entitled to it now you can apply for it again in the future if your condition deteriorates.

2. WHAT HAPPENS ONCE THE FORM HAS BEEN COMPLETED?
(a) When the form is completed, your doctor will send it to the Skipton Fund. The Skipton Fund will then write to you to let you know this has happened.
(b) The Skipton Fund will then check the information on your form. The Skipton Fund will then write to you to tell you whether your application has been successful.
(c) If your claim is successful and you are to receive the £20,000 basic payment, the Skipton Fund will transfer the money to you according to the instructions you gave in the registration form. The same will apply should you subsequently apply successfully for the £25,000 payment, unless you tell the Skipton Fund otherwise.

3. WHAT HAPPENS IF MY DOCTOR IS UNABLE TO PROVIDE THE INFORMATION REQUIRED?
(a) If your doctor is unable to provide the necessary information, eg because some or all of your medical records are missing, they will send the form to the Skipton Fund anyway with an explanatory note. The Skipton Fund may then decide to provide your doctor with a different form that allows a fuller explanation of your circumstances.

4. WHAT DO I DO IF I DISAGREE WITH A SKIPTON FUND DECISION?
(a) If you disagree with a decision of the Skipton Fund you can appeal. You should contact the Skipton Fund for details on how to do this.
(b) If the Skipton Fund makes the basic payment of £20,000 but does not agree that you are entitled to the additional £25,000 payment, this does not prevent you from applying again in the future if your condition deteriorates.
THE SKIPTON FUND – ADDITIONAL INFORMATION

Were all the blood products provided by the NHS prior to September 1991 capable of transmitting Hepatitis C?

It varies from product to product. Factor VIII and IX blood clotting factor concentrates manufactured by the National Blood Service in England and Wales were treated to inactivate the Hepatitis C virus from 1985.

Factor VIII blood clotting factor concentrates manufactured by the Scottish National Blood Transfusion Service were treated to inactivate the Hepatitis C virus from April 1987.

Factor IX blood clotting factor concentrates manufactured by the Scottish National Blood Transfusion Service were treated to inactivate the Hepatitis C virus from October 1985.

Products manufactured in Scotland were commonly used in Northern Ireland.

Will I lose other benefits I am entitled to under other Government schemes if I receive payments from the Skipton Fund?

No. Payments made from the Skipton Fund will be disregarded when assessing means tested Social Security benefits and tax charges/credits. They will also be disregarded when you are means tested for housing improvement and repair grants or for residential care charging. However, if you are asked to provide details about your income on a form, you should declare your Skipton Fund payment(s).

Will any payments I have received from other schemes, or as a result of litigation, be deducted from the payments made to me by the Skipton Fund?

No.

Will I have to prove that it was NHS treatment that caused me to have Hepatitis C?

It depends. If you have received certain blood products (including Factor VIII or Factor IX blood clotting concentrates) then the Skipton Fund will assume that it was this treatment that caused your infection. Other forms of treatment will be considered on a case-by-case basis.

Can I see what my doctor has written about me on the application form?

You are entitled to see the answers your doctor has made to the questions in the applications form. If you want this information you should ask your doctor.

What happens if I receive the basic £20,000 and I either develop cirrhosis, liver cancer or have a liver transplant in the future, or am already in this position?

You will not be able to apply for the additional £25,000 payment at the same time as you apply for the basic payment – you can apply for the additional payment at any time but will need a separate application form which you will be able to obtain from the Skipton Fund. If you apply for the additional payment and are unsuccessful, you can apply again if your condition deteriorates, but not usually within a year of a previously unsuccessful application. You will only receive the second payment if Skipton Fund has first checked that you are entitled to the basic payment.

If you think that you may already be entitled to the second payment you should contact the Skipton Fund for further guidance and an application form.
• What happens if my appeal against the Skipton Fund decision is not supported?

If your appeal is not supported by the Appeals Panel then you can ask the Courts to review your case. This is called a judicial review.

• Do I need the help of a lawyer when applying for a payment from the Skipton Fund?

The Skipton Fund application process is designed to allow people to take forward their application themselves. The forms only require you to provide very basic information and your doctor will supply the necessary medical input. There is therefore no need for you to consult a lawyer. However, you are free to seek legal advice if you wish, for example, if you are considering appealing against a Skipton Fund decision. The decision is yours, but please note that the Skipton Fund will not pay any legal costs that you may incur.

• I wish to apply on behalf of the estate of someone who died between the 29 August 2003 and 5 July 2004—what do I do?

If you are the former parent, partner or other next of kin of such a person, or are the executor of that person’s estate, you should contact the Skipton Fund for an application form. The guidance that comes with the form will explain what you need to do. The Skipton Fund will only accept a single application in respect of a deceased person.

• I wish to apply on behalf of someone who is unable to apply by themselves (for example because they are disabled or too young) — what do I do?

The form should be completed with the applicant’s personal details. If necessary, please provide a “care of” address. You should record your name and relationship to the applicant where indicated.

• I have been infected with Hepatitis C through contact with someone who is eligible – what do I do?

If you have not been directly infected with Hepatitis C as a result of NHS treatment with blood or blood products, but instead have been infected by someone who has, you are eligible to make a claim to the Skipton Fund. If you know the identity of the person who is/was the source of your infection, please wait until they have made a successful application before applying yourself. Once their application has been approved, complete and return an application form, noting your circumstances where indicated. If you do not know their identity, or if they died before 29 August 2003, then you should complete an application form as far as possible, return it to the Skipton Fund and wait for them to contact you.

• Will the Skipton Fund make payments to people who have been infected with other diseases as a result of receiving blood or blood products from the NHS?

No. The Skipton Fund only makes payments related to infection with Hepatitis C.
Convener and Members of the Health Committee,

Smoking, Health and Social Care (Scotland) Bill – Stage 1 Consultation
Part 4: Discipline

Optometry Scotland welcomes the harmonisation of disciplinary procedures of family health service practitioners, and as you would expect, we are firmly committed to the concepts of improving patient protection and optimizing NHS resources.

In general OS supports the future role envisaged for the NHS Tribunal but thinks that the policing of these proposals may be difficult. Consideration must also be given to the place of trainees and students since these people also have close patient contact.

OS does agree that all the primary care professions should be included in whatever scheme for fitness is produced, but there should be a realistic assessment of a practitioner’s risk profile. The various family health service practitioners will have very different degrees of patient contact and opportunity to cause harm to those patients. The Tribunal when assessing any one practitioner’s risk to the patient or the NHS must take this into consideration.

The General Optical Council responded to the Scottish Executive consultation document in June 2004 and the Health Committee may wish to ask for a copy of that submission, as it is relevant to this part of the Bill. It is unfortunate that the National regulatory bodies are not mentioned in the Act or its appendices, as it would appear essential that there is clearly defined co-operation and demarcation of responsibility between the General Optical Council and the NHS Tribunal.

It might be extremely difficult to decide whether a person is a fit person following a conviction that does not result in a successful prosecution. It may be more appropriate for the National Regulatory bodies to be the arbiter and take responsibility for the character of their registrants. It may be more appropriate for Health Boards to refer suspected people to the regulatory body rather than to a whole new system of investigation. This would give a consistency of approach throughout the UK.

OS does have some specific reservations and these are outlined below with reference to the relevant part of the Bill, Policy and Memorandum or Explanatory Notes section.

Policy Memorandum Section

Number # 103
This states that the “NHS Tribunal is the principal disciplinary body for family health service practitioners”. Should this be reworded to the same as Section # 107 of the Explanatory notes which restates this as the “Tribunal is the principal NHS disciplinary body for FHS practitioners”?

Number # 104
OS would ask that definitions or examples of “unsuitability by reason of professional or personal conduct” be produced.

Number # 107
This proposal suggests that a practitioner while suspended will continue to be paid, but if an Optometrist is unable to work, he/she cannot generate income, and therefore cannot be paid. This requires clarification, as the financial penalty of suspension will be considerably different depending on whether the practitioner is a Health Service salaried employee or an independent contractor.

Explanatory Notes Section

Number # 114
This states that a body corporate may be suspended or disqualified on the grounds of fraud or unsuitability. OS disagrees with this proposal. Each situation would need careful investigation before making a decision, as it would be unfair to punish an entire organisation for the act of a
single individual. A corporate body may have a large number of practices, but could be disqualified in total, based on the actions of one or two people. The actions of one individual may be unknown to anyone else within the body corporate, or may be malicious in their intent to that body corporate.

OS suggests that cases of fraud or unsuitability should be directed to the individual or practice concerned and not to the body corporate as a whole. Similar arrangements should apply to franchises and partnerships.

In conclusion

OS would not support an extra layer of administration if it duplicates tasks already performed by the National Regulatory Bodies, or which such bodies could easily assimilate.

OS thinks it is important that, and would be advisable for, the FHS practitioner groups to be closely involved in any policy development or review that follows on from the Bill.

Yours sincerely,

Hal Rollason
Chairman
8 March 2005 (7th Meeting, Session 2, (2005)), Written Evidence

SUBMISSION BY ALZHEIMER SCOTLAND

Alzheimer Scotland has welcomed the overall success of the Adults with Incapacity (Scotland) Act 2000, though aware of a number of important issues which have arisen since its implementation, including the relatively poor uptake of the provisions of Section III for intromission with funds, and the vexed question of when to apply for Guardianship measures under Part VI.

Alzheimer Scotland recognises the particular professional concerns which have led to patchy use of Part V of the Act, and is content to support the proposed amendments to the Act.

We do so because they should:

i) help improve compliance with Part V of the Act,

ii) increase recognition that the Principles in Part I of the Act should be applied whenever any form of medical treatment is required for an adult with incapacity.

However, we have a number of concerns:

i) Part V of the Act was introduced without doctors being provided with the necessary guidance and training on the assessment of mental capacity. This has not yet been remedied. That guidance and training will now need to be extended to other professions. Alzheimer Scotland believes that no professional should be permitted to issue certificates of incapacity unless they have had that basic guidance and training.

ii) The proposed widening of the professional groups issuing certificates of incapacity should not be seen to diminish the need for comprehensive inter-disciplinary consultation in assessing the needs of adults with any incapacity, always involving the adults concerned and their informal carers.

iii) The proposed extension to the duration of certificates of incapacity should not be seen to diminish the importance of regular and comprehensive re-assessment of any ongoing treatment.

iv) Alzheimer Scotland has been particularly concerned by continuing reports of inappropriate prescribing of psychotropic medication to people with dementia in care homes, sometimes over long periods; and of covert administration of medication.

Part V of the Act was introduced without any specific registration or monitoring arrangements. There is an onus on the Scottish Executive, the professional bodies and monitoring organisations to help ensure that its provisions are universally applied and properly recorded, in order to secure the protection of some of the most vulnerable people in our communities.

SUBMISSION BY ENABLE

Proposed amendments to part 5 of the Adults with Incapacity (Scotland) Act 2000

Introduction

ENABLE is the largest voluntary organisation in Scotland of and for people with learning disabilities. We have a voluntary network of members throughout Scotland and over 500 national members of whom two thirds have a learning disability. We also have over 4000 members in 65 local branches. We provide both a legal and information service as well as campaigning on behalf of people with learning disabilities and their carers. ENABLE also has a limited company, ENABLE Scotland, which provides a range of services for children and adults with learning disabilities.
including supported employment, small care homes, community day services, short breaks and out-of-school care for children.

The introduction of the Adults with Incapacity (Scotland) Act 2000 ("the Act") followed many years of campaigning by various organisations, including ENABLE, for the law to be revised. We broadly welcomed the new legislation and have responded to various consultations. We have consulted our members in connection with this paper. Our primary concern is to make sure any changes to the legislation provide a definite benefit to adults with incapacity rather than health or other professionals. However, we recognise that practical issues have arisen with the implementation of the Act that were

Extension to the range of health professionals who can sign certificates

The legislation currently allows only doctors to sign Certificates of Incapacity. Where a person appears to lack capacity any other health professionals involved must ask a doctor to authorise the treatment. This can cause delay in receiving appropriate treatment as well as unnecessary stress. In our experience this is particularly an issue in relation to dental treatment although the situation will be the same for the other health professionals currently excluded.

In principle we have no objection to the proposed amendments to the Act. We acknowledge this may lead to a quicker and better service for people with learning disabilities. However, carrying out treatment under Part 5 is a two-step procedure. Firstly, a decision must be taken on whether or not the treatment is necessary. Secondly, a judgment about a person’s ability to consent needs to be made. Careful consideration needs to be given to the guidelines issued to health professionals on assessment of capacity. Furthermore given that there still appears to be a lack of clarity among doctors about when the Act should be used we would like to see a commitment to further training. This is covered below.

Extending the duration of certificates of incapacity

The legislation currently provides that the maximum length of a Certificate of Incapacity is one year. Our view is that, given one doctor can grant a Certificate and the procedure is not subject to the same checks as guardianship, one year should continue to be the norm.

In principle we do not object to an amendment to the Act allowing Certificates to last for three years in certain cases. However, the guidelines on using longer certificates should be very clear and their use should be restricted to circumstances where there is little or no prospect of capacity being regained. We would suggest that where a longer Certificate is granted it would be good practice to carry out an annual review. The majority of people for whom it would be appropriate to grant a longer Certificate are likely to be receiving regular medical care. Accordingly a review is not unreasonable or unduly burdensome.

We would also emphasis that great care should be taken in assessing any person’s capacity. Even where a condition is unlikely to improve a person’s capacity may not always be constant. For example, the capacity of a person with a learning disability may improve over time where better or more appropriate support services are provided.

Codes of Practice and Training

If the proposed changes to the Act are made then the Code of Practice will also need to be amended. We suggest that the contents of the Code should be considered carefully and a further consultation exercise should be undertaken before the changes are finalised.

In our experience there continues to be some confusion amongst doctors about Part 5 of the Act. In particular, there seems to be a lack of clarity about when it is appropriate to issue a Certificate of Incapacity. There also appears to be little information about the potential use of Treatment Plans.
We have experience of cases where parents or professional carers are still being asked to sign consent forms for adults over the age of 16.

We believe there continues to be a strong need for additional training and awareness raising among doctors. If these changes are implemented the number of people who can potentially sign a Certificate of Incapacity will be substantially increased. Consideration must be given to properly resourced training about the Act. Such training should include not only the application of the underlying principles and how to assess capacity but also communication skills. In our experience user led training is the best way to make an impact. Ideally, we would also like to see the provisions of the Act and communication skills become an integral part of the initial training of health professionals.

SUBMISSION FROM SCOTTISH ASSOCIATION FOR MENTAL HEALTH

Part 5 – Miscellaneous - Amendments to the Adults with Incapacity (Scotland) Act 2000

SAMH was a member of the Alliance for the Promotion of the Incapable Adults Bill. We welcomed the passing of the Act, as we believe that it provided a much needed updating of the law in accordance with human rights, protection for adults with incapacity, and protection for health professionals by providing a clear legal framework within which treatment can be given.

We firmly believe that any changes to the Act, regulations or Codes of Practice must not be taken lightly. There must be cogent justifications for any changes; they must not be seen to be watering down provisions designed to safeguard the rights of adults with incapacity for the convenience of professionals.

Extension to the range of health professionals who can sign Certificates of Incapacity

SAMH is aware of concerns that the current provisions, which mean that only a registered medical practitioner can sign the certificate of incapacity, are leading to delays in adults receiving treatment for acute symptoms, such as dental treatment for the relief of pain. We are not opposed to other health professionals, such as dentists or opticians, being able to sign a certificate of incapacity relating to treatment within their area of expertise provided that they are suitably trained in relation to the Act's provisions and the assessment of capacity. Whilst we can also see an argument for nurses being able to sign incapacity certificates, we believe that this should be restricted to nurses in more senior grades (say grades F and above).

Research published last year by the Scottish Executive stated that: “Medical practitioners, and GPs in particular, have expressed a lack of confidence in their skills and abilities to assess capacity” and;

“The need for further guidance on the assessment of incapacity and communicating with the adult emerged from at least three different source: the review of information and training; the review of the codes of practice; and feedback from stakeholder groups, especially the medical profession”.

Assessing capacity requires particular skills, including communication skills, and a thorough knowledge and understanding of the relevant provisions of the Act and its underpinning principles. It should be a requirement that health professionals, to whom powers are to be extended, undertake accredited training in assessing capacity before they are empowered to sign incapacity certificates. NHS Education Scotland could develop an appropriate training programme.

Extending The Duration Of Certificates Of Incapacity

SAMH is not opposed to the upper limit of the duration of certificates being extended to 3 years with the strict proviso that this should only be possible in relation to adults with little or no prospect of capacity being regained. Whilst we can see that this may apply to adults who have advanced dementia or profound learning disabilities, we cannot see that it should apply to people with mental health problems as these result in fluctuating levels of capacity.

We note that the provisions in the Bill envisage that the circumstances in which the certificate might be extended beyond one year will be prescribed in regulations. We believe that it is essential that
there is wide consultation with all relevant stakeholders in relation to the content of these regulations.

SUBMISSION BY ROYAL COLLEGE GENERAL PRACTITIONERS (SCOTLAND)

Thank you for seeking our comments on this bill.

The RCGP supports the level of protection of vulnerable people given to them through the Adults with Incapacity (Scotland) Act 2000 and, as such, supports the principles underpinning this legislation.

The RCGP feels that this is a sensible piece of legislation, in that there is clearly a need for protection for adults without capacity. But overall there are concerns relating to the additional administrative burden and workload on GPs as a result of the legislation, and the perception that the certificates are another piece of possibly unnecessary paperwork.

However in light of this, and with specific reference to the two proposed changes to the Adults with Incapacity (Scotland) Act 2000, which are contained within the Smoking, Health & Social Care Bill, section 30, the RCGP welcomes the changes as a positive move to reduce the administrative burden on GPs.

On the proposed changes, the RCGP would make the following comments:

Amendment One: The extension of authority to grant a certificate

Concerns over the reliance on medical practitioners alone to sign the certificate were raised by the RCGP through the Adults with Incapacity (Scotland) Act 2000 Review. It was felt that other professionals such as nurses, dentists, community psychiatric nurses, might in fact be much more familiar with the patients.

As such, the RCGP welcomes proposals contained within section 30 of the Smoking, Health & Social Care Bill, to extend the authority to grant a certificate under section 47 (1) to health professionals who have the relevant competencies to assess the capacity of a patient.

Currently the Adults with Incapacity Act limits responsibility for assessment of incapacity to medical practitioners only. The RCGP believes this is inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialists, clinicians and clinical psychologists.

In addition, we support the view of the BMA, which is concerned about issues raised by the Health Committee during its early discussions on this Bill (11 January 2005). Extending the ability for other health professionals to issue certificates will not remove overall responsibility for the care of patients from the general practitioner or other doctor, rather it is intended that this amendment would prevent unnecessary delay and discomfort for patients requiring treatment. GPs would continue to issue certificates of incapacity for general authority to treat, but it would no longer be necessary for doctors to issue certificates for treatments provided by independent health professionals.

Many healthcare professionals, other than medical practitioners, have specific training and expertise in dealing with incapable adults and are in a position to judge an adult’s capacity for making decisions regarding treatment. In addition, doctors may not understand specific (e.g. dental) treatments in any detail and would therefore not be best placed to judge the capacity needed in those circumstances.

The broad definition of ‘medical treatment’ in the Adults with Incapacity Act potentially limits the access of incapacitated adults to routine treatment without formal assessment. Subsection (2)(b) lists those persons who will be able to issue a certificate, but only in respect of their own area of clinical practice. Care must be taken to ensure that terms such as dental treatment or nursing treatment are not interpreted narrowly. The essential requirement is that the practitioner doing the
assessment is capable of assessing capacity and forming a view on the likely benefit to the adult of the treatment proposed.

The RCGP and the BMA acknowledges that the list of those persons who will be able to issue a certificate can be amended by regulations subject to consultation. The RCGP supports the view of the BMA that clinical psychologists be added to this list.

Amendment Two: Duration of certificates

The RCGP have previously raised concerns over the one-year validity of certificates and as such welcomes the proposed changes, as supported through previous consultation.

This position is based on cases where patients, for example, with severe learning disabilities or progressive dementia, are unlikely to recover. Seeing them annually, simply to fill in a further certificate is seen as a waste of valuable time and simply an exercise in bureaucracy. Therefore, the proposal to extend the maximum duration of the certificate of incapacity to three years, with the length of the certificate being dependent on the nature of incapacity of the individual, is strongly advocated by the RCGP as a sensible measure.

In summary, and in its whole, the RCGP welcomes the changes proposed in the Smoking, Health and Social Care (Scotland) Bill, that would amend the Adults with Incapacity (Scotland) Act 2000.

These changes will improve the health care accessible by those vulnerable people using the health care system, while paving a way forward to eradicate some of the bureaucracy that arose from the original Adults with Incapacity (Scotland) Act 2000.

Yours sincerely

Dr Mairi Scott FRCGP
Chair
Royal College of General Practitioners (Scotland)

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 30

Main Objective: Easing authorisation of medical treatment for adults with mental incapacities.

Do you agree with the main objective of this part of the bill? yes

If yes, why?

RCN Scotland supports the extension of the legislation to include nurses as health professionals able to assess capacity and issue a certificate of incapacity thereby enabling the nurse to treat a patient incapable of consenting.

Are there any other comments you would like to make?

Section 30 (2) (b) is welcome as it extends powers to registered nurses in a specialist area to issue a certificate to allow a general authority to treat an adult with incapacity. It would mean that those nurses make the assessment of capacity. This may be particularly useful for nurses working with people suffering from dementia who may be better placed to see the incremental changes in capacity.

RCN Scotland understands that the effect of section 30 (2) (c) (ii) is that the new power for nurses in a specialist area to make this assessment would be limited to the nursing care needed. However, this goes against the overall purpose of the certificate which is to allow "general authority to treat". It may be that the Committee will need to check this against an example. Would an MS specialist nurse have the legal power to certify nursing treatment only for a patient with MS who lacked capacity, or does this power give her legal authority to authorise medical treatment (say the start of artificial hydration and nutrition)? The policy memorandum does not make this distinction
clear in relation to nursing and medical treatment. The example that is given relates to dentistry but this does not take into account the multi-disciplinary working between a specialist nurse and a doctor in relation to setting the boundary for the powers to be included in the certificate to be issued by the nurse.

The policy intention is to make two amendments to section 47 of the 2000 Act. The first will extend the authority to grant a certificate under section 47 (1) to health professionals who have relevant qualifications and training to assess the capacity of patients. This group is in addition to “registered medical practitioners” who are capable of making an assessment of the patient’s capacity as required in terms of section 47. Importantly, the certificate will only be valid within their specialism, for example a dentist could only authorise dental treatment. The authority to issue a certificate will be expanded in terms of the Bill to include dentists, ophthalmic opticians and registered nurses, but there is provision also to extend to other professional groups by regulation. Consequential changes will be made to other sections in Part 5 of the Act.

Issues to consider here are whether there are categories of nurse who cover a range of different conditions that may lead to a lack of capacity, say older people’s nurses, and assess whether this power is too wide for them because of the range of conditions or illnesses that may lead to a lack of capacity. Such nurses in a wider role may need different types of training in the assessment of capacity. However the RCN believes that it inappropriate to set out specific categories of nurses in legislation.

RCN Scotland would like to suggest that any further guidance could be set out in the Code of Practice which supports the implementation of the Act. For example training will be needed to ensure nurses are competent to assess mental capacity. They will also have to understand for which treatments they can consent i.e. are within their nursing specialism. It is likely that dentists and other health professionals will also need training and we note there are no costs identified in the financial memorandum. This is clearly going to be the case and the very real costs will be:

A) to design and deliver the training;
B) to identify, release and backfill nurses for the training;
C) to assess competence in practice; and
D) to identify that potentially nurses undertaking this role will merit job evaluation under Agenda for Change and this may attract a higher salary.

These costs are not only to the NHS but also the independent sector which has large numbers of care homes caring for the elderly and some specialising in dementia care employing some 5000 nurses.

RCN Scotland does not propose that a register be kept centrally of competent nurses. However, it should be included in the Code of Practice as good practice to keep records of nurses and others who are trained to assess capacity. This is a matter of public accountability as well as professional recognition.

RCN Scotland is currently unaware of the existence of a ‘nursing tool’ to assess competency but we are continuing with our search. We would also draw to the attention of the Committee the role that Nurse Consultants should be playing in Scotland to put strategic developments into practice. RCN Scotland’s manifesto for the 2003 election called for a targeted approach to the establishment of Nurse Consultant posts in all mainland NHS Boards in key areas including mental health, cancer, coronary heart disease, older people’s care, children and public health. Unfortunately, despite Ministerial commitment for a tripling of current numbers to a target of 54 by 2005, only half of that number are currently in place.

RCN Scotland believes the Minister and Chief Nursing Officer should put funds in place to require NHS Boards to create Nurse Consultant posts in these areas as well as Child Protection and Learning Disability nursing. Nurse Consultants and specialist/advanced nurses in mental health, older people’s nursing and learning disability would be ideally placed to lead modern nursing care with excellence in practice, evidence based care and service developments as core elements.
The Committee should also note that the NMC is currently consulting on a framework for the standard for post registration nursing i.e. advanced practice. The outcomes of this work could inform future nursing developments.

SUBMISSION BY BRITISH DENTAL ASSOCIATION

Part of Bill: Part 5, section 30
Main Objective: Easing authorisation of medical treatment for adults with mental incapacities.
Do you agree with the main objective of this part of the bill? Yes
If yes, why?
The legislation to allow a dental practitioner to sign and issue a certificate under Section 47 of the Adults with Incapacity (Scotland) Act 2000 within his or her own professional area will facilitate the care of adults with incapacity, particularly when emergency relief of dental and oral pain and discomfort is required. Under the existing act, delays often occur in the treatment of patients suffering from dental pain whilst a Certificate of Incapacity is being sought.
In addition, the dental practitioner skilled and experienced in the care of patients with special needs may well have more understanding of the procedures and the ability to assess a patient’s capacity for consenting to specifically dental treatment than a medical practitioner.
If not, why not?
Not applicable
Are there any other comments you would like to make?
No

SUBMISSION BY EC HARRIS

Introduction
Thank you for attending and participating in the high level seminar which took place on 20 May 2004 in Edinburgh, and which was the final element in the Scottish Executive’s public consultation on ‘the use of Joint Ventures to deliver primary care/joint premises’. The seminar concluded that Local Improvement Finance Trusts (LIFT) will most likely work in Scotland as a potential means to help deliver primary care facilities for the 21st century.
The NHS LIFT ‘model’, which is already being used in England, is an initiative designed to encourage greater integration of service delivery within the primary and community care sector.
Trevor Jones, Chief Executive and Head of Health at the Scottish Executive, gave the key note address at today’s seminar which was facilitated by leading international consultancy EC Harris, and co-sponsored by legal practice DLA and major accountancy firm Grant Thornton. More than 70 delegates, representing a wide range of organisations with an interest in the health sector in Scotland, attended the event. These included: local authorities, health boards, housing associations, enterprise agencies, property developers, funders, consultants, contractors, ‘Communities for Scotland’ and the ‘Scottish Health Partnership Forum’.
Delegate groups debated the Scottish Executive’s key consultation points on ‘the use of Joint Ventures to deliver primary care/joint premises’. This paper outlines the conclusions that were made following the seminar’s seven different workshops to debate key consultation points. These points were:
The scope and definition of the proposed powers to enable Scottish ministers and Health Boards to form and hold shares in joint venture companies.

The coverage and size of joint ventures, any possible alternative models and their structure and governance arrangements.

The formulation and operation of joint ventures and how they should be regulated.

The consideration of the structure of joint ventures as companies limited by share capital.

The application of Community Planning Partnerships and their planning processes as vehicles to establish joint premises developments.

The governance arrangements for public sector individuals acting as directors of joint venture companies.

The suitability of the LIFT model for Scotland and any unique conditions in Scotland that would merit variations to the model adopted in England.

Private Sector views on the English LIFT model and the likely interest in a Scottish LIFT.

The conclusions to each of these consultation points is summarised in the next section.

a) The scope and definition of the proposed powers to enable Scottish Ministers and Health Boards to form and hold shares in joint venture companies.

It is suggested that the proposed powers be drawn as flexibly as possible in both scope and definition.

Although the most likely joint venture vehicle is a company limited by share capital (the objects of which are the provision of facilities to persons exercising functions under the National Health Service (Scotland) Act 1978), the opportunities for synergies with urban regeneration projects would indicate it is also worth extending the scope of the powers to include the formation and participation in "public-public" joint ventures including by means of a company limited by guarantee or the use of a limited liability partnership (for reasons of tax efficiency and transparency) the objects of which are to undertake regeneration of urban communities. Such vehicles may not themselves undertake the provision of facilities but may delegate that obligation to subsidiary (possibly joint venture) vehicles with the private sector.

Furthermore, if Scotland is to develop a joint venture arrangement similar to LIFT, the powers of the Scottish Ministers and Health Boards to form and participate in joint venture companies should reflect that LIFT Companies (i.e. the vehicles in which the public sector investment would be held) are likely to be holding companies for the subsidiary vehicles (fundco and holdco) which will likely be established to undertake the individual waves of each LIFT scheme rather than the vehicles which actually undertake the provision of facilities.

The proposed powers should also include the ability to delegate the appropriate functions of the Health Board to the relevant joint venture vehicle and allow for potential cross subsidisation between government departments. For example, the returns derived from one subsidiary (e.g. providing healthcare facilities) may be used to invest in another project undertaken by LIFT Co (e.g. for community services accommodation, education or regeneration).

It is assumed that the intention is to limit application of such powers to the provision of facilities (which itself should be interpreted in the widest sense to include services, equipment and any funding agreements etc ancillary thereto). However, although ultimately a matter of policy, given that in England, the provision by LIFT Companies of limited clinical services is under consideration. It may therefore be worth drafting the powers sufficiently widely (e.g. “for an approved purpose”) to avoid the need for further legislative amendment in the event that such a policy should be required.

The powers need to limit the exposure of the partners and minimise the risk of losses. To cover Directors taking personal liability for risks above those incurred within their normal duties, insurance protection will be required.

Clearly, the capability and training of officers to become Board Directors in LIFT Co needs to be considered at the earliest opportunity, together with the cultural impact of becoming a shareholder.
a) The scope and definition of the proposed powers to enable Scottish Ministers and Health Boards to form and hold shares in joint venture companies. There should be a definition of the required competencies and personal qualities for the role of Board Directors. This should be used to select the most capable individuals for these roles and should also drive the training programme to ensure that there is support and succession planning to protect the interests of the partnership.

In summary, it is important the powers provide the opportunity for:

- Flexibility
- Demonstration of Value for Money
- Checks and balances (i.e. Corporate Governance)
- Aligning the investment needs of Public and Private sector partners.
- The Secondary Fund Market
- Exit from the partnership

b) The coverage and size of joint ventures, any possible alternative models and their structure and governance arrangements. If a LIFT type structure is to be replicated utilising project financing then it is suggested that individual schemes will need to have sufficient "critical mass" to attract funders. This is particularly important, as bid costs may be higher during the implementation period until the process becomes familiar and standardised project documentation has evolved and become accepted.

However, this concept has to be balanced against the interests of local communities and wherever possible maintaining "ownership" of individual schemes at a local level.

Health Boards and Local Authorities should continue to be able to form joint ventures with each other and the private sector (e.g. as on West Lothian) without use of the ultimately selected template being mandatory.

Alternative models include traditional joint ventures (i.e. a virtual vehicle), and the use of companies limited by guarantee or limited liability partnerships. The regeneration sector has also spawned a number of alternative delivery models, which may be worth considering.

As mentioned above, public-public joint ventures for purposes, including inter alia provision of healthcare facilities may be worth considering in certain circumstances, particularly where the overall objective is urban regeneration.

The structure and governance arrangements of whatever vehicle is ultimately selected can be tailored to meet individual requirements as necessary, and thus the structuring of such arrangements is not seen as an obstacle or impediment to achieving stated objectives.

c) The formulation and operation of joint ventures and how they should be regulated. The role that Partnerships for Health has played in facilitating the implementation of the LIFT model in England would appear to have been important to its success. A similar structure (i.e. a body such as Partnerships UK in conjunction with NHS Scotland) should be tasked with interfacing between the Scottish Executive and individual projects during the establishment stage.

It is essential that such a body is aware that a "one size fits all" structure is unlikely to work in Scotland. Alternatively, whatever joint venture model is selected, the risk transfer model embodied in the LIFT Lease Plus Agreement appears to present a useful template that could be replicated (e.g. even on a conventional lease structure).

Consideration is needed as to the overall role of the joint venture. There were two case specific examples discussed; the overall strategic partnership that is created to form a long-term vehicle for delivering a diverse range of outputs that may not be fully defined at the outset. With this in mind, the partnering aspects of the appointment and agreements are paramount as this will be a relationship based on mutual values and objectives. Alternatively, it may be desirable to set up more tactical arrangements that are designed to deliver specific programmes or projects.
The structure of the joint venture should clearly identify the roles and responsibilities of the partners involved and needs to achieve a meeting of cultural and practical requirements.

From the public sector perspective, there should be a recognition that the traditional purchaser/provider relationship must evolve. There needs to be greater awareness of the balance between commercial focus and service delivery. Whilst there will be areas for mutual compromise, some requirements in the public sector (i.e. corporate governance, Standing Orders, Financial Instructions, etc.) are not negotiable.

There was a concern that in the English LIFT model, the appointment process was skewed by the over emphasis on the quality of design. There was a danger that consortia were appointed on the strength of the Architectural input rather than their partnering qualities.

There will be a necessity to demonstrate value for money at all stages. It may be possible to obtain benchmarking information from other PPP projects within Scotland, plus data from LIFT in England.

It is essential that standardised controls for monetary commitments are in place from the outset. These should be written in to the agreements and should contain no ambiguity on the roles and responsibilities of the partnering organisations and the individuals involved.

d) The consideration of the structure of joint ventures as companies limited by share capital. There are a number of structures that can be adopted and tailored to meet the circumstances of an individual scheme. The exact structure should be flexible enough to support the objectives of each area. Alongside this, however, the shareholders agreement needs to be clear in terms of rights and obligations.

Robust public sector strategic planning is needed to reduce the "comings and goings" within the joint venture. However, this must be balanced against the need for flexibility of structure to allow other partners (public & private) to join or leave during the tenure of the company.

Experience in England has shown that changes to the structure of the partnership have inevitably incurred the burden of additional time and costs to all parties.

A balance is needed between flexibility and deliverability.

A company limited by share capital is seen as the best option because of affordability (it will allow greater borrowing) and the fact that it is a tried and tested model.

e) The application of Community Planning Partnerships and their planning processes as vehicles to establish joint premises developments.

In the existing Scottish legislative framework, there is a statutory responsibility to involve stakeholders in consultation processes. There is a wish to avoid duplication of existing mechanisms.

Community Planning Partnerships are considered a good forum and appear to be central to developing the process of planning premises, given their role in facilitating joint working and long term planning. However, community-planning consultation is a specialist, skilled activity and the availability of resources could be an issue.

There is a concern that Community Planning Partnerships could create tensions as they have limited involvement and experience of the planning process for creating physical assets.

There are numerous initiatives from the Departments of the Scottish Executive many of which involve Community Planning Partnerships and these need to be tied together by the Executive to avoid confusion and conflict between the different parties. Inter-Departmental communication and cooperation within the Scottish Executive is seen as essential to achieving this aim.

There is a need to develop the link between local and strategic planning, which was perceived to be missing from the current LIFT process.
f) Methods to ensure that all appropriate stakeholders are fully engaged in the planning process.

The scope of the planning process needs to be clearly defined. For the purposes of the consultation workgroup it was taken to apply in its broadest sense to the overall planning and delivery of projects.

Existing frameworks can be applied - Community Planning Partnerships within the Scottish context and the SSDP used in English LIFT projects. To optimise engagement, a Scottish process probably needs to draw on both.

The Strategic Service Delivery Plan (SSDP) should be initiated and driven by the Health Boards and draw in key public sector stakeholders such as senior GPs but not involve the private sector - this is for later.

NHS Scotland seen as playing a greater role than its English equivalent because of the size and structure of the Scottish health sector. Question whether an independent "Partnerships for Health" is needed or the existing unit can be strengthened to take on this kind of role.

Early stage planning needs to be focused very much on healthcare driven objectives - regeneration is a by-product, not a driver.

Local conditions will affect the balance of input from different stakeholders - local authorities may take a greater or lesser role according to the circumstances, for example, so the process needs to be flexible enough to accommodate these variations.

The process of stakeholder engagement should be carefully planned throughout, with clear ground rules and system of champions / spokespeople as appropriate, who are able to represent the interests of their stakeholder groups effectively.

What clearly doesn't work is where the key spokespersons for the project are not stakeholders (e.g. consultants!).

Each SSDP is local to a particular area, but it may not be communicated to all of the stakeholders in the locality. Some partners become involved late in the process and others fall away as Financial Close is approached. It was felt that within the English LIFT process, the consultation process was piecemeal and caused delays to the programme. It was suggested that it could be improved by having agreed milestones and objectives with a fixed close that is linked to specific outcomes.

The group would like to see the focus of LIFT broadened to include other community based services beyond health, though it was recognised that this could create issues around service planning. It was suggested that a regeneration "badge" would allow a wider range of services to be included in the LIFT, though there was a clear need for a single Agency to take the lead. It was recognised that this approach could carry a risk of the priority objective of improving health outcomes in the community being diluted.

It may be helpful to embed the supply chain in the joint venture vehicle at an early stage to ensure that their views contribute to the planning stages. Examples of potential benefits include identification of sites and broader development opportunities that cannot be realised by the public sector in isolation.

g) The governance arrangements for public sector individuals acting as directors of joint venture companies.

Such arrangements should not be problematic. Public sector individuals undertaking such a role is a fairly well worn path and problems of "conflicts" are likely more apparent than real. In any event, the constitutional documents of the joint venture companies including Shareholder Agreements between shareholders commonly regulate issues as between investors including the conduct required should a conflict of interest arise.
On the other hand, training of public sector individuals undertaking such a role in such practices may be beneficial. It may also be worth appointing a body to undertake monitoring roles to compare practice across projects and potentially provide support should difficulties arise.

From the public sector perspective, the parameters for reinvestment of the proceeds derived from joint ventures should be clearly laid out.

There will always be an imperative to demonstrate transparency and auditability in all transactions. All decisions, fiscal or otherwise need to be taken in the light of the evidence available at the time. This will drive the requirement for independent monitoring reporting.

Additionally, the interpretation and development of policy must flow through the process to avoid inconsistent decision-making.

One important topic covered by this area of policy will be Conflicts of interests. There should be clear guidance for public sector individuals on how to identify and resolve any areas of uncertainty and how to react, should a conflict arise.

Consideration to how conflicts are to be dealt with (e.g. “Chinese Walls”, etc.) could be developed prior to the formation of joint venture companies. There are many existing examples of these protocols already in existence and a suitable model from elsewhere could be easily adapted.

h) The governance arrangements for public sector individuals acting as directors of joint venture companies. There would not appear to be anything unique to Scotland, which would suggest LIFT is not a suitable model. However, there are some peculiarities that would have to be addressed. Examples of these are provided below.

The Employment Protocol
This will probably affect the pricing model. However, in this respect it is no different to other PFI/PPP Schemes undertaken in Scotland;

Legal system e.g. land issues
Title to land is held by the Scottish Ministers rather than Health Boards and this would probably require some amendment to the standard LIFT documentation. More generally, well-drawn documentation, which represents a workable framework, is more likely to be successful. The LIFT model in England appears to have reached a sensible balance between public and private sector interests and if LIFT is to be replicated for Scotland, time spent adapting the documentation is likely to reap rewards down the line.

Demographics
It may be difficult to balance critical mass with local community ownership if schemes in the highlands are bundled together. Community involvement and participation is likely to be key to the success of such initiatives;

Political Climate
The Scots are generally more hostile to PFI/PPP than their southern counterparts. However, the fact that the public sector stands to benefit from potential profits through participation in the joint venture vehicle may prove a selling point.

Scottish PFI Market
The market is fairly sensitive. Care must be taken with the timing of projects coming to the market. However, this may prove to be less sensitive as different contractors may be attracted (i.e. smaller players) given the size of the individual schemes. However, the quality of standard documentation will play a critical part, as there is unlikely to be an appetite to reinvent the wheel and incur significant bid costs.
Structural and organisational characteristics
No PCTs, so who drives the local agenda? Because the same Boards run primary and secondary care in Scotland there will be different challenges than in England (where PCTs and acute trusts are separate).

Scotland has no PCTs, there are 15 Health Boards. The individual Boards have flexibility to structure health organisations in their geographical area. It was uncertain how LIFT would be implemented — ie driven centrally by the Scottish Executive or devolved to the Health Boards for local interpretation. Whatever option was chosen, it was seen as essential that the policy should be as fully developed as possible before the roll out.

The SSDP must reflect and integrate the estates strategies of all of the stakeholder organisations.

PfH are not present in Scotland, will there be an equivalent created?

However, it was believed that involving LAs will be easy because of the level of joint planning that already goes on. It was believed that as a result LIFT in Scotland will be even more flexible with more exciting outputs.

Staff side issues characteristics
It was felt that the staff side was stronger in Scotland i.e. where JVs would displace existing public sector staff this would be resisted very strongly. Employment protocol ie TUPE. FM – UNISON was believed to be against LIFT in Scotland.

Geographical characteristics
Geographical issues - the conurbations of Glasgow and Edinburgh are similar to England, however, there are some very remote communities with small populations in Scotland. The challenge will be how these communities can be joined into viable JVs. It will be even more critical to encourage Local Authorities to be involved because of the need to gain critical mass in remote areas. One size fits all won’t work – geography/remote areas. The geographic factors of Scotland are different to England, ie central belt of population and remote and sparsely populated rural areas.

Socio Economic characteristics
Overall it was believed that there was not as much deprivation in Scotland and so they are starting from a better position

Summary
Self evident that some form of LIFT model could work but not exactly the English model. Key issues include: population density, condition of estate, perceived investment requirement. What is the size of the market? Concern from the private sector about broadening the scope beyond the relatively "low tech" approach seen in England so far.

There may be opportunities to learn from and improve upon the English approach. Examples include
Is the 40%:60% shareholding split in LIFTCo appropriate for Scotland?
What central support will be available (e.g. equivalent of Partnerships for Health)?

It was stated that strong project management of the process was considered essential to the success of LIFT.

i) Private Sector views on the English LIFT model and the likely interest in a Scottish LIFT. The robustness of future programmes of work is factor that will influence the private sector interest in joint ventures, i.e. lack of certainty/guarantees on pipeline workload. Each phase should ideally be profitable as a stand-alone venture.

Agreements need to be long term and exclusive to be most attractive to the Public Sector. Exclusivity, however, was seen as complex as e.g. Local Authorities may also have other exclusivity agreements.
Bid costs are considered high, therefore cashflow and funding to financial close and the speed of close are issues. Within the English LIFT model contracts now defined to enable recovery of bid costs.

Due to high bid costs, bidders in Scotland may not wish to bid for projects that are too big.

Deliverability. Land ownership issues have been a problem in England. The Public Sector needs to raise its game to ensure robust strategic planning so that commitments can be made.

Scope of services within the deal. Most members in the group agreed that soft FM should be included – although one contractor felt that it should definitely not be. Clinical services should not be included. Will the private sector be interested in LIFT if FM is not included, or only partially included? Very interested - this is a hybrid PFI / land play.

Funding Issues:
• It was seen as desirable/essential that funding goes into the main LIFT CO.

• LIFT in England was seen as good and the timing was right (political pressure to deliver). That same time pressure may not be there in Scotland. However, primary care is leading the drive to deliver improved healthcare services.

• If there is more time available, there may be benefit from waiting and learning lessons from the English experience.

• Banks may not wish to fund projects that are too small to be financially attractive.

• How can Scotland reduce the costs of LIFT compared to PPPs? (NB this may be a misconception – are the LIFT costs higher on fair comparison of all services?).

• This approach may suit the size of contractor base in Scotland.

• It would be helpful if a portfolio approach could be adopted to help spread risks.

• It may be appropriate to implement 1 or 2 pilots in geographically distinct areas (e.g. Central Belt, Highlands)?

• Perceived lack of public sector skills. Some kind of PfH-type facilitator required.

3. Conclusion

Delegate groups debated the Scottish Executive’s key consultation points on ‘the use of Joint Ventures to deliver primary care/joint premises’ before coming to the conclusion that LIFT was a model that could be adopted in Scotland. The adoption of LIFT is subject to legislative changes being enacted which would allow private sectors organisations to enter into joint ventures with Scottish health boards. The delegates concluded that a number of related issues would need to be addressed to enable LIFT to work effectively in Scotland. These include:
• There needs to be recognition of the differences in demographics and geography in Scotland versus the experience so far of LIFT in England. This could require batching of geographic areas to achieve the critical mass required to make the LIFT model viable and hence attractive to private sector investors.
• Long term strategic planning is required from the Scottish Executive and the local health boards to avoid a piecemeal approach and to provide long-term certainty for private sector investors.
• A flexible approach is required rather than a ‘one size fits all’ model. This would allow for differences in the ownership structure of LIFT Companies, provide flexibility for changes over time, and flexibility on the range of services to be included in each respective LIFT.
• Whilst LIFT can be a catalyst for broader regeneration initiatives, focus should not be lost on the overarching objective of LIFT which is to deliver primary health facilities for the 21st century and hence improve overall patient health outcomes.

An executive spokesman from the Scottish Executive said: “Today’s seminar has played a valuable part in the Scottish Executive’s consultation process. We are committed to engage with all potential stakeholders and we very much welcome the opportunity to receive the views of those who have attended and contributed to today’s successful event.”

Ken Talbot, Head of EC Harris’ Scottish Operations, said: “This seminar has been a unique opportunity for those involved in, and those interested in, primary care in Scotland to contribute to the public consultation process that will help to establish the framework for the delivery of 21st century primary care facilities in Scotland. We hope that the conclusions drawn today will contribute positively to the public consultation process that will help shape government policy for Scotland, including potential legislative changes required to allow public private partnerships in this area.”

SUBMISSION BY COSLA

COSLA is pleased to have the opportunity to give oral evidence to the Health Committee on the Joint Ventures elements of the Smoking, Health and Social Care (Scotland) Bill. As the Committee will know, COSLA has already submitted evidence on the Bill generally and, specifically, on financial aspects. As requested, the following comments are restricted to the Joint Ventures provisions. Our comments will focus on the following areas:

• Consultation on Joint Ventures
• Concerns and Opportunities on Joint Ventures
• Views on what should happen now

Consultation on Joint Ventures
The Committee will be aware of the perceived lack of involvement of Scottish Local Authorities in the joint ventures elements of the Bill. These sections of the Bill do have relevance to local government, if not immediately, then potentially in the longer term. From the practical perspective, local authorities have a range of experience, good, bad and mixed in involvement in private partnerships. The overall principle of partnership with non-local government bodies has not, and will not, be rejected on ideological grounds.

There is a view that the development of the Joint Ventures section of the Bill has been internalized within the NHS system. As a result, whilst there has been officer level contact, this contact has been restricted to the applicability or otherwise of the English model in Scotland rather than focusing on a wide range of options. There has been no political engagement on the issues – an omission that is particularly concerning given the fact that COSLA has previously highlighted a similar omission in relation to the NHS Reform (Scotland) Bill.

This lack of prior political engagement gives rise to fears – perhaps unjustified - about a lack of transparency in the approach adopted and a consequent suspicion about the focus on the LIFT (Local Improvement Finance Trust) Scheme.

COSLA feels that the following should have been the subject of prior consultation and will now be seeking clarification from Ministers as to:

• What the partnership schemes are designed to achieve;
• The scale of the intended schemes
• Whether there is a wider strategy behind the proposals (either within an NHS Board area or at national level)

Concerns and Opportunities
The principle of Ministers enabling Health Boards to have access to a greater range of investment sources to support the development of infrastructure and better integration in service planning is
accepted. However, it cannot be assumed that, as a matter of course, local government will benefit in the same manner as the NHS. Similarly, it cannot be assumed, as the financial memorandum suggests, that this section of the Bill will have no financial impact on local authorities.

Although the provisions in this Bill are directly targeted at the NHS, and, it is understood, specifically the general practitioner estate elements of the system, the consequences of enabling this will fall directly within the scope of local government – something COSLA must highlight.

The Executive has been investigating the suitability for Scotland of the LIFT Finance Trusts being implemented in England by the Department of Health on the basis of their potential flexibility for joint premises developments. The Executive has concluded that the decision on the development approach most suitable for each Health Board area in Scotland is one to be taken locally in conjunction with other partners.

Introduction of LIFT type entities may offer an appropriate way forward in some parts of Scotland, particularly where there is an urgent need to find a way to address the strategic planning deficit in closer collaboration with the private sector and other public sector agencies.

In other areas, partners may decide that their objectives for the medium term are already sufficiently well scoped and that a variety of delivery vehicles may offer an appropriate way forward. These could still involve joint ventures with the private sector or wholly within the public sector. It is understood that the Executive intends, once these powers are in place, that all Health Boards and local authorities will be invited to confirm how they intend to deliver their respective infrastructure development strategies to identify whether joint ventures may offer an appropriate vehicle.

An area by area approach is something COSLA would support but again it must be clear that this is in fact the intention and not a covert means of promoting a national approach without proper consultation with COSLA.

For the avoidance of doubt, COSLA see merit in allowing local partnerships to come to a strategic decision based on what suits their needs. The provisions in this section of the Bill will not determine local government’s involvement as the ability to enter into partnerships already exists.

COSLA believes that there is scope through joint ventures to investigate the possibility for enhanced joint working, including capital projects between local authorities and the NHS. As with other areas of joint working COSLA, and local government, are supportive of this provided there is real and demonstrable added value to both parties and the communities they serve. Pressure to enter into joint ventures should not be seen as an expedient vehicle to assist the NHS to overcome any difficulties with securing appropriate capital resources to overhaul an ageing estate. At present the Scottish Executive way of handling this issue is creating a suspicion that this, rather then providing an enabling framework, is the aim.

What should happen now
COSLA has already indicated that we are not necessarily opposed to this aspect of the Bill on ideological grounds. Our concerns are about the need for proper political engagement and a clear understanding on whether or not Ministers have made decision on this being a local decision making process or a national framework. If so should it be the LIFT scheme or are there better way of handling joint investment in infrastructure to enable better service delivery?

In COSLA’s view there now needs to be political engagement and a clear discussion on how to proceed next. That is what is currently missing. We feel that this should involve the Ministers for Health and Local Government and Finance and believe that there are opportunities to enhance partnership work and services to citizens if we secure open dialogue at political rather than officer level.

Finally, COSLA would also be willing to have a discussion of the implications of this element of the Bill. To date, the focus has been on the NHS improving its locally based estate (GP surgeries) and that this will lead to service improvements. Whilst COSLA does not disagree with this as an objective, we are aware that investing in this area of work means either not investing elsewhere or shifting existing priorities. This has yet to be acknowledged and COSLA would wish to make sure
that we were not investing capital at the expense of resources that would otherwise have been directed at delivering services.

Conclusions
COSLA intends to raise these issues with Scottish Ministers with a view to exploring our concerns and receiving the clarification and assurances required in connection with these sections of the Bill.

COSLA hopes that this submission, despite its late timing, for which we apologies, is helpful to the Committee.

Yours sincerely

Alan McKeown
Policy Manager, Health & Social Care Team

SUBMISSION FROM STUC

Joint Ventures

The STUC welcomes the opportunity to give evidence to the Health Committee on this important issue. The STUC is Scotland’s Trade Union Centre. Its purpose is to co-ordinate, develop and articulate the views and policies of the Trade Union movement in Scotland. The STUC represents around 630,000 working people and their families throughout Scotland. Our affiliated organisations have interests in all sectors of the economy. Our affiliates are strongly represented in the NHS and health sector generally. Trade union members also have an interest as users and funders of health services.

Fundamentally the STUC is opposed to private business taking over the ownership, financing and management of any public sector infrastructure and services and tying the public sector into exclusive long-term contracts with private sector companies. The STUC and its affiliates supports the continuing process of improvement and development of Scotland’s public services. We believe that public services should be run on ethical lines based on the principles of selflessness, integrity, objectivity, openness, accountability, competence and equality.

However, it is our belief that PPP and PFI undermine these principles as they undermine accountability, transparency and flexibility. We reiterate our long-standing opposition to the involvement of the private sector in the delivery of public services and reject the notion that the use of PFI and PPP is the only or best method of financing the build and delivery of public services. We remain committed to our stance of opposition to the government’s continued promotion of PFI and PPP.

We are convinced that the joint ventures model and NHS LIFT programme for primary care as detailed in this consultation are further variants of PFI and PPP models of investment and will be extended to all NHS services. We endorse joint working between public sector organisations where it improves the effectiveness of our public services, and have proposed the establishment of public sector networks for this purpose. However, when joint working refers to working with the private sector through joint ventures and NHS LIFT, it is unacceptable.

The STUC is deeply concerned that the commercialisation of the NHS has reached the point of the Scottish Executive proposing the direct investment of public sector money for the purpose of making profits for the private sector. Furthermore, we are very concerned that other public services will be commercialised in this manner.

Specifically the STUC have concerns regarding:
• The requirement of public sector partners i.e. to hold shares and to become members of boards of directors of profit making companies as required under this new venture. We believe this will cause problems with accountability and conflicts of interest.

• The plans for majority shareholding of the private sector in LIFTCOS - as it raises questions on control as it brings new and different commercial aspects to public services.

• The lack of clarity as to how the Joint Ventures will be evaluated and state our belief it will be necessary to fully monitor and review all contractual and governance arrangements in the interests of transparency and accountability.

• The ability of national joint venture companies involving Partnership UK to give independent advice to local LIFT projects.

• The affordability and value of money of the LIFT scheme given that participants in the scheme will be required to commit themselves to long term contacts and put extensive resources into the setting up of the scheme and into leasing and maintenance but will not own the building at the end of the contract.

• Possible job losses, which will be sustained through the use of Joint Ventures. As the premises owned by the LIFTCOS will be maintained and serviced by them.

• Potential new issues of capacity and risk with the LIFT schemes and it is unclear how much of this risk will actually be transferred to the private sector or be borne by the public sector.

• Possible escalation of PFI costs during contract negotiations. The risk of such cost increases in LIFT will be borne by the Health Boards and other public sector partners.

• Whether the schemes proposed in last year’s Scottish Executive consultation are to be treated as PPP/PFI schemes and, therefore, be covered by the PPP staffing protocol. We strongly believe that the protocol should apply to all joint ventures involving the private sector and we would seek positive clarification in the Bill.
SUBMISSION BY SCOTTISH NHS CONFEDERATION

The Scottish NHS Confederation is the independent representative body for NHS boards and special health boards in Scotland. We are grateful to the committee for this opportunity to give evidence on the Joint Ventures element of the Smoking, Health and Social Care Bill.

The Confederation supports the principle of allowing NHS boards to enter into joint ventures. Extending this ability to the NHS will give boards additional options for the development of premises and facilities and has the potential to enhance partnership working within the public sector by allowing the NHS to take part in the kinds of joint ventures that are already undertaken by local authorities. It could also generate additional resources for health and other public services.

Investment is badly needed for the provision of modern, fit-for-purpose healthcare premises in many parts of Scotland. A range of financial pressures – such as pay modernisation and increased prescribing costs – mean that NHS boards have very little flexibility within their annual resource allocations to invest in facilities development. Although the Scottish Executive has released additional funds for this purpose at various times in recent years, other sources of investment are required to meet the existing need. Having the ability to enter into joint ventures with either public or private sector partners will provide NHS boards with an additional tool for the provision of high quality healthcare facilities and improved access to services for the public.

The potential to use joint venture companies as a vehicle for exploiting intellectual property developed within the NHS is also welcome. This is an untapped resource that the NHS has neither the time nor expertise to take forward. With sensible joint venture arrangements in place, those who do have the expertise in a very complex field can help release the potential on a shared risk and reward basis.

Local authorities already have the power to enter into joint ventures and have used it in a variety of ways. Examples include the Craigmiller Partnership urban regeneration company in Edinburgh and North Ayrshire Ventures Ltd, between North Ayrshire Council and the EDI Group which aim to create community facilities such as roads, schools, housing and office space, to bring employment in to the communities. The new legislation would not only give the NHS the same powers that local authorities already hold, with their attendant flexibilities, they could also, by allowing the NHS to take part in these kinds of partnerships, add a specific health improvement element to local regeneration work.

One of the joint ventures models that could be adopted in Scotland is the NHS LIFT (Local Improvement Finance Trust) model that has already been widely used in England and Northern Ireland. More than 50 LIFT projects are underway or have been approved, ranging from developments of £100,000 to £20 million. Results from the early projects have been encouraging and provide valuable lessons for Scotland. Projects so far have delivered one-stop facilities offering a wide range of health and social care services under one roof. Local authority involvement has extended far beyond social care, however, to include environment and transport considerations – participants have testified that this has helped to break down silo mentalities and nurture a partnership ethic between local service providers. Many are situated in deprived urban areas and are making a significant contribution to local community regeneration. Considerable attention has been paid to ensuring that the new facilities are based on good, user-friendly design, and several new primary care centres have emerged as significant local architectural landmarks.

NHS LIFT is not the only possible joint ventures model, and the English model could certainly not be imported in its entirety to Scotland without some adjustment to take account of our different structures and demography, for example. However, the experience so far demonstrates the potential that joint ventures powers for NHS Scotland could realise. Although the expectation is that the new power will be used mainly to develop new primary care facilities, it would not have to be restricted to that and the potential to extend into other areas of healthcare exists.

Another potential benefit for developing healthcare facilities through joint ventures lies in the choice and flexibility that it would provide for independent primary care contractors, such as GPs, dentists and pharmacists, in allowing them to lease premises from the joint venture company. This could prove an aid to recruitment in remote and rural areas, for example, where the need for independent
contractors to make significant long-term investment in buying, renting or upgrading premises can act as a disincentive.

We are aware that there are objections to what is seen by some as an extension of PFI and private sector involvement in delivering healthcare. The Confederation does not intend to take part in a debate about the rights and wrongs of the NHS working with the private sector. However, in order to clarify the context in which these developments would take place, we would point out that private sector involvement in primary care premises is not new – many GPs and dentists already rent their premises from private sector companies. Furthermore, unlike PFI, joint venture companies are not merely a contracting mechanism, but allow the NHS to enter into long-term partnerships and to see a return on their investment by sharing in any profits generated. Private sector partners would be restricted to the provision of facilities and their maintenance only; they would not be involved in the actual delivery of the service. Crucially, joint venture companies do not have to involve the private sector at all – they can be ‘public-public’ partnerships between the NHS, local authorities and other public sector agencies such as the police, and as such could be a valuable extension of the integrated partnership working that is already being developed through Joint Future and Community Health Partnerships. Finally, we would emphasise that joint ventures are not compulsory. They would merely be another option open to the NHS, and individual boards can choose whether or not to enter into them. NHS boards can continue to pursue premises development through traditional funding routes.

The question of there being a potential conflict of interest for public sector employees or board members sitting on the boards of joint venture companies has also been raised as an objection. The Confederation does not believe that this scenario would, in reality, present any significant problems; the principles of public sector governance by which NHS board members abide would continue to have primacy. However, we recognise that the potential exists in theory, and would recommend that governance arrangements for joint venture companies are carefully reviewed to ensure that conflict does not arise in practice. Protocols could be issued in the form of guidance from the Executive to ensure that there is clarity about roles and a consistent approach across Scotland.

There is clearly a good deal of detail still to be worked out on what form or forms joint venture companies would take and on benefit for the NHS would be maximised and on shared ownership of risk and reward. We would expect Ministers to ensure that the service is kept involved in the further development of these proposals. We would also urge that no ‘one-size-fits-all’ approach is adopted and that flexibility is built into the final system in order to allow local NHS boards to make decisions that respond to their local circumstances in the most appropriate way. On the other hand, given the potential range and number of partners becoming involved in specific joint ventures, there is a danger of arrangements becoming excessively complex. Consideration should be given to making arrangements as streamlined as possible, whilst taking the different approaches of the various partners into account.

**SUBMISSION FROM UNISON**

Introduction

UNISON Scotland welcomes the opportunity to respond to the call for evidence from the Scottish Parliament’s Health Committee regarding the above Bill. While welcoming some of the general principles and aims of the Bill, UNISON Scotland would like to comment on some particular issues highlighted in the call for evidence.

Part of Bill: Part 5, section 31

Main Objective: Allowing Scottish Executive to participate in joint ventures to provide services and to exploit intellectual property.

Do you agree with the main objective of this part of the bill? No
UNISON Scotland is opposed to private business taking over the ownership, financing and management of any public sector infrastructure and services and tying the public sector into exclusive long-term contracts with private sector companies. There is a concern that such schemes involving the private sector are under misguided pressure to pursue off-balance sheet schemes and this has encouraged the unnecessary transfer of staff.

UNISON Scotland has concerns regarding the requirement of public sector partners i.e. to hold shares and to become members of boards of directors of profit making companies as suggested in this new legislation. We believe this will cause problems with accountability and conflicts of interest.

UNISON Scotland is also concerned that there is no indication as to how the Joint Ventures will be evaluated and we believe it will be necessary to fully monitor and review all contractual and governance arrangements in the interests of transparency and accountability.

UNISON Scotland is concerned at the job losses, which will be sustained through the use of Joint Ventures. The premises owned by the joint venture companies will be maintained and serviced by them. There is also concern that, as in the past with other PFI schemes, costs will be cut and profits increased by worsening staff pay and terms of employment and career opportunities for new staff, so creating a two tier workforce.

There is a further concern that there will be new issues of capacity and risk with the joint venture schemes and it is unclear how much risk will actually be transferred to the private sector. As with any other private company, joint venture companies could fail and so there will be risks in the public sector contracting with them and also in being shareholders.

UNISON Scotland is concerned that the cost of using PFI has tended to escalate during contract negotiations. The risk of such cost increases in joint venture will be borne by the Health Boards and other public sector partners. Therefore a joint venture agreement is likely to make significant claims on the revenue budget of the organisation for many years with a consequence to other services.

For further information please contact:

Matt Smith, Scottish Secretary
14:02

The Convener: We move to oral evidence on part 5 of the Smoking, Health and Social Care (Scotland) Bill. The first session deals with section 30, on the authorisation of medical treatment for adults with incapacity. The committee papers include background briefings by the Scottish Parliament information centre on part 5, as well as submissions from a number of those who are present today.

I welcome to the committee the first panel of witnesses, which includes: Dr Alan Jacques, convener of Alzheimer Scotland; Nicola Smith, legal adviser of Enable; and Sandra McDougall, legal officer for the Scottish Association for Mental Health. Can I have brief introductory statements of no more than about two minutes each? You are welcome to forgo making a statement if you wish.

Dr Alan Jacques (Alzheimer Scotland): Thank you for inviting us along today. Alzheimer Scotland is the principal organisation for people with dementia and their carers in Scotland. We have had a long-standing interest in the bill, its progress and its success. We have been delighted overall with the success of the Adults with Incapacity (Scotland) Act 2000, but it has been a disappointment that part 5 of the act has been underused throughout the country, although we are aware of some areas in which it is being used and has worked perfectly well.

We are aware of the reasons why the amendments to the 2000 act have been brought forward in the bill, and we are content with them. However, we see them as part of a wider context of making sure that part 5 of the act works effectively, which involves issues about training and awareness and the way in which part 5 is used.

Sandra McDougall (Scottish Association for Mental Health): I thank the committee for the opportunity to give evidence on behalf of the Scottish Association for Mental Health. For members of the committee who might not be familiar with SAMH, it is both a major provider of services to people with mental health and related difficulties and a campaigning organisation.

Our general position is that there must be convincing reasons for any amendments to the Adults with Incapacity (Scotland) Act 2000. Any changes must have a potential benefit for adults with incapacity and must not be aimed simply at reducing the burden on professionals. Although SAMH is not opposed to the amendments that the
The bill seeks to make to the 2000 act, there are provisos attached to that position, which have been set out in more detail in our written submission.

Nicola Smith (Enable): I also thank the committee for giving us the opportunity to give evidence. Enable is the largest voluntary organisation in Scotland and for people with learning disabilities. We are very much a member-based and member-led organisation. We have more than 4,500 members, most of whom are in 65 branches throughout Scotland. Like the other two organisations that are represented on the panel, we were heavily involved in the alliance that campaigned for the introduction of the Adults with Incapacity (Scotland) Act 2000. We have a legal and information service that regularly gives advice and assistance to people in connection with the act. We recognise that, as the act has been implemented, some unanticipated practical issues have arisen, but we feel that any changes to it should be justified and should be made in the interests of adults with incapacity rather than for the convenience of professionals.

The Convener: Thank you. I invite questions from the committee. Jean Turner will lead off.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Good afternoon. It would seem that you welcome the fact that more people than just general practitioners will be able to issue certificates of incapacity. A concern about training is common to all your submissions. The submission from the Scottish Association for Mental Health refers to research that says that some general practitioners “have expressed a lack of confidence in their skills and abilities to assess capacity”.

It is important that whoever assesses capacity knows how to do so and that the necessary training is in place. I would like to get your feedback on that.

Enable commented:
“We have experience of cases where parents or professional carers are still being asked to sign consent forms for adults over the age of 16.”

There are still some problems with the system as it stands and we are about to extend responsibility to different people. What do you have to say about training?

Nicola Smith: Enable is regularly asked questions about part 5 of the 2000 act, many of which stem from the fact that doctors are apparently not aware of when it would be appropriate for them to sign a certificate. Quite often, parents and carers are still asked to sign consent forms to allow treatment to take place. That concerns us because the act is no longer new—it has been in force for more than two years. It is a bit disappointing that such problems are still being experienced.

We welcome the idea of more people being able to sign certificates because we think that that will lead to quicker treatment for people with learning disabilities. That measure must be backed up by training and awareness raising among professionals.

Dr Jacques: From the beginning, we have said that there would need to be quite a lot of training in relation to the 2000 act. The idea that someone may be incapable of making highly significant decisions about their life is a major matter on which to make a decision.

At the extremes of capacity and incapacity, the issue may be quite simple but, in between, the concepts get extremely complicated. For example, people can change their degree of capacity; they can be capable of making some types of decision but not others; and there can be difficulties with communication. All sorts of factors have to be taken into account. The assessment of capacity is not a simple process of saying that so-and-so is capable of this and not capable of that. There are large training implications that, as far as we are aware, have never been fully addressed. I understand that the issue is being discussed with NHS Education for Scotland but, as has been said, it is a little late in the day for such consideration. Some of the difficulties that we are addressing today would not have arisen if the issue of training had been covered right at the beginning. A lot of work still has to be done on doctors and the other professions that might become involved.

The Convener: Are you saying that the only discussions that you have had about training were held recently with NHS Education for Scotland?

Dr Jacques: I understand that the Executive has been discussing training with NHS Education for Scotland.

The Convener: But you were not included in those discussions.

Dr Jacques: No.

The Convener: Have any of the organisations that you represent been included?

Sandra McDougall: No.

Nicola Smith: No.

Dr Jacques: No. There was a lot of discussion when the 2000 act first came into force, but the issue was shied away from because it is difficult and complex for medical practitioners.

The Convener: Right. If it is complex and difficult for medical practitioners, the implications
of extending the provision well beyond medical practitioners means that it will be equally complex for all the professions on the list at proposed new section 47(1A)(b) of the 2000 act.

Dr Jacques: Yes, but the issues are the same for all of them. We have to consider how we assess reliably somebody’s capacity to make particular types of decision.

Kate Maclean (Dundee West) (Lab): I sat on the previous Justice and Home Affairs Committee when the Adults with Incapacity (Scotland) Act 2000 went through the Parliament. The provisions are complicated, particularly given that people might be capable of taking some decisions but not others. I agree absolutely that training is important, but I wonder what kind of training programmes could be implemented, given the complex nature of the act, and who would be responsible for running them.

Dr Jacques: Those matters would probably be for NHS Education for Scotland. They fall within its remit, and it is well placed to provide training, because it is a multiprofessional organisation that covers all bits of the national health service and can call on specialist expertise from psychiatrists, psychologists and nurses. There is plenty of information around; it is a matter of getting it into a simple, usable form for the wide variety of information around; it is a matter of getting it into a simple, usable form for the wide variety of practitioners involved, which should not be impossible.

The Convener: Would you expect to be consulted about training?

Dr Jacques: Yes.

Nicola Smith: Yes. It is really important that training focuses on the principles of the 2000 act and involves service users. We find that involving service users, such as people with learning disabilities, in delivering training is the best way to get the message across. We feel strongly that they should be involved. We would also like to see training on assessing capacity and on the 2000 act included in the initial training for medical practitioners, nurses, opticians and dentists. For future generations that would mean that the issues were covered at an early stage.

The Convener: If the bill goes through, but the training requirements are addressed no better than they have been, what do you think will happen? Will we be back here in another two years’ time with more problems?

Sandra McDougall: The provisions will probably not be used.

The Convener: So without the training you think that the provisions will not be used.

Sandra McDougall: Yes, or we will find ourselves in the position that has been reflected in research to date, in which general practitioners and such like are saying that despite the fact that the 2000 act has been in force for some time, they do not feel confident about assessing capacity.

Dr Turner: What do you think about physiotherapists being included in the list of people who can assess? Many people will need the services of a physiotherapist. I imagine that, like others, they would like training.

Sandra McDougall: The same arguments apply to physiotherapists as to the other professions that are listed in the bill. I am not sure how the Executive arrived at that list, but I was a bit surprised that it does not include clinical psychologists. At one stage, it was suggested that clinical psychologists should be included in the list, but I am not sure why they are not included.

14:15

Dr Turner: If people were not asked about the list, they would not have been able to highlight any apparent anomalies in it.

The Convener: Can we get a quick run around the witnesses to seek their views on whether the power should be extended to physiotherapists and clinical psychologists?

Dr Jacques: As I understand it, the reason for the list is that certain groups of practitioners arguably provide treatments quite separately from doctors. For example, dentists usually carry on their treatments without reference to doctors. The question is whether we should put in an extra loop by requiring the dentist to consult the patient’s doctor before treating the patient. A similar question should be asked of any other profession that might be added to the list. Whether it is necessary to include a particular profession is a matter of judgment.

In assessing capacity, the question that is asked is not whether a particular treatment is the right one but whether the person can consent to it. The fact that people have not always been clear about that distinction has sometimes clouded the issue.

The Convener: We need guidance on who should be in the bill. There is a question mark over whether physiotherapists and clinical psychologists should be included in the list at proposed new section 47(1A)(b). You seem to be suggesting that the list of professions at paragraph (b) should remain as it is given that patients will be under the care of those professions because of the doctor’s involvement.

Dr Jacques: That may be—

The Convener: You made the suggestion, Dr Jacques—I am just trying to clarify an issue that has been raised with us.
Dr Jacques: I have explained what the issue is, but I could not say whether physiotherapists and clinical psychologists should be included in the list. The issue is whether the profession in question provides a separate treatment or whether the involvement of the doctor is necessary as part of that treatment.

The Convener: We cannot legislate to enable a profession to issue the certificate for one treatment but not for others. The profession must either be totally enabled or not enabled at all.

How do the other two witnesses view the issue?

Nicola Smith: Given that capacity is based on the ability to understand the decision in question, the best person to assess capacity will usually be the person who knows about the treatment and who can explain it. That person should decide whether someone understands the decision. If that person is in any doubt, it would be good practice for them to seek a medical opinion.

A parallel situation exists with powers of attorney. Under a different part of the Adults with Incapacity (Scotland) Act 2000, solicitors can sign a certificate to say that someone is capable of granting a power of attorney. In many cases, it is quite clear whether someone has capacity. In borderline cases, it is good practice for a solicitor to seek a medical opinion.

The Convener: I do not want to get drawn into questions surrounding solicitors. We are trying to pin down whether physiotherapists and clinical psychologists should be included. Basically, you appear not to be fussed whether they are or are not included in the list.

Dr Jacques: I would add only that—like psychiatrists, community psychiatric nurses and trained psychiatric nurses—clinical psychologists would be likely to have the particular skills and interest in the subject of capacity.

The Convener: We will ask all our questions about training before moving on to another subject.

Janis Hughes (Glasgow Rutherglen) (Lab): My question touches on training. The written submission from SAMH states:

"Whilst we can also see an argument for nurses being able to sign incapacity certificates, we believe that this should be restricted to nurses in more senior grades (say grades F and above)."

I assume that SAMH's suggestion does not preclude the requirement that such nurses would have specific training. Just because a nurse is at grade F or above, that does not mean that the nurse will have had specific training. Can you elaborate on that issue further?

Sandra McDougall: We said that about nurses because we were thinking more in terms of numbers. We imagine that there would be many more nurses involved in the care and treatment of adults with incapacity than there would be members of some of the other groups, such as dentists or opticians. One of our suggestions is that people should undergo an accredited training course but that might not be necessary for all nurses, given that the numbers are greater. If the number of nurses was to be restricted, it might make more sense for more senior nurses to be involved. A senior nurse could issue the certificate of incapacity but delegate some of the responsibility for carrying out care functions to other nurses at more junior grades. That would be permissible under the 2000 act, as long as the more junior nurses were acting under the instructions, or with the approval, of the person who issued the certificate.

The reference to grade F came about as a result of our consideration of NHS grading scales. Grade F seemed to be the more senior nursing grade; below that grade were the newly qualified nurses, auxiliaries and assistants. We thought that grade F reflected someone who had a bit more experience.

Janis Hughes: I understand your point.

To pick up on a point that Ms Smith made, in its evidence the Royal College of Nursing states:

"This may be particularly useful for nurses working with people suffering from dementia who may be better placed to see the incremental changes in capacity."

You also talked about the people who work most closely with the patients. I understand what you say about why you picked grade F and above but if a more junior graded nurse was better able to assess the level of need of a patient, perhaps you are being a bit prescriptive.

Sandra McDougall: I can see that argument, but just because a more senior nurse was responsible for issuing the certificate, that would not mean that they could not consult other nurses.

Janis Hughes: Fair enough.

I will move on to a question about extending the duration of certificates of incapacity. All three organisations have agreed in principle to accept the need for extended certificates, but only in the case of people with confirmed long-term incapacity. How should those people be assessed? How do you identify people with long-term incapacity? Who would fit into that category?

Dr Jacques: We are not saying that the proposed changes are necessary; we are saying that we are going along with them, which is a slightly different thing.
Janis Hughes: You agree in principle.

Dr Jacques: We are saying that it is okay to make those changes. However, we are quite concerned about the change to which you refer, because we think that a regular reassessment of people's needs over a long period of time is absolutely central to good care. We would be worried that a provision that makes it okay—or looks as if it is okay—to assess someone only every three years would send out the wrong message. We are saying that we are okay about the proposed change but we are not enthusiastic about it.

We admit and agree that there are people whose mental state—such as severe dementia—might not change and is very unlikely to change for considerable lengths of time, certainly longer than three years. The provision would have to apply to someone whose illness was well established and had been deteriorating over a long period of time already. It would be quite a serious decision to move someone on to assessments every three years. The most important thing is that people who have a long-term illness should be reviewed regularly by a multidisciplinary group that has an interest in their care.

Janis Hughes: Enable's evidence on that is that it would be good practice to carry out an annual review. However, Enable also believes that three years is acceptable. What would be the difference between carrying out an annual review and continuing with the current practice of issuing annual certificates?

Nicola Smith: That is a valid point. Although we do not object in principle to an extension, we feel that it will be difficult to identify the people for whom a three-year certificate would be appropriate. Indeed, it will not be appropriate for an overwhelming majority of people with learning disabilities. However, we cannot speak for other organisations and groups. It is difficult to imagine a person without capacity who will not be under medical supervision or care for three years. As a result, I agree that if an annual review is being carried out a certificate should be issued at the same time.

Janis Hughes: And that is what you prefer.

Nicola Smith: Yes.

Janis Hughes: But you are not opposed to three-year certificates being issued in certain circumstances.

Nicola Smith: That is right, provided that the guidance and codes are clear about when it would be appropriate to issue such certificates. However, as I have said, I think that they are unlikely to be appropriate for most people with learning disabilities. They might be more applicable to other groups, such as people who have dementia.

Mrs Nanette Milne (North East Scotland) (Con): My questions are for Alzheimer Scotland in particular, but the other witnesses might like to comment on them.

In your submission, you express concern about "continuing reports of inappropriate prescribing of psychotropic medication to people with dementia in care homes", especially the surreptitious prescribing of such medicine. I, too, have received representations on that matter from an interested person. Will you comment further on your concerns? What should be done to put things right?

Dr Jacques: This is a major issue, and it differs somewhat from the matters that are under discussion today. I am not sure whether the proposed amendments to the 2000 act will improve the situation with regard to excessive use of psychotropic medication and covert medication. If anything, it could be argued that the amendments go slightly in the opposite direction. Indeed, lengthening the period of certification might be seen to encourage very long-term use of medication without review. As far as this issue is concerned, we could take many different steps without necessarily amending the 2000 act.

We must ensure that there is good multidisciplinary assessment and discussion between doctors and nurses about prescribing medicine; assessing the patient's needs; other forms of treatment and help that might be available; and the question whether such drugs are really necessary. The people who are concerned about the person's care must sit down and think seriously about the matter; it is not a matter of simply making out a prescription after a quick in-and-out visit. Before we can move forward, we need a culture change that touches on training matters; the organisation of care among the professions, carers and the people with dementia; the review and supervision of such care; and the approach of the monitoring bodies. As a result, a range of issues must be considered to ensure that there is less overuse of psychotropic medicine and less covert medication.

Mrs Milne: What do you think of the suggestion that the matter should be controlled by regulation rather than by a code of practice?

Dr Jacques: That was discussed right at the beginning of the process. We, among others, suggested that a regulation in respect of the longer-term use of psychotropic medication could be made under section 48 of the 2000 act. A requirement could be made for a second opinion in the same way as happens under the Mental Health (Care and Treatment) (Scotland) Act 2003.
Mrs Milne: Presumably, patients could be monitored in the same way.

Dr Jacques: Yes.

Mrs Milne: Does any other organisation wish to comment?

14:30 Nicola Smith: We do not have a strong view on the issue; we have not discussed it in any detail. From the comments that have been made, however, it sounds as if the issue needs to be looked at a bit more deeply.

Sandra McDougall: We believe that a second opinion would be desirable. The arguments that have just been made were put forward before. I think that the argument against comes down to resource implications. A great many people would be covered by the measure, which means that a large number of second opinions would be required. Resource issues mean that the measure has not been included in the regulations so far.

Dr Jacques: One other related issue, particularly in relation to covert medication, is the interface between the bill and the Mental Health (Care and Treatment) (Scotland) Act 2003. There is considerable need for guidance for practitioners on when the bill will apply and when the 2003 act will apply. That will need to be covered in the codes of practice for the 2003 act.

Mrs Milne: Clearly, there is an overlap.

The Convener: No other member has a question. Shona Robison was late in arriving and I am not sure whether she wants to come in on anything. We have covered most of the key issues that were raised in the submissions.

Shona Robison (Dundee East) (SNP): No.

The Convener: Okay, thanks.

Does any witness want to make a closing statement?

Sandra McDougall: I included the extension of the duration of incapacity certificates in our submission, but perhaps I should emphasise that SAMH does not believe that such extension is appropriate when the sole cause of incapacity is mental illness; someone’s capacity can fluctuate greatly over a period of time.

The Convener: Thank you. I thank the three witnesses for coming before the committee and for their written evidence.

I welcome the second panel of witnesses on part 5. Dr Mairi Scott is chair of the Royal College of General Practitioners Scotland; Pat Dawson is head of policy and communications for the Royal College of Nursing; and Robert Hamilton is from the British Dental Association. I ask you to make brief introductory statements of no more than a minute or two, after which we will ask questions.

Dr Mairi Scott (Royal College of General Practitioners): In our written evidence, we stress that we support the level of protection that the Adults with Incapacity (Scotland) Act 2000 gives, and has given, to vulnerable people. Our response is about the practicalities of the act and the need to ensure that it is complied with appropriately and properly. Two of the amendments in the bill will help in that respect.

The extension of the authority to grant a certificate is an appropriate and quite sensible amendment to the 2000 act, given the way in which the health service now works, in multiprofessional and multidisciplinary teams. The extension to the duration of the certificate will help enormously with workload implications. There is a safety net to allow the revoking of the three-year certificate, should a patient’s condition change. That is a sensible legislative measure.

Pat Dawson (Royal College of Nursing): Good afternoon. The RCN takes a similar view. We feel that there will be some devil in the detail around the codes relating to implementation, but we are broadly supportive of both the main changes to the Adults with Incapacity (Scotland) Act 2000 that are set out in the bill.

Robert Hamilton (British Dental Association): Our view is very similar. The British Dental Association supports the general principles of the Adults with Incapacity (Scotland) Act 2000. However, in practice, some of its provisions have been unnecessarily disadvantageous to the client, especially with regard to dental treatment. In some instances, delays can be caused in the provision of treatment for pain or appropriate care. We therefore support the provision that will enable suitably trained dentists to authorise certificates.

The Convener: Thank you.

Issues have been raised in respect of the adequacy of training for general practitioners, which will have to be extended to the professional groups that will be included under the new legislation.

Dr Turner: You probably heard the previous witnesses say that training is important, and you have all said that in your written evidence. Where should that training take place? I imagine that there may be a cost to training and workforce planning in the implementation of training.

Robert Hamilton: Some training on the issuing of certificates is included in the undergraduate syllabus for dentistry. There is further training in the general professional training syllabus on graduation, when dentists undergo one or two
years of post-qualification education. I have spoken to the people at NHS Education for Scotland, who are preparing something to cover the necessary training for dentistry; they will introduce that fairly soon.

The Convener: Are you saying that it is sufficient to include the training in the degree courses?

Robert Hamilton: No. It is probably more appropriate to have the training in the general professional training and possibly even further on, once dentists are fully qualified.

Pat Dawson: I am aware that NHS Education for Scotland is considering the preparation of multidisciplinary education in relation to the issue. With colleagues, I have searched for a nursing tool and have been able to provide the committee with an existing tool around assessing capacity. As members may know, legislation on mental health and mental capacity is being considered by the Westminster Parliament, and there might be products of that review down south.

Our regulatory body is looking at both the review of the pre-registration programme and the advanced practice, both of which may be areas in which the preparation and training elements could usefully be put in the context of this extension to the role of the nurse. We are content that, through working in collaboration with NES and others in Scotland, such tools and training can be provided. There is, of course, a cost element, and we have identified that in our evidence.

Dr Scott: I agree that the training should sit with NHS Education for Scotland and that it should be multidisciplinary. I see no reason why it should not be, and the provision of such training would seem to be a sensible use of resources.

The training would take place during basic specialty training. In reality, unless the young doctor had had experience in psychiatry during that time, it would take place during the year that they spent attached to the practice. As you know, we have said before that that training period is too short. We are well aware of the difficulties and have been looking to extend the training period for some time, but we need support from the Scottish Executive to do that. That training is additional, and to do more of it would require more time.

The Convener: Do you recognise the issues that were raised by the previous witnesses in respect of parents or professional carers being asked to sign consent forms for people over the age of 16? Do you recognise that the training has perhaps, so far, not been sufficient for the purposes of the 2000 act?

Dr Scott: It would be interesting to know where the examples came from—whether or not they came from general practice. I am not sure about that.

The Convener: I assume that they must have come from general practice—that is where the power lies at the moment. Is that not correct?

Dr Scott: They might have come from other areas of the health service. Other practitioners can sign under parts of the 2000 act. Having said all that, if what you say is the case, that is a training issue. You are absolutely right: it could simply be a matter of confusion, which could be sorted out quite straightforwardly.

Shona Robison: I note from the RCN’s evidence the point about the key role of the nurse consultant. Could you say a little more about the barriers that exist in that area?

Pat Dawson: Towards the end of the committee’s discussion with the previous witness panel, I heard some comment about the potential grade or competency of staff who might be asked to take up the new power. We would point out that the provision is not set out in any restrictive way. I understand where the previous witnesses were coming from, but the provision will apply to nurses in specific roles with specific expertise; they have quite an expert skill. At this stage, we would not necessarily want the provision to apply to all pre-registration education. The power would be used by those nurses who work with the particular client groups for whom the 2000 act applies.

Our organisation’s ambitions for the further development of nurse consultants are quite right. However, I draw the committee’s attention to the appendix that the Scottish Executive has supplied by way of further evidence, which says:

“in general, it is envisaged that nurse practitioners, practice nurses and nurse consultants are the groups most likely to use these powers.”

We accept that nurse practitioners and nurse consultants have a degree of autonomy—the new role of nurse consultants emphasises that—but we suspect that other areas of practice will be relevant. Those areas will concern not necessarily practice nurses but, more important, nurses who work with people with learning disabilities, psychiatric nurses, nurses who work in palliative care and the range of specialist nurses who work in clinical practice with degenerative diseases. Although the provision might promote the role of nurse consultants, we do not see it as a route to restrict the application of the role concerned to those with certain job titles.

Dr Turner: Are any difficulties being experienced with how things work in practice at present, with respect to feedback being given to the general practitioner—the family doctor—of the patient who requires the certificate? There is a requirement to have information on the patient’s
medical history, and there is a need for continuing communication with the GP, so that they are aware of everything that is going on with the patient.

Robert Hamilton: Having asked around the country, I am aware that there are a number of difficulties in dentistry in that respect. When a certificate or authority is asked for, the general medical practitioner will sometimes not sign it, for some reason. There have been problems in obtaining certificates to enable treatment to be given. I could not really say what the reasons for that are. Perhaps the doctors do not feel competent about authorising dental treatment.

We envisage that most of the dentists who would be concerned by the provisions would be community dental officers and senior dental officers, who have a specific remit for the treatment of people with learning disabilities or dementia. I have spoken to general dental practitioners, who feel that they would have a lesser role in this area. I reiterate that, in community dental services, the communication with general medical practitioners and the situation with obtaining medical histories is fairly good in the main.

Kate Maclean: Can you clarify that? Surely the GP is being asked to decide about a person’s capacity, not about any dental treatment that is required. I cannot understand why doctors would be reluctant to make such decisions.

Robert Hamilton: In certain areas, the certificates that we request are not forthcoming, and we do not always get feedback on why that has been the case. That delays treatment, and it means that a further phone call to the medical practitioner is required.

The Convener: Perhaps Dr Scott should be brought in on that point.

14:45

Dr Scott: There is an issue about consent and understanding procedures. If the GP felt that they could not adequately explain the procedure and that they could not respond to questions from the patient to ensure that they had understood it, they would have difficulty in being the person who signed the certificate. That is why we support the suggestion that the dentist—or whoever delivers the treatment—should explain the treatment appropriately to the patient. Proper explanation requires the person who is doing the explaining to check that the explanation has been understood and to respond to any questions that the patient might have. The process is complex and the legislation would ensure that that problem area was covered.

Janis Hughes: The Royal College of General Practitioners says:

“Currently the Adults with Incapacity Act limits responsibility for assessment of incapacity to medical practitioners only. The RCGP believes this is inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialists, clinicians and clinical psychologists.”

Is the suggestion, therefore, that there should be extra training for medical practitioners who do not have experience in the area of incapacity?

Dr Scott: There are medical practitioners who have no need of such training. For example, laboratory specialists will not be called on to make the kind of decisions that we are talking about unless they are delivering specific care to patients or are investigating them in some way. However, there are other professional groups—such as community psychiatric nurses—for whom such training would be extremely appropriate.

Janis Hughes: I believe that the Royal College of General Practitioners, unlike the previous witnesses, strongly supports the extension of the certificates’ duration to three years. Could you comment on some of the evidence that we have heard on annual assessments and the other downsides to having three-year certificates?

Dr Scott: The issue concerned linking regular review to the provision of a certificate. Clearly, the cases of patients who are incapacitated at that level for three years will need to be reviewed regularly—probably more frequently than annually, in terms of their clinical care. That review should be multidisciplinary, because those patients have complex needs.

Completing a certificate is quite time consuming because there is a legal requirement to check certain things—it would take between 45 minutes and an hour to do it properly, or a shorter time if the practitioner knew the patient. Remembering, each June, for example, that it was time to redo the certificate and completing all the associated work would, in some ways, distort the flow of care because it would be an additional thing that people had to do. However, I agree totally that regular review of such patients is good clinical practice and I hope that that is being done.

Janis Hughes: Do you have any concerns about extending the duration to three years?

Dr Scott: No. The extension has the caveat that, if the patient’s condition changes, the certificate can be withdrawn.

Mrs Milne: I wanted to probe with Dr Scott the issue of the use of psychotropic drugs in care homes. I presume that that issue concerns GPs more than anyone else. The witness from Alzheimer Scotland suggested that it would be
appropriate to have two medical opinions before such drugs were prescribed. Do you have any comment to make on the general principles of prescribing such drugs in care homes and on who should make the decision to prescribe them?

**Dr Scott:** That is not part of the issue on which we were asked to give evidence. Therefore, my response is tempered by the fact that I would like to see the evidence that Alzheimer Scotland and others have before making an informed comment.

In general terms, we do not want inappropriate prescription of powerful medicines to take place. It should not be encouraged in any way and part of proper professional care would be to ensure that that does not happen.

**The Convener:** That covers most of the issues that members wanted to be raised. Since all three witnesses are pretty much in agreement with the proposals, I will give them the opportunity to talk about any specific experience that they have of the existing system not working and why they think that it should be changed.

**Robert Hamilton:** There have been instances in which care home staff have drawn our attention to a resident who has an abscess and we have been concerned about the individual’s capacity to consent to the treatment. However, when we have asked for a certificate to enable us to deal with the matter, there has been a delay. It can take up to two weeks to get a certificate from a doctor, and that is not appropriate for someone who is in pain, especially as the procedure is fairly straightforward.

Loss of dentures is also a problem, as there can be delays. If someone with Alzheimer’s disease loses dentures, that can be significant, because the ability to wear dentures is learned and they can lose the concept of wearing dentures. The delay can be important, so we should at least make a quick start on replacing the dentures.

**The Convener:** Is Pat Dawson aware of any examples from the nursing profession?

**Pat Dawson:** When we rooted around for evidence for the consultation before the bill was introduced, a large number of issues came to us on the flu vaccinations. However, I will comment on paragraph 15 of annex A of the Scottish Executive’s supplementary evidence. I am a little concerned that it says:

> “the Code of Practice will set out the circumstances in which it would be appropriate for nurses and other proposed signatories to issue certificates.”

I hope that that is not a signal that the Executive wants to implement a restrictive practice with lists of people and named individuals who can issue certificates. We have all tried to put forward the expanding and emerging new ways of working in the health service. We have autonomy and regulatory practice that protect the patient in addition to what is proposed in the bill. The changes should be more enabling than restrictive.

**Dr Scott:** The flu vaccination is probably the best example in which the workload implications were considerable. There are practices that have a much higher burden of the elderly because of the number of nursing homes in the area, so the impact can be quite disproportionate. As Pat Dawson and Robert Hamilton said, we need to try to ensure that patients get good care in a reasonable timeframe and that that is not prohibited by a legal process that, by its nature, can be slower than we would want it to be.

**The Convener:** That deals with everything. I thank the witnesses for coming to the committee.

We have a gap while we wait for the next sets of witnesses, so the meeting will continue in private for item 3. I advise all members of the public that the meeting will resume in public at approximately 10 minutes to 4.

14:53

*Meeting continued in private.*

15:51

*Meeting continued in public.*

**The Convener:** We reconvene the meeting to discuss sections 31 and 32 of the bill. The first panel of witnesses comprises David Fox from Turner & Townsend Management Solutions and Howard Forster from E C Harris. I understand that Alex Macleod of Skanska is ill and is unlikely to arrive. I ask for brief introductory statements of just a minute or two from each witness before we ask questions.

**David Fox (Turner & Townsend Management Solutions):** I am happy to kick off—I will give the story so far. After an initial bedding-down period of the procurement route in England, the local improvement finance trust joint venture model has developed from being a purely health-focused model to one that delivers other services on a best-value basis, including social care and care for the elderly, and libraries and sports facilities. It also creates third-party opportunities.

With political will, the model has encouraged joint thinking throughout public sector departments, which has resulted in multiple use of space and allows the public sector pound to work harder. Many projects are in their early stages, so value for money is being assessed continually because many benefits follow the establishment of improved facilities and delivery of services after the settling-in period.
That said, we believe that room for improvement exists. Despite the apparent success, there is certainly room for improvement in Scotland, especially because Scotland is upstream of implementation in England and is ideally placed to benefit from that. Partnerships for health have highlighted many aspects for improvement that have been incorporated in their later projects, but the new market in Scotland offers the opportunity to do more than just to jink around the edges.

In developing a Scottish model, we would consider simplification of what is a complex model for relatively simple facilities, provision of assurance of continuing opportunities that will encourage the private sector to invest for the long term and design of individual schemes so that scheme sizes are attractive to bidders but will also deliver value for money. We support the development in Scotland of joint ventures that would be delivered in a manner that reflects Scotland’s needs and which also benefits from the lessons of England.

**Howard Forster (E C Harris):** I am a partner at E C Harris, which has been involved in more than 17 schemes in the south and therefore has practical hands-on experience of NHS local improvement finance trusts in operation.

We ran a session in Scotland last year with a cross-section of the market, and from experience we believe that the proposed joint ventures model will bring significant opportunities and benefits, particularly in urban regeneration. To support those comments, I state that from practical experience we observe that, in particular, the planning structure that supports NHS LIFT has enabled local authorities and health service organisations to come together—in many instances for the first time—to consider joint planning of their estates. In doing so, greater impact has been made than would be achieved by simply replacing primary care accommodation.

We have seen a number of significant examples of that in Merseyside and farther afield, which have contributed to wider urban regeneration agenda and supported sustainable communities. From practical experience, we support the introduction of a model that would encourage wider discussion among public sector organisations and which would enable them to enter into joint planning and delivery of physical assets.

**Shona Robison:** I have questions on two aspects of the contracts, relating to risk and cost increases during contract negotiations. On the first issue, can you outline where the bulk of the risk lies, should a joint venture company fail? Who picks up the cost burden?

**David Fox:** In terms of a joint venture company, many of the principles are similar to those of private finance initiative projects, in that the contracts are designed to ensure that the public sector stays whole and that the impact is, at worst, a delay in implementing the project through a retendering process, either for the LIFT partner or perhaps for a contractor. There are examples from the PFI industry in which the provisions within PFI contracts, which are reflected in the LIFT contract, have been used successfully in such circumstances. In fact, close to here, in East Lothian, and in Tower Hamlets in London, the provisions of the contract have been used to replace a failing contractor who was providing the construction service, in a situation where the works were carried out in parallel with step-in by the public sector. The provisions were such that the public sector was compensated and a new contractor was put in place.

**Shona Robison:** Who compensated the public sector?

**David Fox:** The public sector was compensated through the clawback mechanism.

**Shona Robison:** Was clawback from the failing contractor?

**David Fox:** It was, in effect, from the funders. The funders provide the capital and also a degree of equity support. In the case to which I referred, an SPV—a special purpose vehicle—was involved. The provisions in the contract in that case allowed the public sector to step in, maintain the construction process and retender. Effectively, the value of retendering and construction works was handed over to the new successful contractor, net of any costs. Such provisions are normally in place within a PFI-type contract. Howard Forster may want to enhance that answer—or otherwise, given his intimate knowledge.

**Howard Forster:** In the NHS LIFT structure, design and construction risks are distributed through subcontracts. The cost of any delay in construction is borne by the subcontractor building partner, and is passed down through the subcontracts.

Similarly, the risks that are associated with life-cycle maintenance and provision of facilities management are passed down through an FM contract; the risks are borne by the FM supplier. As in a PFI contract, the joint venture vehicle is protected from any of the risks’ coming back to it by the provisions of those two contracts.

16:00

**Shona Robison:** What is your view of the contracts, given that public money is involved in them? Do you think that they should be made...
public so that everyone can see the provisions in them in advance of any problems that arise?

David Fox: It is fair to say that the model contract is a public document, which is available on the websites of Partnerships UK and, I believe, the Parliament, although I may be corrected on that. However, contracts for individual projects reflect many of the bespoke items that are specific to those projects and there is some commercial confidentiality attached to them. I noticed smiles when I mentioned commercial confidentiality—the base provisions are public knowledge, but the specifics about particular sites are kept confidential.

Howard Forster: NHS LIFT adopts the same standard for PFI contracts, with some minor modifications. The provisions are now widely understood and are—

The Convener: That may be the problem, of course.

Howard Forster: I accept that.

Shona Robison: Unison Scotland has given evidence to the committee in writing and will appear before us later today. In its evidence, it says:

"the cost of using PFI has tended to escalate during contract negotiations. The risk of such cost increases in a joint venture will be borne by the … public sector".

Do you have a view on that?

Howard Forster: In the LIFT market, the average time between the placing of an advert in the *Official Journal of the European Communities* and the financial close is about 17 months. That period is relatively short compared with the periods that have traditionally been borne in similar PFI negotiations. To my knowledge, the cost escalation in the schemes in which we have been involved has been relatively limited. In the mainstream PFI market, cost escalations are mainly due to delays in projects and inflationary pressures during those delays. That has not been apparent in the LIFT market; on the first 42 schemes that have been bid on have been straightforward. Although they represent a spectrum of schemes, most are relatively small and have been well thought through by the public sector before they come to the market. Because the client has a clear grasp of what it wants, the risk of its changing the brief is relatively small, according to my experience of 17 or so LIFT schemes.

David Fox: The experience to which Unison referred certainly matches our experience of early PFI-type schemes. At that time, there was perhaps not much understanding of the balance to be struck between obtaining a price from the market in the tenders and ascertaining for how long that price should be maintained, be it six months, a year, 18 months or whatever. If we want a price to be maintained for at least a year, interest will be built into it. As the industry matures, there is greater understanding of that balance and—which is probably more important—of the fact that the scope of projects must be more comprehensively and robustly developed, thought out and reflected in the specification. The specifications of many of the original PFI and LIFT projects—dare I say it—left a bit to be desired. Many of the cost escalations, apart from inflation, reflected things that had been missed out of contracts.

Shona Robison: Do you regard the contract for the new Edinburgh royal infirmary as an example of that?

David Fox: It was one of the first projects in Scotland to be carried out under PFI. I am sure that lessons have been learned from that contract and reflected in subsequent contracts. However, I do not have intimate knowledge of the contract and therefore cannot comment on it.

Shona Robison: You will appreciate the public unease about that contract, given some of the difficulties that were experienced with the model of PFI that was used. There might be some scepticism about what improvements have been made in respect of PFI.

David Fox: In order to alleviate such scepticism and to give comfort to elected representatives such as yourselves and to the industry in general, the Scottish Executive must be complimented for implementing what it calls the key stage review process, which is closely modelled on the gateway process that the Office of the Deputy Prime Minister and the Office of Government Commerce—the OGC—have implemented. At key stages in the development of a contract—before the issue of tender documents, before the naming of the preferred bidder and before the close of the contract—an independent review of the documentation and work to date is carried out. In the Executive’s case, that has been done by Partnerships UK.

That review throws up issues that are associated with previous problems and it ensures that promoters of projects get it right. Problems must be revisited before a project goes out to tender or before a preferred bidder is appointed. That represents the spreading of best practice by experts in the field to promoters who might be less experienced and it is one of the means by which we in the industry intend to avoid repeating the problems of previous years.

Shona Robison: What is the percentage of profit that a company could expect to make under the new model of contract?
David Fox: I cannot comment specifically on LIFT, although Howard Forster might be able to do so. For a typical PFI project, the level of return, as it would be termed, would commonly be between 12 per cent and 13 per cent. I stress, however, that that is over 30 years—that does not refer to a one-year contract. 13 per cent over 30 years might not sound like an awful lot, but that is attractive to the marketplace. There is a long-term opportunity and there are opportunities to establish partnerships in the event of expansions of a project, through change mechanisms. That is effectively a win-win situation for both parties.

I ask Howard Forster to comment on LIFT.

Howard Forster: The experience of LIFT to date has been broadly similar to that.

The Convener: I invite any other specific questions on the subject of cost increases and risk.

Dr Turner: I have a question relating to something that Shona Robison said.

The Convener: Is it to do with cost increases and risks?

Dr Turner: It is to do with outline business cases not being perfect. Does business cases’ not being perfect have anything to do with the fact that you might get only one contractor bidding? The idea is that a project should be cost effective. As many bidders as possible would be wanted, but it costs companies a lot of money to bid. If an outline business case were not up to standard, would the UK organisation—I have forgotten the name of the company.

David Fox: Partnerships UK.

Dr Turner: Does Partnerships UK sort out business cases that are perhaps not perfect? As you said, costs would escalate if a project was to go ahead despite the business case’s not being complete at the beginning, in which case the bidders would find out that they would have to add in this, that and the next thing.

David Fox: I will start; Howard Forster can perhaps add to what I will say. Every outline business case in the UK is now reviewed independently. In England, cases go through what is called the projects review group; in Scotland, they go through the Scottish Executive. Each business case is rigorously analysed by independent bodies, predominantly Partnerships UK, which is the body in which the general expertise in the United Kingdom market is most concentrated. That process highlights gaps or aspects that should be in place but are not—for example, not all the land might have been acquired or not all the planning permissions be in place—and gives bidders much more confidence that when a project comes to the marketplace it is robust, comprehensive and well developed, and that there will be a relatively smooth run through the procurement process. In other words, the risk of abortive bid costs is much reduced.

Howard Forster: Mature design is now expected at the outline business-case stage. It is expected that, before an advert is placed to invite tenders, the scheme will have been developed to the extent that departmental layouts and sample room layouts are in the design. One would go to the marketplace when one arrives at an outline business case that has that degree of certainty of design. That is expected in NHS LIFT in England and throughout the PFI market in healthcare.

Dr Turner touched on the number of bidders for a project. The LIFT market is different, because the nature of the projects is different and has attracted a much wider market than traditionally bids for the major PFI health projects. To my knowledge, it is something in the order of 19 bidders. In addition to the more traditional firms that bid for PFI contracts, many have come out of what is described as the third-party development market; some are property-led companies and some have been housing associations, such as Bradford and Northern Housing Association, which has rebranded and is now called the Accent Group. An interesting range of different types of proposal has come from the market. To my knowledge, there was a minimum of two bidders on the 42 projects in the LIFT market. I think that the last project to come to market attracted the fewest bids, but in all the earlier waves the lists were eight bidders or more long. The market has been attractive to bidders.

Dr Turner: Is that because the projects are smaller than hospitals?

Howard Forster: I think so. Relatively speaking, the initial bid costs are less against a reasonable deal volume.

David Fox: I suspect that you are thinking about the more limited tender lists that we have had in Scotland over recent years. The capital value of construction works within a LIFT project is attractive to a much wider range of contractors because of the type of relationship and the fact that the contract is spread over a number of years. Perhaps only a limited number of contractors could carry some of the recent education projects that have had a capital cost value of £90 million to £100 million, whereas the smaller year-by-year value in a LIFT-type project makes such projects more attractive to a much wider range of contractors, which increases the number of contractors that bid and, hence, the competitive pressure that creates value for money.
Carolyn Leckie (Central Scotland) (SSP): Three aspects of the consultation document that you submitted to the committee make me worried about the risk to the public sector. I should say that I am a member of Unison and have direct experience of the impact of privatisation on the health services. In the document, you refer to facilities management’s not being included in LIFT projects, which indicates that it is perceived as being too much of a risk to the private partners. Will you expand a wee bit on that?

Another paragraph mentions
“the critical mass required to make the LIFT model viable and hence attractive to private sector investors.”

That is obviously about diminishing the risk to the private sector. Could you give detail on what you mean by that? What is the impact on local services? How much makes a “critical mass”? Does that mean that there will be reductions in access to local services?

You also say:
“Each phase should ideally be profitable as a stand-alone venture”.

Obviously, that again relates to concerns about minimising risk to private sector profits. Could you expand on that and on what its impact would be on the public sector?

16:15
Rather than give us a projection over 30 years, could you tell us what has been the impact so far of LIFT schemes, with which you have been involved in England, on the growth of profits for the companies involved? Similarly, what has been the impact on the public sector in respect of terms and conditions, service provision and so on?

The Convener: It would be helpful if you left jobs until we have dealt with cost increases and risks.

Howard Forster: I believe that the first question was about FM. I did not think that Carolyn Leckie’s other questions were all related to cost increases and risks, but that they were all different.

The Convener: Indeed. If you could confine your answers to the questions that relate specifically to cost increases and risks, we will mop up some of the other issues later.

Howard Forster: I am not sure that any of the questions directly relate to cost increases. I can respond to each question in turn, however.

The Convener: That would keep us moving.

Howard Forster: FM content in NHS LIFT schemes is limited to hard facilities management, such as building services. It has not so far been extended to soft facilities management. It is probably worth saying that limited services have been delivered to general practice facilities in primary care over the period. You should bear it in mind that the market is already mixed. A number of general practice premises are in private sector ownership and are run by GPs; they might not have any facilities management services. To some extent, the services are being newly provided to the primary care market.

On whether the absence of FM in the marketplace would be an issue, the answer is—on the whole—no. For some of the batched primary care schemes that are coming onto the market and which are not LIFT schemes—such as in Stockport in south Manchester—there would be a market for working with private sector organisations on design, construction and replacement of facilities and the associated financing outwith FM contracts. There would be a market if FM provision were not included, although FM is relatively new in the primary care market. In saying that, I am setting aside any concerns relating to off-balance sheet issues and so on. I am not an accountant, so I would not want to comment on what that would do to a risk profile. Regardless of whether FM was excluded from NHS LIFT schemes or not, the market would be attractive. The market is different to the one relating to major health care private-finance initiatives.

The second question related to critical mass. It is fair to say that there is a minimum bid cost associated with LIFT schemes, which has so far been of the order of £500,000 to £1 million. Certainly, before a preferred bid is arrived at, individual schemes will have cost the private sector between £250,000 and £500,000. Clearly, if a bidder is about to make that sort of investment and can expect to win only one in three bids, the bidder would want to ensure that the overall value of the projects that would be secured in that market is reasonable.

The 42 LIFT projects that are currently on the market vary enormously in terms of value. For example, in the Manchester, Salford and Trafford LIFT scheme, many primary care trusts have come together to procure jointly, whereas Dudley South Primary Care Trust might have only three to five schemes. I come back to my earlier point; such schemes are still attractive to the marketplace and the marketplace still responds.

Because of the geography of Scotland, different scales and types of procurement would be needed. My expectation, based on experience, is that there would still be good competition and at least two bidders if the value of the deal were more than £10 million to £15 million overall. That might represent three or four primary care premises; the cost of building a typical primary
care facility is between £3 million and £5 million for the scale on which they are built these days.

The third question was about profitability and how it looks currently. It is impossible to say. The first schemes have just been completed, so it is too early to offer a view and certainly too early to make observations. The first built projects are just being completed now within NHS LIFT in England. The only figures are those that have been modelled; they are broadly comparable to PFI marketing.

I am not quite sure what the point about growth in profits was about.

Carolyn Leckie: What have the benefits been so far?

Howard Forster: There have been very few because construction has just started and the facilities are not finished. Even the comparison between the estimate of how much a building will cost versus its actual cost, which is a risk borne by the private sector, is yet to be evidenced and understood. It is probably just a little bit too early to be asking those questions.

Carolyn Leckie: Are the share prices increasing?

David Fox: I cannot comment in detail on NHS LIFT, but I can give you a typical example of a PFI project. I stated earlier that, over a 30-year period, a PFI project would provide a return of something like 13 per cent. It is important to note that until year 20 to year 22 of a 30-year contract, the special purpose vehicle of the successful company is in the red; it is making a loss and it goes into profit only in the final few years of the contract. I would be surprised if the LIFT projects were any different, although I could be proved wrong as I do not have intimate knowledge of that particular vehicle.

Carolyn Leckie: You did not answer the question about guarantees and pipeline workload in each phase being profitable as a stand-alone venture. How do you envisage that working? Is that to take account of the worries that the project would not be profitable?

Howard Forster: No. The nature of a LIFT procurement is that a partner is appointed—by way of competition—for two or three projects out of a batch of projects. A batch might contain as few as five projects or as many as 30. Each individual project within the overall project will be a contract in its own right. Each contract needs to be bankable and able to secure external funding, and it must go through the same due diligence tests as any PFI contract. The contracts must be robust in the way that they respond to public sector governance and value for money tests; they must also respond robustly to private sector tests such as cash flow protections and ensuring that the contracts distribute risk appropriately. Each tranche of the overall LIFT relationship has to be robust. That goes without saying.

Private sector involvement is partly about profit, but it also has wider objectives. I refer to what was known as the Bradford and Northern Housing Association—now the Accent Group—which distributed its profits to its other objectives. It was not about return for individuals, companies or share value.

David Fox: To provide a bit of comfort on your first point about FM and FM services, the evidence from the Scottish Trades Union Congress identified that Scotland has the staffing protocol. That is not a feature to the same extent in the English market and it is one example of how NHS LIFT, as developed in England, would have to be adapted for the Scottish marketplace. There will be other issues, because we are considering a Scottish solution, not just the importation of an English solution that may or may not be appropriate.

The Convener: You talked about staffing protocols. Kate Maclean has a question on jobs.

Kate Maclean: Your report mentions that the employment protocol will probably affect the pricing model. The small paragraph about staff-side issues states that the staff side is stronger in Scotland and that that might create difficulties. People are concerned that job losses may occur as a result of the use of joint ventures and that two-tier workforces would be created in certain premises. Has that happened in England? Will you expand on that? I could find no other references to staffing or job issues in the report.

Howard Forster: To be clear, that document comes from the observations of the 70 people who attended the seminar, who were from public and private sector organisations, including staff-side organisations. We tried to give a representative view. The document represents a range of views and does not necessarily contain my personal observations of the market.

So far, NHS LIFT has not had the impact that you describe. As I said, we need to understand the nature of the premises and the existing services that support them. We are talking about GP practices extending into much wider functions because, as things stand, many premises do not have facilities management services at all. New services would be introduced under the proposals.

On a separate issue, one of the affordability constraints for primary care organisations in using the lease plus arrangements within the LIFT scheme, rather than the previous arrangements, is that new services are being introduced. Facilities management, guaranteed replacement and
grounds maintenance are relatively new services. Where they existed previously, they were generally managed by individual practices, which made their own arrangements. Most of the LIFT companies with which I have dealt are interested in using local suppliers to manage existing services, but on the whole the services are absolutely new.

One can see that from the state of primary care facilities in the UK. The 2,500 GP practices throughout the UK are not being regularly repaired or maintained and no life-cycle replacement is taking place. As a result, we have a huge backlog of maintenance and buildings that are decaying and not fit for purpose. However, the situation will improve, because we are securing some of the required services through the new contracts, and on the whole that is for the first time in the primary care market. Therefore, the changes will not have an adverse effect on existing staff because there are no existing staff.

Kate Maclean: So existing public sector workers will not be transferred to joint-venture companies.

Howard Forster: That may happen for limited numbers of staff. I do not know the profile for primary care in Scotland so I cannot provide specifics, but, if that happened, the same provisions as for any transfer of undertakings would apply. However, from my experience, such cases will be limited. So far, I have not observed that as an issue in any of the 42 schemes in the NHS LIFT marketplace.

Carolyn Leckie: You did not quite answer my earlier question. The scheme has obviously had impacts. The issue is not just about terms and conditions and the employment protocol, because that does not relate to final salary pension schemes. What has the impact been on such schemes in England? Another issue is staffing levels and ratios. Historically, the contracting out of cleaning services has resulted in staffing ratios plummeting. Since the introduction of the LIFT schemes in England what has happened to the numbers in various staff groups compared to patient turnover?

Howard Forster: As far as NHS LIFTs are concerned, the answer to the latter part of your question is fairly straightforward: as there are no soft facilities management services, none of the contracts includes any cleaning or catering services. For the reason that I have just given, those services are in many cases brand new. I have to say that I have not come across that issue in the public or private sector.

16:30

Carolyn Leckie: Have you compared the terms and conditions of new staff involved in new services with those of the NHS or local government workforce? Studies into PFI and overall staffing levels carried out by Allyson Pollock and others have highlighted that, although the scheme might not directly employ people, there are indirect impacts because of the costs to the authority of funding the contract. Have you considered the impact on overall staffing levels in public authorities?

Howard Forster: As none of these facilities is operational—one might be operational in south-east London—it is too early to make such observations.

Carolyn Leckie: Do you think that there will be an impact and, if so, have you taken any steps to avoid it? Do you think that a reduction in overall staffing levels would be a bad thing?

Howard Forster: What I said is that, so far, there has been no such impact. It has not presented itself as an issue. It is still too early to make those comparisons. The private sector has to go to an employment marketplace and attract an appropriately skilled staff to deliver what are on the whole new services to facilities that, historically, have not had those services delivered.

Carolyn Leckie: On what terms and conditions are those staff being recruited, and how do they compare with those of staff in public bodies?

Howard Forster: I do not know the detail of the terms and conditions.

The Convener: Would they vary from project to project?

David Fox: As far as staffing levels, pensions, wage rates and so on are concerned, we have the staffing protocol, which came into being a short while ago and which the Executive has implemented on all relevant PFI projects. No doubt your good selves will make your views known to the Executive on the question whether the protocol should be similarly applied to any LIFT joint ventures that might come along. Certainly, since the creation of the staffing protocol, one of the key themes in the projects in which I have been involved has centred on staffing levels, the protection of pensions either through admitted body status or through broadly comparable schemes and the avoidance of a two-tier workforce. Indeed, that has been reflected in the project documentation issued to the various contractors. I would be surprised if this situation were any different.

Janis Hughes: You said that no soft FM services are included in English LIFT models. Have there been any discussions about doing that in Scotland?

Howard Forster: Not that I am aware of. However, to my knowledge—I have worked on 17
deals—only hard FM services have been included in NHS LIFT market deals. I cannot say that absolutely and would need to test it out, but I think that that statement is correct.

Carolyn Leckie: The E C Harris report says that most people agreed that soft FM services should be included, so that is something that you are obviously aspiring to.

You also said that public bodies were involved in the consultation. However, when I counted them, I found that 14 out of 58 consultees were public bodies and the rest were involved in private finance, construction and so on. As a result, the document will reflect those interests.

I have to say that I am not sure about the accuracy of the report. The veracity of your argument is brought into question by the comment:

“Overall it was believed that there was not as much deprivation in Scotland and so they are starting from a better position”.

How on earth did you reach that conclusion?

Howard Forster: Clearly, any audience that discusses such a matter will have a bias. The audience was not perfectly balanced because we sent out an open invitation for the session and those who wanted to attend came along. We certainly did not exclude anyone and, as we have said, we extended the invitation specifically to staff-side organisations, which did not attend.

Returning to the first point, I welcome the idea of providing soft FM services in primary care premises where they do not exist at the moment. The member referred to a marketplace, but, as I said, I am talking in general not about the Scottish health care market, but about what that looks like in the primary care setting and in the provision of primary care facilities.

Currently in primary care provision in the UK, buildings are not being maintained and are not receiving the soft and hard FM services that are typically received in other markets in other parts of the health care sector. The issue is one of levelling-up. On the whole, I would welcome the introduction of new services to facilities that have not benefited and also to primary care services that have not benefited from that sort of provision in the past.

The Convener: I call Shona Robison for a last brief question.

Shona Robison: In your report, under the heading “Political Climate”, you say—no doubt you are stating a fact—that

“The Scots are generally more hostile to PFI/PPP than their southern counterparts.”

You go on to say:

“However, the fact that the public sector stands to benefit from potential profits through participation in the joint venture vehicle may prove a selling point.”

Are there any examples of the public sector making such a profit?

Howard Forster: As I said, it is too early to be drawing conclusions—

Shona Robison: How likely is it?

Howard Forster: In NHS LIFT, the public sector has 40 per cent of the shareholding of the joint venture vehicle, which means that it has a 40 per cent share in any benefits that accrue in that arrangement. That is different to anything that has gone before in terms of other PPP models. It gives the public sector a stake and a share in that and gives it influence over the distribution and use of the profit.

I refer to the Bradford and Northern Housing Association and its objectives. The committee might like to engage in a conversation with Bradford and Northern Housing about its operation. Certainly, its motives are neither share value nor profit in the sense that those are understood, but of redistributing value into the wider regeneration objectives of the organisation. Although the benefit of LIFT is beginning to prove itself, it is too early to offer specific numbers or observations.

The Convener: Although Nanette Milne is interested in examples south of the border, they have been discussed consistently throughout the questioning. We have quite limited time. Is there anything further that you wish to raise on the subject, Nanette?

Mrs Milne: I have a question that leads on from what was just said. You spoke about differences of scale and so forth. I notice that under the “Consultation Point Conclusions” heading on page 11 that you say that

“It may be appropriate to implement 1 or 2 pilots in geographically distinct areas”.

Perhaps lessons from England could be learned for the pilots. Will you elaborate on that?

Howard Forster: In the main, the first 42 LIFT schemes in England were directed at the major towns or inner city conurbations. I think that it is fair to say that, although it was not universally the case. The next nine schemes, which come under what is described as the fourth wave, cover Kent, for example. Possibly the schemes in the fourth wave are more comparable to some of the geographies in Scotland.

I apologise for the fact that some of the comments in the report are naive. As I said, the report represents the views of those who were in
the room. I apologise if I am coming across as being naive about the geography of Scotland. That said, the observations of the people in the room and of the private sector, are that it would be very different to bid, let us say, for a Glasgow or greater Glasgow scheme than it would be to look at one in a more rural community where general practice was distributed over a much wider geography. It is likely and sensible to suppose that the planning and approach to that scheme would be different.

I think that the group was saying, “Would it not be sensible to try that out.” The suggestion was for some pathfinder schemes that could explore the two extremes to see what they would look like and how Scottish planning partnerships could be involved in the process. That is part of the recommendations. It is likely that the way in which Scotland would engage other wider public sector stakeholders within the process would be different, and sensibly so.

I imagine that the issues that arose in Kent, such as the need to involve the ambulance service more formally within the partnership, are more relevant in wider rural settings than in city settings where adjacency issues are easier—albeit not easy—to overcome and where access to facilities is less of an issue. Those points are reflected in the observations in our submission.

David Fox: In the Scottish context, there are a couple of linked points that we have already discussed. First, we can learn from the recent wave of education PPP projects, in which the interest of bidders varied depending on the value of the projects and their geographical complexity. We need to consider the right balance between bidder interest—bigger tender lists help to drive value for money—and the ability of bidders to deliver projects.

At the moment, we are perhaps at the starting point for the next stage that the Executive team will need to consider. Taking account of those experiences, they will need to consider which trusts—

Mrs Milne: I must interrupt you. When you say “trusts”, do you mean health boards?

Howard Forster: Yes, he means health boards.

David Fox: Sorry. People will need to take account of the experience of education projects and of the consultation process that has already taken place. They will need to assess what is the ideal combination of project value and geographical spread that will maximise interest from potential bidders and thereby drive the competitive pressure that will deliver value for money.

Some health boards might opt for a combined project similar to the Manchester, Salford and Trafford LIFT. Although those are substantial conurbations, it was felt that a combined project would be better at driving value for money. Such an exercise needs to happen, but it would need to be consulted on and tested before it goes ahead.

Mrs Milne: What was included in the Manchester, Salford and Trafford project? What did the project comprise—

The Convener: Nanette, please speak more clearly into your microphone; the rest of us cannot hear a word that you are saying.

Mrs Milne: Sorry. What facilities were produced by the Manchester, Salford and Trafford project?

David Fox: The Manchester, Salford and Trafford LIFT is a large-scale but reasonably typical LIFT project that will provide facilities in which primary care trust services can be delivered in the Manchester and Salford areas. The facilities include GP surgeries. Because our company was involved in assisting the successful bidder for that project, I know that that LIFT has presented an excellent opportunity to combine health and many other related public sector services, so that the space is multi-used and works harder for the public purse. That is a successful example of how a LIFT can drive efficiencies so that there is more cash to put elsewhere.

Janis Hughes: My questions are on community planning. In his introduction, Mr Forster said that the LIFT model would be more beneficial than more orthodox methods in providing primary care services. Will he elaborate on why the LIFT model is more beneficial?

Howard Forster: There are two aspects to that.

First, the model fills a gap in the planning process for primary care accommodation by replacing the current mix of different approaches by which GPs might replace their accommodation. For example, GPs might previously have rented accommodation that was designed and built for them by a private sector organisation, or they might have worked with the public sector health organisation—the health board in Scotland or primary care trust in England—or, alternatively, they might have held their general practice surgeries in part of their own house. In many cases, the accommodation needs of GP practices would be considered in the light of their practice population, but in the absence of wider considerations pertaining to the whole town or area. However, the NHS LIFT model has accelerated the process whereby primary care providers—principally, general practitioners but also optometrists, pharmacists and other providers within primary care—are brought together in the planning process. They are surrounded with the capacity and skills to help them to think about their
future needs for their premises. Historically, that did not really happen.

16:45

The other aspect of that is the point that was just made about mass. In St Helens, a primary school—Ravenscroft Community Primary School in Knowsley, which is well worth a visit and is being constructed as we speak—came together with the primary care trust and the two sites were combined. The primary care site that was up the road has now been moved to the primary school site, and a common access has been created. A community centre has been put in the middle of that. Maximum use is being made of the land, and those community functions are being brought together. The local community is engaged in the school and there is no vandalism of the school—there never was, but the old GP practice was vandalised every week. There have been benefits to bringing the community closer to primary care provision.

Another example in St Helens involves the church. The Archdiocese of Liverpool has given over one of its sites for a GP practice. That has attracted other investment—residential and retail investment—and is having an impact on the overall regeneration of Duke Street, west of the town centre. Those are two examples of where wider planning has occurred and where the deficit in planning, even within the health care sector, has been dealt with.

Janis Hughes: I hear what you are saying. Both the examples that you have given are in England, but you say in your report that the framework is different in Scotland. That is why we have devolution—because we have different ways of dealing with things here and different issues to address. I was a bit concerned about your comment that "There is a need to develop the link between local and strategic planning, which was perceived to be missing from the current LIFT process."

The committee knows only too well from previous experience about the lack of strategic planning in the NHS and how vital it is that things are planned strategically. It concerns me to hear you acknowledge that there are gaps and that strategic planning has perhaps not been addressed properly in this process.

Howard Forster: Some people who attended the consultation observed that. My personal experience is that the process has been more joined up than I have seen historically within a primary care setting. I think that you have an approach to infrastructure that gives you an advantage over some parts of England. I agree with that. I have observed that and that was mentioned in the conversation that we had at the consultation. Your strategic partnerships are perhaps stronger here and better suited to this model, and you already have experience of joint venture structures.

In many parts of England, it was new for organisations to come together in that way. Even within primary care, as I say, there was a deficit in planning. Historical structural changes had perhaps led to the loss of some of the skills around that; nevertheless, we have seen the benefit of joint planning with local authorities, local education authorities, education providers generally, the faith school sector and the church sector. It has been very practical to do that, and I have offered those practical experiences. The schemes that I have been involved in have been better than I have seen previously, but there is a long way to go. We are trying to ensure that those opportunities are considered systematically in every scheme that is developed; however, realistically, that is probably not where we are now.

The Convener: How old is the oldest of the schemes in England to which you refer?

Howard Forster: The schemes that I am involved in—

The Convener: I mean the ones with which you are familiar. You have referred to schemes south of the border, but you have also said that it is too soon for us to look to them for examples. How far down the line is the oldest model of this kind in England?

Howard Forster: The first financial close was 18 months ago, and the facility is now complete in London. The schemes that I have been involved in are under construction and are not yet complete; however, it is early. The LIFT market in England is roughly three to four years old. The process for bidding is 17 months to financial close and it takes 12 months to construct the larger schemes. It is not likely that, over the past three to four years, there have been a huge number of such schemes.

The Convener: Is it true that only a handful of schemes have been completed in England?

Howard Forster: That is correct.

The Convener: Under this model, the public sector provides the shareholders and directors. In the handful of LIFT schemes that have been completed, have issues of accountability and conflicts of interest been raised, especially in relation to the public sector directors?

Howard Forster: It has been a major issue regarding how the primary care trusts and other public sector organisations have set up the LIFTs. The governance arrangements for strategic partnering boards, what the shareholder
agreement does and how it affects individuals have been much discussed. We should bear in mind the fact that Partnerships UK has been closely involved in the procurement and setting up of LIFT companies. That means that a Government body has supported the process and considered the issues.

The Convener: Have there been any subsequent controversies or arguments? Have any concerns been expressed?

Howard Forster: I imagine that concerns will be expressed at some point, but to my knowledge that has not yet happened in the marketplace.

The Convener: Thank you for your attendance. You are welcome to take a seat at the back of the room and to listen to the evidence that is given by the next panel of witnesses. If you want to leave, you may do so.

David Fox: I would like to clarify some evidence that I gave earlier. When talking about risk, I gave the example of East Lothian. East Lothian was not an example of there being a step-in on the SPV. The SPV was still in place—it re-tendered and carried the cost associated with that. The project arrangements in the example that I gave applied south of the border.

The Convener: I welcome our next panel of witnesses. They are Alan McKeown, health and social care team leader for the Convention of Scottish Local Authorities; Tim Huntingford, chief executive of West Dunbartonshire Council and joint chair of the joint premises project board of COSLA; Hilary Robertson, director of the Scottish NHS Confederation; and Susan Aitken, policy manager of the Scottish NHS Confederation. I invite one representative of each organisation to make a brief introductory statement. It should not be longer than a minute or two.

Tim Huntingford (Convention of Scottish Local Authorities): COSLA is strongly committed to partnership working. We have demonstrated that through the involvement of local authorities in joint future work and community planning. We are in favour in principle of joint ventures and recognise the advantages of shared premises for health and local authorities. That approach offers the potential for regeneration, the provision of state-of-the-art premises and, most important, improved seamless services for the public.

However, local authorities need to be full partners and to be fully involved. We are concerned that in previous initiatives, such as the health improvement programmes and, more recently, community health partnerships, local authorities have felt that they are on the margins, while health services and the Health Department have led.

We are in favour of the provisions in the bill, but wish to ensure full local authority buy-in to produce developments that are flexible and responsive to local needs and circumstances. LIFT may be one model but it is not the only one. COSLA feels that it is for local partnerships to determine their strategies and approaches to the issue.

Hilary Robertson (Scottish NHS Confederation): From discussions with our members, we are confident that there is general support for the principle of joint ventures as outlined in the bill. Joint ventures would give boards another option for the development of premises and facilities, without removing any of the existing options. That would result in a welcome increase in flexibility. The application of joint ventures to the exploitation of intellectual property is very welcome. That is currently an untapped resource.

Much detail has still to be worked out. We are talking about a power that boards do not have at the moment, so there is no practical experience in the NHS. We would welcome the NHS being closely involved in developing the proposals.

The Convener: The session will not work if all four panellists answer every question, so I would be grateful if the witnesses could do what they did with their introductions. I will ensure that each organisation gets a fair crack of the whip. If committee members want to ask a specific question of an individual, please make that clear.

Shona Robison: The panellists heard the previous discussions about risk and increasing cost. I want to ask both the Scottish NHS Confederation and COSLA how, as guardians of the public purse, they can ensure that the public sector does not, in LIFT contracts, take more responsibility for risk than it should do. When things go wrong, how can we guarantee that the public purse will not bear the brunt?

Tim Huntingford: I cannot give any guarantees. That is the kind of detail that will need to be carefully worked out. When local authorities, the health service and the private sector work together, the devil will be in the detail. Local authorities are gaining experience of that through the huge upsurge in PPP contracts for the regeneration of schools. Lessons can be learned and I hope that they will be applied.

Shona Robison: You say that lessons can be learned. Obviously, delays and quality issues have arisen in some areas with the schools programme. Have lessons been learned?

Tim Huntingford: I think so, yes. We are becoming much more skilled as more and more people become knowledgeable. As several previous witnesses have said, a considerable body of knowledge is developing elsewhere in the
United Kingdom. We can build on that to try to ensure that lessons are learned and mistakes avoided.

Susan Aitken (Scottish NHS Confederation): We would agree with that, and with the point that the devil will be in the detail. Governance arrangements, and arrangements concerning the balance and sharing of risk and reward among the range of partners, will require a lot of work.

The NHS came rather late in the day to joint ventures, which gives us some advantages. We can learn lessons that Scottish local authorities have already learned from being involved in joint ventures. Through the LIFT scheme in England, we have learned that we can use the best bits of models and discard the bits that have not worked. We can get the best of both of worlds.

A lot of work remains to be done. Our members—the NHS boards—are enthusiastic and see a lot of potential in the joint ventures model, but at the moment it is just potential. A lot of detail has still to be worked out.

The Convener: Are there particular things from south of the border that you have already decided are not appropriate for Scotland?

17:00

Tim Huntingford: I have limited knowledge in that area. In the early days in England, one of the problems was that the LIFT model was heavily health oriented. The sort of developments that have been referred to started in later phases. Local authorities and other partners have joined in to make truly joint ventures—as previous witnesses have said, developments in the early days were mainly to do with primary care premises. People have talked the talk about partnership down south, but they have only latterly started to implement partnerships in reality. That is an important lesson for us in Scotland.

Susan Aitken: So far, there is nothing specific that we absolutely must actively avoid, but there are certainly things that cannot be transferred wholesale. Obviously, there are different structures in Scotland. Previous witnesses have alluded to the very different geography here, and NHS LIFT projects have tended to be in inner city areas. One of the main issues in Scotland is primary care premises in remote and rural areas, so we will develop our own model and start from scratch in many ways.

I echo what COSLA said about partnership. Some later LIFT projects have involved a much wider range of services, including library services. There have been local authority environmental and leisure services and a much wider range of things on board; we would look to emulate that. That has already started in Scotland in projects that have been developed through more traditional funding routes—the committee may have heard of the Dalmellington area centre in East Ayshire, for example, which was a joint NHS-local authority project. NHS and local authority services and other community services come under a one-stop shop premises. There are other projects in West Lothian and other parts of the country. Therefore, there are already partnership models with a wide range of services to benefit the community that we can consider.

Kate Maclean: I want to ask the same question about jobs that I asked the previous panel. Do you have any concerns about workforce issues? In particular, I want to ask COSLA about having premises in which there are staff who are employed by a joint venture company and staff who are employed by a local authority. In the Scottish Commission for the Regulation of Care, for example, difficulties were caused by two sets of public sector employees coming together. Do you foresee any such difficulties with the proposals that we are considering?

Alan McKeown (Convention of Scottish Local Authorities): We have experience of such issues in the joint future work that has been done between local authorities and NHS bodies on matters such as terms and conditions, pay and holidays. That has proved to be a bit of a stumbling block, but we have managed to work our way through it. We would want to consider where the differences lie in our work and how we would overcome them. We would not want there to be dramatically different terms and conditions and rights and responsibilities for employees. We would try to even things out as much as we possibly could.

Kate Maclean: Local authorities are still trying to work through single status. The proposals in the bill seem to add another dimension that might create even more difficulties.

Alan McKeown: I do not think that we will rush into LIFT or LIFT-type schemes. As we pointed out, the potential is there, but there is a long way to go in our discussions, which are currently at the officer level. Our submission says that we have not yet had political discussions. We need to go through a level of detail honestly and openly, but that is yet to happen. You are right to say that single status is being worked through. Tim Huntingford can talk more about that than I can, but there are many issues to be worked through.

Carolyn Leckie: I do not know whether you heard the previous evidence session, during which questions and concerns about jobs were referred to. The E C Harris consultation document says that, as a result of links with local authorities,
"LIFT in Scotland will be even more flexible with more exciting outputs."

Do you know what it means by that, and does that statement cause you any concern?

The companies have expressed a wish that soft facilities management be included. Will you rule that out? I have experience of the joint future initiative from an NHS point of view, and I know fine well that lines of accountability have not been sorted out; there are vast differences in terms and conditions between occupational therapists in local authority employment and occupational therapists in NHS employment. Will all those issues be negotiated and resolved with the trade unions before any contracts are entered into?

In the evidence that we have heard today from all sides, the response to a number of questions has been, “The jury’s still out. There isn’t enough evidence.” If we cannot assess the impact on staffing levels, service provision, terms and conditions, and lines of accountability, does that not indicate that the bill is premature? We have been unable to work out what the problems are, because there is not enough evidence or experience.

On the specific question—

The Convener: Carolyn, could you focus your questions? I am worried that they are not being followed.

Carolyn Leckie: I am worried that I will not get back in.

Will you rule out facilities management? What detailed discussions have you had on the impact on terms and conditions and service provision? Is there any evidence of the efficacy of the schemes?

The Convener: Can you get to a set of questions that the witnesses can answer? If you simply go on and on, that will ensure that you will not get back in.

Carolyn Leckie: The questions are quite specific.

The Convener: If the witnesses can unpick the questions from that speech, could they try to answer them?

Carolyn Leckie: In addition, will you rule out facilities management?

The Convener: Carolyn, enough.

Alan McKeown: I will try my best.

First, on the legislation, if the bill is enabling, that is fine and that is the end of it. Secondly, on facilities management, staffing, and terms and conditions, of course we will talk to the unions; we always seek to do that. We have a good relationship with the unions through the joint future work. We have sought to build up that relationship and we will continue to do so. It is too early to say what the situation will look like, but there is an absolute guarantee that discussions will take place.

The third point is the opportunities that joint working will bring. It is true that our geographies are different, our governance arrangements are slightly different, and with community health partnerships we have a completely different local feeling, but CHPs are very new. The ink is not even dry on half of the schemes. We have yet to determine whether CHPs will add value, but there is a framework for better working. Through our joint future work, we have the scope to do innovative things in rural, urban and mixed areas. We could look at the full range of services that could be provided from one-stop shops, for example, which would provide exciting opportunities for our communities.

You are right—the job is big. That is because we are at an early stage in the process, and we need detailed discussion at every level to ensure that our governors, who make the decisions on investment, know exactly what they are dealing with. Right now it is too early for that, but that is why groups are being established and why we are giving evidence.

Carolyn Leckie: I have one specific question—

The Convener: Can the NHS Confederation answer the question as well?

Susan Aitken: I concur with Alan McKeown. On trade union involvement, the NHS in Scotland operates on a partnership basis. Without question, the Scottish partnership forum and all the local partnership forums on the staff side and NHS board side will be involved in any discussion about this major development. That goes without saying. It also goes without saying that the staff protocol that will be adopted for joint ventures will be the one that was adopted for PFI. It had not occurred to us that that would not continue. The protocol has been adopted and is accepted across the NHS, so I do not see that being an issue.

I see nothing sinister in there being exciting opportunities for doing even more between the NHS and local authorities. Much potential and enthusiasm exists and there are many ideas out there about partnership working, which we have started in Scotland. The joint future initiative is one element of that and community health partnerships will be another. In some ways, many of the issues are not new. As Alan McKeown said, we are addressing differentials in pay and conditions. That matter has not been resolved, but people know about it. That aspect of the process will continue for joint ventures.
Apart from that, everything is up for discussion, as Alan McKeown said. The bill is certainly not premature; without it, nothing can be considered, because the NHS does not have the power. Local authorities already have the power, but we cannot consider extending partnerships under the proposed model without the bill. The bill is enabling and will compel nobody to participate in joint ventures—for example, it does not assume that all NHS boards will enter into joint ventures. However, without the bill, there would not be much point in discussing the other details, because the NHS would be unable to participate in such projects.

The Convener: Does Carolyn Leckie still have a specific question?

Carolyn Leckie: My question is very specific. Concern was expressed in the consultation report that E C Harris presented to us about the need to achieve critical mass for any projects that people become involved in. A question arises about the antagonism between achieving critical mass and providing rural services, for example. Have you examined that? Do you have concerns? What do you expect to happen? Are rural services in danger?

Susan Aitken: We have not examined that specifically, but my response to the question whether rural services will be in danger is no, because the aim is to provide new services. Existing services are unlikely to be withdrawn—"downgraded" is the common term these days—as a result of such an initiative. In fact, they will be extended and enhanced. If NHS boards enter into joint ventures, they will do so to enhance and develop existing services and to build on what exists.

The Convener: You said that the bill was enabling legislation, and Carolyn Leckie was right to refer to it as all being quite vague. If the bill is passed this year, what is a ballpark figure for when you expect a brick to be laid?

Tim Huntingford: The joint premises project board that I co-chair with a health service chief executive has considered the tension between critical mass and local determination, which needs to be worked through. The evidence suggests that the timescales for developing LIFT schemes in England are reducing. The previous panel said that the first scheme took 18 months to develop, but we are receiving evidence that that period can be reduced to a bit over a year. If the bill were to be passed, the detailed guidance issued and LIFT models adopted, work would probably begin a bit over a year after that.

The Convener: We could be talking about 2007.

Tim Huntingford: Yes.

The Convener: Nanette Milne is interested in what is happening south of the border.

Mrs Milne: Have you noted from schemes south of the border any good or bad examples for what we will do up here?

The Convener: I think that we have asked about that.

Mrs Milne: I suppose that we have.

Susan Aitken: I do not know much about the LIFT projects that have been completed in England, but I know that some of them are expected to make significant contributions to community regeneration by bringing not only services, but new and often well designed user-friendly state-of-the-art buildings into communities that have had no such services before. There seems to be a lot of enthusiasm for that, and I see no reason why we should not seek to emulate that kind of result.

17:15

Tim Huntingford: The partnership needs to be genuine. One of the concerns in Scotland has been that a driving force behind the initiative is the problems that we have in our urban areas, such as Glasgow. Nobody has mentioned it yet, but dentists' premises are a major problem in Glasgow, because most of them are up a close in tenement buildings.

The Convener: At least Glasgow has dentists.

Tim Huntingford: Yes. Trying to deal with the problem of single-practitioner GPs has been a driving force for the Health Department. From a local authority perspective, we are much more interested in regenerative activities that will bring services together, such as the kind of things that you heard described as happening in St Helens. I am talking about not only local authority social work services, but environmental health, leisure services and other local authority services. We must free up our thinking about what the initiative could deliver, rather than thinking that it is mainly about trying to overcome the backlog of inappropriate primary care premises.

The Convener: I will make an observation about something that puzzles me and on which you might wish to comment. The provisions on joint ventures are obviously significant for COSLA and the Scottish NHS Confederation, but in your evidence so far, you have said repeatedly that you do not know much about what is going on down south. That surprises me. Why do you not know much about it? If that is where some of our evidence should come from, why do you not know more about what is happening there?
Susan Aitken: We know what is happening in that we know about the kind of projects that are being developed—the examples about which your previous witnesses spoke and we have just spoken—and the impact that they can have on community regeneration, for example, but we do not know about the long-term financial impact because there has not yet been a long term. In addition, we are wary of assuming that the LIFT model could be transferred wholesale. It shows potential and is an example of what could be achieved, but there is no assumption that LIFT as it operates in England will be the model that we use in Scotland.

Alan McKeown: In our written submission, we said that a number of issues have been internalised in the NHS system and that external partners have been brought in late in the process if at all. Joint ventures are coming in only at the bill stage, in the same way that the CHPs came in late, and we are playing catch up. Tim Huntingford has been the chair of the joint premises project board only in the past two months; I am now joining the board and we are seeking additional representatives for it. There must be an earlier process and, as Tim Huntingford said, the partnership needs to be genuine. We are concerned that we will be brought into the process late, as has been our experience, and that we will not feel that the partnership is genuine.

The Convener: So you have concerns about that.

Alan McKeown: Yes. We are concerned about late involvement. We accept some responsibility, as we could have done a bit more, but there has been no political engagement at this stage, just as there was limited engagement on the CHP debate. If joint ventures are to be truly successful, that political engagement must happen quickly and openly. An area-by-area strategic approach is fine, but if critical mass is a key issue and we are to have regional boards around Scotland, that is a different ball-game and we need to have an honest discussion about it if it is going to work. We need to get it on the table and discuss the issues that come with it.

The Convener: Are you saying that you have not yet discussed those issues with Government?

Tim Huntingford: There has been some discussion. There has been a very steep learning curve for me, because I have been involved with the joint premises project board only for the past couple of weeks. If I had been asked to give evidence to the committee in three weeks’ time, I would by then have been to England to see LIFT schemes for myself. It was interesting that when the Deputy Minister for Health and Community Care spoke to COSLA leaders about a month ago, primarily about the bill, 99.9 per cent of the discussion was about smoking issues—that was unsurprising—and only fleeting reference was made to the joint ventures provisions. However, those provisions are important for local politicians. We have not yet done enough to alert local politicians to the matter, but the Executive has not done enough, either.

The Convener: The timing of this meeting is not particularly good, given that you have not yet visited the schemes in England. However, if you have observations to make after your visits, please put them in writing to us, if you have the time to do so.

Shona Robison: Would it have been more appropriate for the provisions on joint ventures to have stood alone, rather than be included in a bill that addresses other matters that will dominate discussions? The danger of tagging the provisions on joint ventures on to the bill is that important issues could get lost among other elements of the bill.

Tim Huntingford: That is a fair comment. I do not like the fact that the provisions are included in a health bill that is promoted by the Health Department and discussed in the Health Committee. Where is local government in all that? The proposals should have been sponsored jointly and should not have been tagged on to the bill. I understand why that happened: there was a wish to get on with things. However, the experience of the discussion at the COSLA leaders’ meeting was typical; a vast majority of people do not know that the bill contains the important element that we are discussing.

Hilary Robertson: I will make a brief point. The bill would give powers to the health service that it does not already have, whereas local government already has those powers.

Janis Hughes: The E C Harris consultation concluded that

“There is a concern that Community Planning Partnerships could create tensions as they have limited involvement and experience of the planning process for creating physical assets.”

What are COSLA’s views on that and, specifically, on how the community planning process can work with the LIFT model?

Tim Huntingford: The experience of working together is growing and I do not agree that it would be inappropriate for community planning partnerships to consider planning. Community planning partnerships represent the table around which all the agencies can gather and they can facilitate more imaginative buy-in, not only from local authorities and the health service but from many partners. For example, the police might be obvious partners in certain locations.
There is an issue about the size of planning units in relation to developments such as those about which we are talking; that creates another tension. In many ways, community planning partnerships represent the right model and the right forum, but whether CPPs in fairly small local authority areas are the right size in relation to the—dare I say it—critical-mass element of LIFT-type initiatives, is another matter. For example, in my area—West Dunbartonshire—the partnership is split between Greater Glasgow NHS Board and Argyll and Clyde NHS Board, both of which cover other vast territories, so there are questions about whether the community planning partnership would be the right size in relation to the planning considerations of the boards.

Janis Hughes: I expressed concerns to the previous witnesses about the consideration that would be given to strategic planning in the LIFT model. The fact that the local authority that you represent covers an area that is spanned by two health boards means that there would be a greater need for strategic planning, which might perhaps be worked into the process. Could that be beneficial in the longer term?

Tim Huntingford: Strategic planning is very important, but we have not had a great deal of strategic planning to date. A critical part of the joint premises project board’s role in considering proposals will be to consider how the different areas—whatever areas are determined—can be involved in joint asset-management planning to meet current and future needs. That needs to happen in a way that has not happened previously.

The Convener: We have five minutes left before the current panel of witnesses must leave. Jean Turner has a final question.

Dr Turner: Are there any concerns about the possible loss of flexibility that might arise if joint ventures for new health centres involve increased numbers of partners such as schools, libraries, optometrists or any private organisations that one might care to name? I worked in a health centre that became too small within eight years of being built, so I know that things can change within the health service and that, like schools, health centres are required to do different things. Might we lose flexibility by being joined to other partners in what might be a long-term contract with payments?

Susan Aitken: Although independent primary care practitioners could be partners in such ventures, they would not have to be partners because they could lease the premises from the NHS board or from the other partners. In fact, such an arrangement could give more flexibility not only to practitioners—such as GPs, dentists, podiatrists and optometrists—but to the NHS board.

That is where planning comes in. As I said earlier, NHS boards will use such projects to fill identified gaps in services by, for example, providing services where none currently exists, or by improving inadequate and inaccessible services and addressing other problems. In identifying needs and gaps, the planning process would very much inform the design of premises and facilities. The aim would be that, at the design stage, flexibility would be built in for future health care needs so that independent practitioners and other services could still be brought in. All the partners in the venture would be involved in that process.

There are other potential benefits for practitioners. In deprived urban areas and in remote rural areas that are currently experiencing a shortage of dentists, one disincentive that practitioners face is that, if there are no premises currently available, they may need to make a big investment by entering a long-term lease for premises or by purchasing new premises. Joint venture arrangements could provide flexibility for such practitioners by allowing them to lease facilities for shorter periods without their having to commit to long-term investment. For example, in parts of the Highlands that currently have no dental premises, the dentist might otherwise need to build new premises. Some practitioners have found themselves in that position.

Hilary Robertson: The principle behind the proposal is about long-term partnerships. Our expectation is that partnerships will grow and develop. From day one, they will be flexible partnerships rather than the static arrangements that were perhaps first conceived.

The Convener: We will hear no more questions because we are running out of time.

I want to make a point about mobile phones in the committee room. Regardless of whether they are set on mute or vibrate, mobile phones still interfere with the sound system. Members’ phones have been going off for about the past half an hour. Please switch them off rather than simply to mute. Kate Maclean is attempting to look innocent, but it is not working.

Kate Maclean: I have just switched it off.

The Convener: It is not working. Shona Robison was also one of the guilty parties.

Kate Maclean: Bad Dundee girls.

The Convener: Yes—clearly it is an issue with Dundee.

I thank the witnesses for coming along. As I said, if you would like to make any follow-up
those value-for-money exercises have been vast experience of a range of PFI schemes how which is used in LIFT schemes. We all know from used in PFI schemes is exactly the same as that capital expenditure.

Therefore, the process is very much market driven—can say, “Oh companies—you will have gathered that the priorities but, with LIFT, the banks and the schemes that are fairly high on its list of capital priorities become distorted, because to achieve “critical mass” means that local health board private partnership built in the first place. Do you view that in the same way as other potential service developments, or is it more acceptable to Unison?

Dave Watson: No it is not. A LIFT scheme is still a 20-year contract. Somebody must at the end of the day pick up the bill and guarantee the financing. Whatever happens, the public sector picks up the bill—we have seen that time and again. Every scheme has a clause that is usually buried in the annex that states that if the whole scheme goes pear shaped the public sector will pick up the bill. The only guarantee in PFI is that the bankers always get their money.

Kate Maclean: I will ask the same question about jobs as I asked the previous two panels. The first panel does not perceive any difficulty regarding loss of jobs or a two-tier workforce. COSLA, however, acknowledged the difficulties that can arise when trying to operate two sets of terms and conditions in one workplace. Can you expand on the fears that you have in respect of jobs and workforces when efforts are made to harmonise conditions in one set of premises?

Dave Watson: We raised the question of the STUC-Scottish Executive PPP staffing protocol in our response to the initial consultation on LIFT and joint ventures. It is interesting that in none of the Executive responses and summaries has anybody yet confirmed that the protocol would apply to LIFT schemes and similar joint ventures. Our view, having considered the Treasury definition of a PPP scheme, is that it clearly would. I have to say that I am somewhat surprised—and perhaps slightly suspicious—that the Executive has not confirmed that. Clearly, it is very important because the protocol deals with two-tier workforces and with pensions issues. That is a subtle hint to the committee that it should ask a question of the minister.

The comparison with England is difficult. I have the same problems as previous witnesses; to be frank, there are no real LIFT schemes in England—there are only a lot of financial schemes that have been developed on paper.

There are also some differences in Scotland, which leads us to be concerned that more staff might be affected in Scotland. There are more health centres in Scotland, particularly in the major cities, whereas there are more private GP practices down south. Health centres are traditionally health board premises that have health board staff—both soft FM and hard FM, to use the PFI jargon. The other difference between
Scotland and England is that there is far more direct staff provision in Scotland in local authorities and in health boards, whereas in England there has been far more use of contractors. Those differences lead us to be concerned that there might be more staffing problems in Scotland.

Carolyn Leckie: I referred earlier to a comment in the E C Harris report. It states:

“It was believed that as a result LIFT in Scotland will be even more flexible with more exciting outputs.”

That is in respect of the relationship with local authorities. I did not get an answer to my question about what “more exciting outputs” means, but it tends to suggest more extraction of profit. Does that relate to your concerns about terms and conditions?

Dave Watson: Many of the reports are littered with management speak. Phrases such as “flexible certainty”, “purchase provider” and “how schemes might evolve” lead us to be concerned that there are risks. We would expect a rate of return of about 8 or 9 per cent on a normal premises contract that was developed by the NHS. That is typical if a contractor is brought in to build new GP premises. There are no clear figures yet for LIFT. It was previously indicated that the rate of return might be as high as 13 per cent, which is clearly much higher. Our understanding is that PFI schemes can have a rate of return of between 15 and 20 per cent. In other words, the rate of return on private finance deals is almost double that of conventional procurement, so it is clear that profit is an issue.

Unison has published documents—unlike commercial contracts, ours are all published on the website so that people can see them and read the analysis—that members can read and see that we have done a lot of work on refinancing and the costs that are involved in the secondary markets, where people effectively sell on their equity share in some schemes. There have been significant profits made. You do not have to take our word for that; the Public Accounts Committee at Westminster has produced many reports on the matter. There is scope to make additional profits and it is not difficult to do so. A typical PFI scheme might have a Standard & Poor’s rating of BBB, whereas public authorities work on an AAA rating. It simply costs more to borrow money in the private sector than it does in the public sector. The profit is added, which leads to the additional cost of borrowing. That is not terribly clever economics but it is self evident. We will pay more through the LIFT arrangement.

Carolyn Leckie: What is Unison’s position on Shona Robison’s point that the matter is so important that it should be in stand-alone legislation? Are your concerns so fundamental, as mine are, that they undermine your support for the smoking ban?

Dave Watson: As you know, the provision was originally to be included in the forthcoming health service (miscellaneous provisions) bill. We were concerned that as soon as the smoking ban was included, other aspects would not get attention. In fairness to the committee, it is clear that you have identified and examined the various provisions.

To be honest, our position is to ask why have the lessons of PFI schemes to date not been learned. What more do we need to know? Do we need more Skye bridges, more Inverness airports, more Edinburgh royal infirmaries and more filthy sewage works? It is bizarre that the schools in East Lothian were cited earlier as an example; they were a shambles for at least nine months when Ballast Wiltshier Investments went bust. I point out that Ballast Wiltshier was consulted by the Scottish Executive on LIFT projects; I presume that the Executive thought that the company had something to offer the consultation. We have plenty of experience of PFI arrangements; we do not need much more. It seems to be pointless to go through what is a hugely expensive process, given all the people who are involved and the joint boards. Millions of pounds will undoubtedly be spent on consultants’ fees simply to dress up the failures of PFI under the new name of LIFT.

Carolyn Leckie: Will the inclusion of the matter in the bill compromise your support for the smoking ban?

Dave Watson: Absolutely not. Our position on the smoking ban is clear; I will be back here next week to tell you that.

The Convener: I will ask you a slightly different question. Is the issue of sufficient concern for you to argue that we should vote against the bill as a whole? The problem is that it contains provisions for free eye and dental checks, the smoking ban and other things. Do you consider the matter sufficiently important that your advice is that we should reject the bill? I would like to hear John Park’s views on that as well.

Dave Watson: I am not in a position to say that at this stage. We hope that the joint ventures provisions will be amended out. If not, we will have to take a view of the longer term. It is clear that some parts of the bill are important—we have campaigned for a smoking ban in enclosed places for a long time and we supported the earlier member’s bill on the subject. We would be reluctant to argue that the bill should be voted down, but we hope that MSPs will amend it so that the particularly pointless part on joint ventures is not included at the final stage.

John Park (Scottish Trades Union Congress): Our position on smoking is slightly broader
because we take into consideration the various positions of the affiliates of the STUC.

The Convener: I understand that.

John Park: We agree in principle with the proposed ban but, as the committee will hear next week, there are slight differences between the positions of our affiliates. We go through an internal consultation process to reach a final position. Sometimes we reach a position that is clear and sometimes we do not. There would have to be more internal discussions about where we stand and whether we feel strongly enough, given our slightly different position on smoking, to support the bill.

The Convener: We should watch this space.

John Park: Absolutely.

The Convener: Does Nanette Milne want to ask any questions about the position south of the border?

Mrs Milne: No, not at this stage.

Dr Turner: I have a question for John Park. You said that you are afraid of privatisation, but will you elaborate on that?

John Park: Do you want my personal opinion or the STUC's position on that?

Dr Turner: Both.

John Park: The STUC has a fundamental position, which will remain in place for ever and a day, I imagine. We believe in public services that are publicly funded and underpinned by fair employment practices, and all the good things that go along with that. The committee should understand that, where policy differences exist, we seek to work with the Executive and politicians. We have a PPP staffing protocol and we are prepared to work through matters. We are certainly not against partnership. We find attractive the idea in the E C Harris report that some partnerships might be public-public only. Private sector expertise is not necessarily required to make partnerships work—they can be driven not by profit, but by the desire to deliver excellent services.

17:45

The Convener: The STUC evidence expresses concern about accountability and about conflicts of interest, which might arise in relation to membership of boards and so on. I asked earlier witnesses about that. Are you aware of specific examples from south of the border in which accountability and conflicts of interest have been an issue, or do you just anticipate that the issue will arise?

John Park: Our concern is twofold. We anticipate that conflicts of interest might occur because people will be put into the lions' den—into situations that they have not been in before and with people who have been in the private sector for a number of years who have been involved in PFI and PPP schemes. There might also be a conflict of interests in working up of bids. If two or more private sector employers are involved, negotiation will take place between the private sector employers as well as with the public sector partners. We must bear it in mind that, if the scheme comes to fruition, issues might arise in the working up of proposals, not only when they are running.

Dave Watson: Members will be aware that, under the companies acts, directors have a fiduciary duty to all shareholders. It is conceivable that problems could occur. In our experience down south, the problems so far have been with letting retail units in some of the early schemes. With a 20-year project, an issue could arise in respect of what should be done if a conflict arises between providing a health-related lease for a new dentist or some other useful health function and a more commercially viable option. I am not saying that there might be tobacconists in health centres, but a clear conflict of interests might arise if somebody offers to pay a much higher rent than a doctor, dentist or some other health-related function. We should remember that the directors will have a fiduciary duty to all shareholders and that the schemes will be weighted 60:40 in favour of the private sector.

Janis Hughes: I declare an interest: I am a member of Unison.

I have concerns about how the LIFT model fits into community planning. Do you have any comments on the strategic planning aspect and about how cognisance can be taken of the NHS's strategic planning needs?

Dave Watson: Page 6 of the E C Harris report mentions tensions with community planning partnerships. In fairness to the people who attended the seminar—75 per cent of whom were from the private sector—I suspect that by “tensions” they meant lots of awkward local people asking awkward questions. To be frank, that is usually what big private companies say about the planning process, so I suspect that that is the difficulty.

Community planning partnerships are important, particularly in Scotland. The partnerships in Scotland are not replicated in England; England works with more market-oriented public service provision. In Scotland, we have tried to build cooperation throughout the public sector, which is the strength of our community planning process. It is still early days, but our process does not fit the
commercial relationships that have been developed in England as part of the LIFT process. Fundamental questions need to be asked about how commercial designs can be matched with the broader planning arrangements that we are trying to develop in public authorities in Scotland.

The Convener: I ask Carolyn Leckie whether she has any other questions.

Carolyn Leckie: I do not, because the elaborate evidence that has just been presented makes an overwhelming case that contrasts sharply with the evidence that we heard earlier. I ask the witnesses to round up their comments.

The Convener: Carolyn, will you concede that I am the convener of the committee? Before I ask anybody to round up their comments, do other committee members have any further points that they wish to make or questions that they wish to ask?

Members: No.

The Convener: Is there anything that we should have cognisance of that we have not asked you or previous witnesses about?

Dave Watson: There are a few matters that you might wish to consider asking witnesses about at some later stage. One of those is land development, which has been hinted at in some of the documents. In our experience of the work in England, the attractiveness of some schemes has been very much dependent on the ability to develop land for housing, for example, as an earlier witness said. You might examine closely how the schemes sell off health board property to create attractive development opportunities for the private sector.

Another matter that you might want to consider is how LIFT schemes are unlike PFI schemes in Scotland, although they are not always unlike PFI schemes in England. With PFI schemes in Scotland, we have learned the lessons; the property is often handed back to the health board at the end of the scheme. It is perhaps not quite such good value as you might think, but that is what often happens. With LIFT schemes, the property stays with the private company so that, at the end of 20 years, the local partners are not left in a very strong bargaining position. A health centre might have GP surgeries and other facilities in it—social work, for example, could be in there, and we are very keen on having one-stop shops with police and other facilities—but will be in the hands of a private company. That company will have everyone over a barrel unless there is another health centre, police station and everything else just down the road that is ready for them to move into. As a trade union official, I am well versed in bargaining positions; I would not want to be in such a bargaining position at the end of the 20 years.

There are other matters that you might want to ask questions on. I might have missed it, but I cannot see a definition of the word "services" anywhere in the bill. The word "facilities" is defined, but not "services". At one seminar that my colleagues attended, a Department of Health official was quoted as saying that they saw no reason, in principle, why clinical services should not be included in the schemes. I noticed that that possibility was also floated in the Harris report or one of the other reports. In England, a number of big American corporations have been keen to get into primary care by employing large numbers of GPs, for example. If the scope of a scheme is wide enough, there is the possibility that companies will move beyond facilities and into clinical services on that basis. That would be of concern to us.

The other issue that is not mentioned anywhere in the bill is whether the Executive proposes to offer subsidies in the form of either direct subsidies for schemes or subsidies relating to development money or pump-priming cash. There is no mention of that in the documents that I have seen. Our experience elsewhere is that, suddenly, large sums of money—in effect, subsidies—are made available to the various PFI units in the Scottish Executive to promote development of schemes. That money has to come from somewhere. If it goes to management consultants, lawyers and so on to pay for developing a new type of scheme, it does not go to the NHS capital budget to develop schemes in the normal way. In essence, we are saying that conventional borrowing is cheaper and therefore worth considering.

The simple quick way to develop schemes is obviously to allow local authorities to use their prudential borrowing powers to develop the facilities using conventional borrowing. Health boards do not have that power. It is a complex area of health service finance, but it may be worth considering whether health boards could be given similar prudential borrowing powers. The problem with the local authority powers is that the Executive provides subsidy only if they go down the PFI route, which is where the schools problem has arisen. In our view, if prudential borrowing is to work, it has to work on the basis of there being a level playing field for both types of financing.

Those are the main points that have not been covered. As always, we will not be slow in writing to you if anything has been missed out or if anything develops.

The Convener: Okay. As with previous witnesses, if there are things that you wish to draw to our attention before the end of the process, feel
free to do so. Thank you very much—you are now free to go.

That ends today’s business in public, so I ask members of the public to leave the committee room.

17:54

Meeting continued in private until 18:09.
The Scottish Licensed Trade Association (SLTA) represents the interests of over 1800 self-employed licensees throughout Scotland; primarily pubs but also a smaller number of hotels, restaurants, bars and nightclubs.

The SLTA is committed to improving the health, safety and welfare of the staff and customers of its members and supports the objective of reducing their exposure to Environmental Tobacco Smoke (ETS).

The SLTA was a founder member of the Charter Group in Scotland and campaigned vigorously for the adoption of the measures by its members. This enabled the group to exceed all of the targets agreed with the Scottish Executive on the provision of smoking restrictions, with the sole exception of a technical issue on the keeping of paper records (where the target was missed by 1%).

It became apparent at the end of the Charter evaluation that our achievement of the agreed targets was seen as insufficient and that more was required in a short timescale. We believed that it was unlikely that this accelerated uptake could be achieved by voluntary measures, as there were widely perceived commercial disadvantages to those operators restricting or banning smoking – specifically that their smoking customers would move to other outlets who had not adopted restrictions.

As a result we proposed legislation to the Executive that:

Smoking should be banned at the bar counter in all licensed premises.

Smoking should not be permitted in any area where and when hot food is being served.

All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be ratcheted upwards to 40% in year 2 and 50% in year 3.

Every licensed premise should have a smoking policy sign at the entrance.

Smoking should not be permitted in any area of licensed premises from which the public are excluded (i.e. back of house).

At the end of year 3 a review of progress would be made and appropriate further steps taken in the light of public opinion prevailing at that time.

We were very disappointed that this proposal did not appear to be seriously considered by the Executive – which then, with minimal consultation, began vigorous promotion of a total ban in all pubs.

We believe that our proposal has been given no serious consideration by the Executive and that it has substantially more merit than the outright ban proposed in the Smoking, Health and Social Care (Scotland) Bill.

Our specific concerns with the Bill are:

Proportionality to any health threat posed by ETS

The Scientific Committee on Tobacco and Health (SCOTH) in its ‘Secondhand Smoke: Review Of Evidence Since 1998’ (www.advisorybodies.doh.gov.uk/ scoth/PDFS/scothnov2004.pdf) set the increased risk of lung cancer from non-smoker exposure to ETS as ‘marginally reduced’ from their previous estimate of 24%. This can be expressed as a relative risk of 1.24, or the risk of contracting lung cancer in any given year as 12.4 in 100,000.
In other words, in a group of 100,000 non-smokers exposed to spouses’ ETS an extra 2.4 people a year may contract lung cancer.

It should be noted that these conclusions are drawn from studies based upon spousal exposure to ETS – not the occasional exposure that customers may get from occasionally visiting a bar or the many staff who work in the industry for a matter of months. In both cases any risk is likely to be much diminished.

It is also worth noting that Baroness Jay in a Commons Written Answer stated that “...A stronger association - of greater than 2 - is more likely to reflect causation than is a weaker association - of less than 2 - as this is more likely to result from methodological biases or to reflect indirect associations that are not causal...”. In other words, if the relative risk was even three or four times higher than that claimed for ETS there would still be doubt as to whether the relationship was ‘causal’.

Even taking no account of the usually low level of staff exposure (most pubs only have a significant amount of smoking in the evening on the later days of the week), and the uncertainty apparently shown by Baroness Jay – both of which we regard as highly relevant – this would equate to a very marginal impact on those employed in Scottish pubs. Assuming 20,000 people work in Scottish pubs and approximately half of whom smoke, 10,000 non-smoking staff could be at risk. This would equate to 0.24 non-smoking staff contracting lung cancer from ETS each year in Scotland. This is not a major or certain health threat; especially if exposure can be limited by the substantial control methods that we have proposed should be enacted.

We find the claims of hundreds of deaths a year of non-smoking bar workers as a result of ETS also to be incredible from our own observations. Across our membership of nearly two thousand licensees we have had literally no feedback at all suggesting that their non-smoking staff or colleagues are dying of lung cancer, for example. If bar workers were at the level of risk indicated by the Executive’s reports we would expect this to be a major issue and concern amongst our members – this is not the case. Our observations absolutely reflect, at worst, the numbers that we have calculated above, not the hundreds of deaths claimed.

Lastly the Health and Safety Executive was tasked to develop an Approved Code of Practice on Passive Smoking at Work. The draft (11 October 1999) stated that (Paragraph 8) ‘Although there is emerging evidence that exposure to tobacco smoke in the workplace may be of itself sufficient to give rise to ill health we cannot, at the present time, be certain of the size or extent of the risk. However we do know that for some people exposure to tobacco smoke can make a pre-existing health problem, like asthma or chronic bronchitis, worse’. The expertise of the HSE in evaluating scientific evidence and risk is substantial and this would appear to be a far more reasonable claim of the health effects of ETS and one that can be borne out by our own experiences.

Whilst staff are seen as having no choice over their exposure, clearly non-smoking customers can choose whether or not to be exposed. With the increasing availability of non-smoking venues, smoking bans where and when hot food is served and the proposed major increase in non-smoking areas we believe that this exposure will be increasingly limited and will pose little or no health threat.

We conclude that action is required to remove or reduce ETS exposure as a source of aggravated medical conditions and annoyance, but that this action should be proportionate to the risks involved and that our proposed regulations cover this very adequately.

Reduction in Smoking Incidence

It is clear from Ireland that there has been a substantial reduction in the duty paid sales of tobacco products and presumably a reduction in consumption following the ban (although this may be affected by some smuggling due to the higher duty). It does not follow however that there is a similar drop in the incidence of tobacco usage (the proportion of the population that smoke) – especially amongst heavier users. In fact the evidence shows that there is little or no effect on smoking incidence amongst regular users.
In Ireland according to independent research agency Millward Brown (November 2004 see Appendix) the incidence of smoking (5+cigarettes a day, adults 18-64) has increased for both men and women after the ban (March 2004).

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<tr>
<td>Men</td>
<td>33%</td>
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<tr>
<td>Women</td>
<td>36%</td>
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In Norway the Directorate of Health and Social Affairs website shows daily smoker incidence (aged 16-74) reducing from 26.3% to 26% from 2003 to after the ban in 2004, a drop of 0.3%. In the year before that (2002-3) the drop in incidence was from 29.4% to 26.3% a drop of 3.1%. Taken over the five years before the ban the annual average decrease was 1.3%.

In 2003-4, the incidence of smokers aged 16-24 actually increased by 0.9% from 22.8% to 23.7% From these data you could conclude that the smoking ban markedly decreased or reversed the decline in smoking incidence that was being achieved previously.

Percentage daily smokers, by age. 1995-2004. Observed result and estimated three-year sliding average

<table>
<thead>
<tr>
<th>Year</th>
<th>Daily smoker 16-74 years</th>
<th>Daily smoker 16-24 years</th>
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<tr>
<td>1995</td>
<td>32.6%</td>
<td>28.7%</td>
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<tr>
<td>1996</td>
<td>33.1%</td>
<td>28.6%</td>
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<tr>
<td>1997</td>
<td>33.6%</td>
<td>30.6%</td>
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<tr>
<td>1998</td>
<td>33.0%</td>
<td>31.2%</td>
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<td>1999</td>
<td>32.0%</td>
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<td>2000</td>
<td>31.9%</td>
<td>31.5%</td>
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<td>2001</td>
<td>29.8%</td>
<td>26.8%</td>
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<tr>
<td>2002</td>
<td>29.4%</td>
<td>27.8%</td>
</tr>
<tr>
<td>2003</td>
<td>26.3%</td>
<td>22.8%</td>
</tr>
<tr>
<td>2004</td>
<td>26.0%</td>
<td>23.7%</td>
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Source: [http://www.ssb.no/vis/english/subjects/03/01/royk_en/main.html](http://www.ssb.no/vis/english/subjects/03/01/royk_en/main.html)

This suggests that whilst smoking bans may stop the light and very light social smokers to give up, and probably reduce the tobacco consumption of heavier users, it does little if anything to cause regular users to stop. The conclusion must be therefore that those regular users that choose not to visit pubs as the result of a ban will continue to smoke elsewhere – especially in the home.

Displacement of Activities
Although it is too early to assess the Irish ban it is clear that there has been a shift away from using hospitality outlets. This can be seen most clearly in the employment trends.

The Irish Central Statistics Office shows that employment in pubs, bars, hotels and restaurants had been steadily growing up to the ban – average +3.2% over the previous year. In the first six months after the ban employment dived by 6%. The rest of the private sector continued to grow at an increased rate from 0.9% to 2.9% in the same period.
From the November 2004 Millward Brown study (see Appendix) it appears that the total proportion of the population using pubs is more or less stable. From this, given the heavy reliance of the pub sector on ‘regular’ (frequent) users, it is logical to conclude that regulars (who include a high proportion of smokers) are being replaced by other users (who tend to be non-smokers) who visit less frequently. Although we are unaware of any specific data on this it is logical that a high proportion of these people now using pubs less or not at all are spending their time at home – and drinking and smoking there. This has health consequences:

Increase in fire risk: In Ireland this is clearly a problem. Batt O’Keeffe TD, Minister of State at the Department of the Environment, Heritage and Local Government stated (6 December 2004, press please from his Department) ‘I am very concerned about the dangers of cigarette smoking in the home, particularly when combined with alcohol consumption. Initial indications are that the percentage of fire fatalities where the confirmed cause is cigarettes is expected to rise again this year. This is a worrying trend and one which we need to nip in the bud as quickly as possible, particularly following the ban on smoking in public places.” In recent years we are unaware that there have been any fire fatalities in Scottish pubs, so this is a new danger that would result from the Bill becoming law - not a displacement of a current danger.

IncreasedETS exposure of minors and other family members: Small children are rarely present in pubs where there is a significant degree of smoking. By contrast they are highly likely to be present in the home. In the event of a ban their exposure can be expected to increase substantially, as is the exposure of other family members. Young children with developing respiratory and other systems could be expected to be particularly vulnerable. Any risks from exposure in the home will typically be greater than in a pub as the space per person is generally smaller and the ventilation worse - leading to less dilution of the ETS.

Increased home drinking: Evidence from Ireland suggests that some drinking has been transferred from the on-trade to take-home. This drinking in an uncontrolled environment is associated with health and social problems.

Uptake by children: children of smokers are more likely to take up smoking than children of non-smokers. A rise in smoking in the home associated with a smoking ban will increase the likelihood that their children will also take up smoking. This is directly against any public health objectives that may underpin this Bill.
Street activity: a high proportion of Scottish pubs, especially those in city centres, are in tenemented blocks with no areas that could potentially be used by smokers outside. The options for the pub user who chooses to smoke are to use another pub that does have an outside area or to stand outside in the street. In some areas, those standing in the street may represent a public nuisance to other pavement users, and will be vulnerable to traffic especially if they spill over the pavement into the roadway.

This is likely to be much more of a problem in Scotland than in Ireland due to the higher density of buildings and the relatively high level of street violence in some city centres.

These people are much better controlled inside a pub than outside it and we envisage substantial public order difficulties and potential injuries as a result.

1. Impact of alternative measures

We are concerned that this Bill implicitly rejects all of the other control mechanisms available. These should have been carefully considered before coming to the conclusion that a smoking ban was the only way forward. We note that harm from ETS is believed to be directly related to the dosage/level of exposure. It therefore follows that techniques that reduce exposure should have a corresponding impact on any harm, however small, from ETS.

Ventilation: Ventilation is a widely used control mechanism against contaminants across all industries. There is no reason why this should not apply to ETS and the pub industry – especially as the vast majority of ETS constituents can be found from other processes.

The 1998 White Paper Smoking Kills (www.archive.official-documents.co.uk/document/cm41/4177/4177.htm) explicitly endorses its effectiveness (Para 7.23) ‘ventilation systems can improve the comfort and welfare of public and employees. The best systems can, provided they are properly operated and maintained, protect non-smokers from exposure to carcinogens’.

Research commissioned by the Association into the effectiveness of ventilation at the Doublet Bar in Glasgow demonstrated conclusively that even relatively inexpensive ventilation greatly reduces the contamination from ETS gases and particles. There are similar studies available from the University of Glamorgan, which demonstrate the same effect in a number of pubs in England and Ireland. Where ETS constituents have known occupational exposure limits (for example particles and carbon monoxide), these are kept well within the acceptable levels.

The peer-reviewed Black Dog study (December 2001 Regulatory Toxicology http://www.ingentaconnect.com) clearly demonstrates that a well-managed ventilation airflow can prevent ETS drifting from a smoking area to a non-smoking area. The synopsis concludes that ‘ventilation techniques for restaurants/pubs with separate smoking and nonsmoking areas are capable of achieving nonsmoking area ETS concentrations that are comparable to those of similar facilities that prohibit smoking outright’.

Separation: Separation of smokers from non-smokers by a wall or partition is also a highly effective means of preventing the exposure of staff or non-smoking customers to ETS. This is especially so if the room is fitted with, even low level, ‘extract’ ventilation which will prevent any ETS from drifting out into the rest of the premises.

Concerns have been expressed that staff would be exposed to ETS if they entered such a room at the end of an evening to collect glasses. In reality there is little problem. ETS contamination is subject to exponential decay as the chart below shows (prepared by the Building Services Research and information Association – BSRIA). Most pubs have a ‘natural’ leakage rate of 1 or more air changes per hour with air seeping through the fabric of the building. This means that the equivalent of all of the air in the room is replaced once each hour with fresh outside air. At this rate – with no mechanical ventilation – the concentration would reduce by about 85% in two hours. At even a low rate of ventilation such as 5 air changes per hour, the contamination would be reduced to this level in about 30 minutes and effectively to zero within an hour.
Loss of jobs and amenity

Research commissioned by the AOB Group, of which the Association is a member, carried out by the Centre for Economics and Business Research (London) to review the economic impact of the proposed ban on both the licensed trade and the beer industry in Scotland found that:

- Employment in the licensed trade can be expected to decline by 2,300 jobs initially (page 5 refers)
- About 142 average sized licensed premises may close as a result of decreased trade (page 5 refers)

The loss of employment is likely to have a negative effect on the health and welfare of the people involved. This will be especially so for the c.140 licensees who will lose not just their jobs, but also their homes and their savings.

The loss of the pubs, which are likely to be in remote or economically deprived areas with few centres for community life, will have a marked and negative impact upon the lives of their regular customers who use it as an extension of their own home. This would be especially true of older people and some people who are emotionally disturbed for whom the pub is the only place at which they can meet other people. We believe that the health (physical and psychological) of these marginalised groups will be significantly and negatively affected by a ban that will force the closure of their ‘local’.

Evaluating alternatives to the ban

We are very concerned that the Executive appears not to have considered our alternative proposals seriously, if at all, in developing the draft Bill.

Our proposals are far more in line with public sentiment than the proposed ban. The Scottish Executive’s own research (MRUK 2004) found that just 18% of those surveyed supported a total smoking ban.

This percentage is borne out by the annual research carried out by the Office of National Statistics at the UK level in its latest (2003) report, which showed just 20% in favour of a ban in pubs, as the graph below indicates.
Our proposals will deliver the result that voters want at the moment. Our plan allows for a review of progress to be taken in the light of public opinion prevailing at the end of the third year. Our further plans would clearly reflect these public preferences.

In our view this is both reasonable and sensible.

Summary

The S.L.T.A. welcomes the introduction of measures to restrict smoking in public places. Our concerns are with the approach adopted by the Scottish Executive and are broadly divided into four areas as follows:-

this legislation assumes, without adequate research and contrary to recent international reports that the best way to improve public health is to impose an outright ban.

the outright ban will lead to public disorder, litter and extra public nuisance incidents, particularly at weekends and in city centre bars.

3. no research has been conducted into similar bans worldwide, since Ireland, Norway and New Zealand are the only countries where such a ban exists.

4. it is too early to assess the impact in Ireland.

5. The public does not want, and is not ready for, a ban on smoking in all pubs.

We are concerned at the speed with which the Executive has proceeded with this measure since announcing its decision to introduce a total smoking ban in enclosed public spaces on 10th November 2004. We support increasing smoking restrictions and increasing the number of smoke free areas, but we believe the Executive should take more time to truly consider whether an
outright ban is the most effective way to tackle the smoking issue, particularly given the ban’s intended introduction in Spring 2006. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

At the Finance Committee meeting which The S.L.T.A. attended in February 2005, it was stated that the Police in Scotland will not enforce the ban, that local councils will require substantial additional funding to enforce the ban and that a major recruitment exercise will need to be undertaken to ensure that officials can patrol pubs the length and breadth of Scotland. The only measures that local councils and the Police have for controlling noise in the street, and litter, are already inadequate to meet current demand. They will require a massive additional investment to solve these problems. We believe that sufficient research is required to assess the cost of implementation.

The Executive’s own MRUK opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in pubs, despite a majority favouring increased restrictions on smoking – but the public do not want, and are not ready for an all-out ban. Even the Executive’s own consultation on a Smoking Ban showed only 18% in favour of a total ban on smoking in pubs. The importance of public acceptance cannot be overstated. Compliance is crucial in terms of enforcing a ban and avoiding public confrontation with officials.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will safeguard the nation’s health, avoid the shift in smoking to the home, protect the hospitality and licensed trade industries and will prove enforceable. Approximately 85% of health problems caused by Environmental Tobacco Smoke are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence.

We urge the Committee to reconsider exemptions for the licensed trade and to take the time to adequately research the implications of this legislation before it is rushed through the Parliament.

Colin A. Wilkinson
Secretary

SUBMISSION BY TOBACCO MANUFACTURERS’ ASSOCIATION (TMA)

TMA Briefing Note

The Tobacco Manufacturers’ Association (TMA) has been invited to give oral evidence to the Committee. The TMA will be represented by Christopher Ogden, Director of Trade and Industry Affairs who will be accompanied by Dr Steven Stotesbury, Senior Scientist at Imperial Tobacco Limited.

The TMA has, to date, submitted for the attention of the Committee:

Submission on Prohibition of Smoking in Regulated Areas (Scotland) Bill April 2004

Supplementary Written Evidence on Prohibition of Smoking in Regulated Areas (Scotland) Bill July 2004

Response to the Scottish Executive’s Consultation on Reducing Exposure to Second-Hand Smoke September 2004

Response to the Smoking, Health and Social Welfare (Scotland) Bill February 2005

ETS – A Summary of the TMA’s Position February 2005

Smoking and Health (Scotland) Bill – TMA Fact sheet for MSPs February 2005.
Tobacco is a Legal Product.

The manufacture, sale (provided the customer is not under 16 years of age), purchase and use of tobacco products are legal activities. Smoking is a matter of informed adult choice. As far as under-aged persons are concerned the TMA is active in supporting youth access prevention programmes. The TMA is a key stakeholder in the CitizenCard proof of age scheme, the largest of its kind in the UK, and contributes significant resource to the No ID No Sale campaign to assist retailers in refusing sales to children.

Smoking in Work and Public Places

According to the latest available data from the Office of National Statistics 50% of people work in places where smoking is prohibited and 38% work in places where smoking is permitted only in designated areas. These arrangements have been agreed between employers and employees and their representatives on a voluntary basis. 4% of people work on their own and therefore determine their own smoking policy. This leaves 8% who work in places where smoking is permitted throughout, not exclusively but partly in the hospitality sector and in outdoor environments e.g. building sites. It is therefore important to get the issue of smoking in the workplace into proper perspective. It is also accepted that many work places are also public places in the sense that they are places which the public may enter by choice or otherwise.

The Evidence on Environmental Tobacco Smoke (ETS)

All proposals to prohibit or regulate smoking in work or public places are based on the premise that ETS causes death and serious disease in non-smokers. The TMA considers that the evidence, taken as a whole, does not establish that ETS causes disease and does not justify the prohibition of smoking. Our detailed analysis of ETS research has previously been submitted to the Committee.

Even if it is assumed that ETS causes serious diseases, there is no obvious reason why it should be necessary to introduce stricter measures than those already in place for, as examples, the risk of exposure to radioactive contamination, workplace noise, radiofrequency radiation or carcinogens generally. In all these cases regulation does not seek zero exposure but rather reductions to levels that are reasonably achievable or which fall below certain minimum dose thresholds. Legislation should be proportionate to the need that it aims to address. Proportionate regulation is more likely to command public respect and is easier to enforce. The European Commission, for example, advises that regulation should not automatically “aim at zero risk, something which rarely exists. In some cases, a total ban may not be a proportional response to a potential risk”.

What the Scottish People Want.

The poll conducted by the Scottish Executive in 2004 on smoking in public places produced results that were unrepresentative of the population of Scotland as a whole as the respondents were self-selecting. Opinion surveys that have used nationally representative and standard sampling techniques (of the UK as a whole in 2004 and of Scotland specifically in 2005) have shown that rather than a majority being in favour of a complete ban, the majority are in fact in favour of exemptions for pubs, bars and clubs.

The TMA acknowledges that tobacco smoke can be irritating to non-smokers but believes that this can be addressed through voluntary means. An accommodation to cater for individuality, freedom of choice and social justice should be sought rather than punitive legislation which will criminalise smokers.

8 February 2005
Introduction
In April 2004, we submitted written evidence to the Health Committee of the Parliament on the
Prohibition of Smoking in Regulated Areas (Scotland) Bill proposed by Mr Stewart Maxwell MSP.
Following the giving of oral evidence to the Committee in June, at the request of the Committee, we
provided supplementary written evidence in July. When we responded to the Scottish Executive’s
consultation ‘Reducing Exposure to Second-hand Smoking’, we consolidated and updated our
earlier submissions to the Health Committee. We trust that those previous, comprehensive and
detailed submissions will be taken into account by the Committee in its consideration of the
Smoking, Health and Social Care (Scotland) Bill, (the “Bill”).

Publication of the Bill was accompanied by the documents required under Rule 9.3 of the
Parliament’s Standing Orders, and research papers and reports published by the Scottish
Executive and NHS Health Scotland. Nonetheless, as requested, the evidence presented here is
very brief. It is confined to Part 1 of the Bill and key observations on the accompanying, supporting
documents.

Part 1 of the Bill
As the long title of the Bill makes clear, Part 1 has no relationship whatsoever to the remainder of
the Bill, which is principally concerned with details of the provision of health and social care
services in Scotland. In our opinion, Part 1 does not sit comfortably with the remainder of the Bill.
We believe that if the Executive legislate in this area then it should be the subject of a stand-alone
Bill.

To a substantial extent, Part 1 is also only enabling legislation. It creates the offences of smoking
(clause 4), knowingly permitting smoking (clause 1) and not conspicuously displaying prescribed
notices (clause 3), in enclosed ‘no-smoking premises’ or parts of premises. Beyond that, it reveals
little about the reach of the ban that might be imposed and leaves a gaping hole to be filled by the
exercise of the powers that it gives to Ministers to make regulations on definitions and other
matters of fundamental relevance and importance to any prohibition.

We do not believe that this is right or acceptable. As Part 1 stands, the Parliament is effectively
being asked only to agree to the principle that a ban, of indeterminate nature, is imposed, without
any reliable, concurrent knowledge of the essential detail. Ministers may seek to provide
reassurance, by stating the intention to publish draft regulations during the course of the
parliamentary proceedings on the Bill. However, there is no guarantee that such indications will
bear fruit and, in any event, it prompts the question, why is the Bill itself not more explicit at the
outset?

The policy basis of the Bill
The policy reason for Part 1 of the Bill is stated in the Policy Memorandum to be the protection of
public health, where it is said (para 10): “The scientific evidence of the health risks of second-hand
smoke is clear and irrefutable”. The principal evidence that is cited in support of this belief is the
reports of the SCOTH1 and the research commissioned by the Executive and NHS Scotland from
Glasgow2 and Aberdeen universities3. We strongly dispute the claim of ‘clarity and irrefutability’
and the reports that are cited in support of this assertion.

In our previous evidence on legislative proposals in Scotland referred to above, we provided
detailed evidence on the epidemiological studies and meta-analyses that have been undertaken
and published on environmental tobacco smoke and health. In that evidence, we explained why,
there was no justification for the kind of prohibition that the Bill would permit, and which Ministers

1 Department of Health, Report of the Scientific Committee on Tobacco and Health (1998) and
3 Ludbrook, Bird, van Teijlingen, International Review of Health and Economic Impact of Regulation
of Smoking in Public Places (2004)
have indicated they intend to introduce. We took great care to provide that evidence in an objective manner that would enable the reader to make his or her own judgement.

The research and reports commissioned and published by the Scottish Executive and NHS Scotland

The research commissioned by Glasgow University, carried out by Professor Hole aims to estimate the number of deaths from “the major smoking-related causes of death in Scottish adults which can be attributed to passive smoking.” His report draws on various published meta-analyses and seeks to relate their risk findings to the Scottish situation.

Nowhere in this report is the evidence for a relationship between environmental tobacco smoke and various diseases examined. Instead it is one of many assumptions made from the outset. The exercise is fraught with sparse information and data, and the necessity to make a number of assumptions.

The evidence for environmental tobacco smoke being a cause of disease is inconclusive. Furthermore, it is difficult to estimate the degree of exposure to environmental tobacco smoke in the population, with any reliability.

Professor Hole’s report cannot be regarded as providing reliable estimates of the impact of environmental tobacco smoke on the health of Scotland’s population.

The Aberdeen University review of the evidence on the health and economic impact of the regulation of smoking in public places must also be put into a proper perspective. The review provides scant information on data sources and methodology, and is replete with assumptions that are highly contestable, all of which makes detailed critical analysis impossible. Its conclusions are speculative, imprecise by their very nature, and unreliable.

Regulatory impact assessments, with which the review approximates, as does the financial memorandum to the Bill, are notoriously unreliable when, of necessity, they are largely speculative in terms of data and conclusions. That fact would be ‘clearly and irrefutably’ demonstrated were they to be followed-up, after an appropriate period, by an assessment of the real, actual effect of the measure in question.

The Policy Memorandum at paras 23 to 27 identifies the steps that were taken by the Executive to consult the public. To coincide with the publication of the Bill, the Executive released four, separate research reports evaluating attitudes to smoking. These reports, commissioned from a variety of private sector research agencies, used different methodological and sampling techniques among both general and specific target population groups. These included an Omnibus survey, a youth consultation exercise, focus groups and a broader public consultation exercise.

Shortcomings in the methodologies deployed compromise the certainty with which conclusions can be drawn from the data. The surveys actually reached conclusions that are diametrically opposed to the position in support of which they were adduced. Far from demonstrating universal public support for an outright ban on smoking in public places, the four reports actually demonstrate strong backing for the introduction of new restrictions but not a blanket ban, and restrictions moderated by exemptions to new legislation.

In the Omnibus survey, of those "in favour of an outright ban" (54%), 66% thought that there should be exemptions, the majority (57%) spontaneously suggesting that pubs should be exempted from any ban and 21% suggesting that clubs be exempted. Only a small minority (24%) were actually in favour of an outright ban without any exemptions.

The youth consultation comprised one national and four regional polls. This consultation had serious design and other methodological shortcomings, but the findings were that a sizeable majority (66%) of the total sample believed that there should be places where smoking was permitted.

Amongst the unspecified twelve focus groups, designed to put qualitative flesh on the bones of quantitative omnibus research, the findings included the telling statement that “… it is by no means
straightforward as to exactly what level of change should be introduced. Many people that we spoke to in the focus groups are not in favour of a total ban for a number of reasons."

The public consultation received a response rate of just under 9% (53,474 completed questionnaires from 600,000 distributed). Given the self-selective nature of the sample, it is unsurprising that 80% of respondents were in favour of a law to make enclosed public spaces smoke-free, with only 18% opposed. On exemptions, the overall response from both individuals and organisations was 35% in favour, 56% opposed. However, many more individuals responded than organisations, and merging the responses conceals the fact that of the organisations which responded to the poll, only 42% were in favour of an outright ban, 44% were opposed.

In short, all four of the pieces of research commissioned by the Scottish Executive were flawed methodologically and statistically. The flaws included: over and under-representation by gender, age, region or smoker status; the aggregation of results across different methodologies and across different groups of participants; the ignoring of possible question framing and context effects; and the use of self-selecting rather than truly representative samples.

In line with other surveys of public opinion, both in the UK as a whole (Forest/Populus 2004) and of Scotland specifically (Forest/Populus 2005), around two-thirds of those polled in the Qualitative Scottish Executive surveys supported a ban when presented with a “ban/support” option. However, when representative samples were asked whether they supported exemptions, the figures reverse – around two-thirds, of either those in favour of a total ban or of the whole sample, were found to be in favour of exemptions. These findings show that the Scottish Executive’s proposed comprehensive ban is out of line with public opinion.

The abandonment of the voluntary approach
At paragraph 12 of the Policy Memorandum, there is an attempt to justify the abandonment of the voluntary approach to the regulation of smoking. There, the Executive acknowledges that much progress has been made through the voluntary approach, albeit less pronounced in the hospitality sector. In the next sentence, the Executive states: “This has led to the conclusion that legislative action is now required if we are to make any real progress in this area.” This is not an obvious and necessary conclusion. Indeed, the progress achieved should surely be regarded as evidence to support continuation of the voluntary approach, albeit perhaps with more ambitious targets and determination on the part of the hospitality sector.

We understand that owners and operators in the hospitality sector believe that they should be allowed to run their own businesses without undue interference. They will obviously do that in their own best commercial interests, having due regard for the health, safety and welfare of their employees, and the wishes and preferences of their customers and clientele. As the public expresses – through the giving of their own custom and through opinion polls – their wish for more non-smoking facilities, those facilities have been and are increasingly being provided. Market mechanisms are well able and suited to determine the most appropriate smoking policies, whether in Scotland or elsewhere in the United Kingdom. We believe that it is wrong to dismiss the merits of voluntarily adopted self-regulation and to ignore the substantial disadvantages of compulsion through legislation, for example that it creates criminal offences.

In order further to justify legislation, however, the Policy Memorandum states that an approach to create separate smoking and non-smoking areas within leisure and hospitality premises “is difficult to justify on public health grounds given that there is no defined safe level of exposure to second-hand smoke…” and that “a complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.”

Even if it is assumed that environmental tobacco smoke causes serious diseases, there is no obvious reason why it should be necessary to introduce stricter treatment than, for example, the risk of exposure to radioactive contamination, workplace noise, radiofrequency radiation or carcinogens generally. In all those cases, regulation does not seek zero exposure, but rather reductions to levels which are as low as reasonably achievable, or which fall below certain minimum dose thresholds. Legislation should be proportionate to the need that it aims to address. Proportionate regulation is more likely to command public respect and is easier to enforce.
European regulation, for example, should not automatically “aim at zero risk, something which rarely exists. In some cases, a total ban may not be a proportional response to a potential risk.”

Conclusions

Our overriding concern is that the Scottish Executive has not yet had the opportunity to examine and review the essential fundamental and scientific evidence before making such an important policy decision.

Furthermore, we are concerned that this proposed legislation does not reflect the views of the Scottish people. The Executive’s own consultation process highlighted the fact that the public were against a blanket ban but recognised a need for greater restrictions. We would urge the Executive to take on board the public’s views and encourage more no-smoking areas in Scotland, whilst allowing smoking to be permitted in certain places.

Finally, we would question the validity and appropriateness of the legislation. If its purpose is the health, safety and welfare of employees then the Scottish Parliament lacks competence to legislate in this area.

We trust that here we have clearly explained, albeit very briefly, why we disagree with the bill. Should the Committee wish, we would be pleased to appear to give oral evidence.

SUBMISSION BY COAL INDUSTRY SOCIAL WELFARE ORGANISATION (CISWO)

The COAL INDUSTRY SOCIAL WELFARE ORGANISATION (CISWO) is a National Charity (registration 1015581) concerned with promoting Social Welfare in Mining Communities and assisting mineworkers, retired or redundant mineworkers and their dependants, offering information advice and support to enhance quality of life. CISWO (Scotland) promotes community regeneration and development through professional support, in partnership with others, to 53 Miners Welfare Schemes and other coalfield charities/community organisations and groups. Striving to empower people and communities through confidential client/beneficiary support and project development promoting social inclusion. CISWO is a member of the COMMITTEE OF REGISTERED CLUB’S ASSOCIATION (CORCA).

CISWO (Scotland) welcomes the opportunity to respond to the call for evidence from the Scottish Parliament’s Health Committee regarding the above Bill.

CISWO (Scotland) agrees with the main objective of part 1 of the Bill prohibiting smoking in enclosed public places.

CISWO (Scotland) supports a ban on smoking in enclosed public spaces not just in terms of the general health benefits to non-smokers but also with regard to the implications on worker health and safety. Believing that under basic health and safety principles employers must protect the health of employees and provide a healthy and safe working environment. Taking the example of Clubs, this duty of care to employees should extend to members, volunteers and user groups. Accordingly, the prohibition of smoking in enclosed public spaces is a basic health and safety matter. As a result of this legislation people will finally be able to socialise and work in smoke-free environments which will not damage their health.

CISWO (Scotland) acknowledges there are wide and differing views being expressed in relation to the Bill and its potential impact both positive and negative on Registered Club facilities. For example there are some Club Management Committees and members who would prefer CISWO not to support the Bill and instead lobby the Parliament to make amendments along the more diluted proposals south of the border. This is not unexpected, bearing in mind many of our communities are entrenched in a traditional culture where smoking is enjoyed by many and to some, is an extremely important part of social life particularly for the older generation. Some are

genuinely anxious how individual smokers are going to cope in their daily lives with such restrictions. Concern has also been expressed that the Bill may inadvertently cause the closure of some important community clubs if the restrictions impact on income needed to sustain the facility. Some continue to ignore the facts that smoking can be an addiction which craves nicotine and is harmful to those around them and are happily supporting the pro-smoking lobby.

On the other hand there are CISWO Club's already partnering Health Professionals and Agencies to provide practical support within their premises for members and their wider community. With encouragement some clubs are already preparing for the new legislation by organising and providing individual and group support and advice, smoking cessation courses and nicotine replacement initiatives. Helping to deliver Peer education, healthy lifestyle and harm reduction. Encouraging and challenging cultural preconceptions about smoking. Bearing in mind the majority of the population are already non-smoking, coupled with the attraction of being able to enjoy socialising in a smoke free environment should ensure a more secure future for many facilities in the medium to long term. However, carefully managing and supporting this radical change will be critical in the short term. Some are clearly up for the challenge while others may never be.

CISWO (Scotland) believes the pro-smoking lobby present flawed arguments in their proposals for alternative legislation using tactics to mislead the public on the dangers of second-hand smoke. Legislation on smoking is required because voluntary regulation has not worked and a major cultural shift is required towards ensuring non-smoking becomes the norm in Scotland, which only legislation will achieve. As the evidence for the harmful effects of second-hand smoking is overwhelming, it is wholly inappropriate to argue that a person’s right to clean air should be overridden to accommodate a smoker. Many of those who have been closely associated with the Coal Mining Industry have been at the forefront of putting health and safety before profit. The Coal Mining Industry has prohibited smoking underground for decades recognising the real risk of gas explosion. This legislation will recognise the real risk from tobacco smoke and put the Scottish Nation’s Health and Safety before the tobacco industry or profit.

CISWO (Scotland) is committed to working closely with the Scottish Executive and Health Trusts to encourage more Miners Welfare Facilities to help lead the way in providing practical and effective support to smokers who may want to cut down or stop altogether. Focusing at the heart of traditional working class coalfield communities, where the need for support is particularly high. When one family is spared the devastation and horror of losing a loved one prematurely through smoking related disease, the Scottish Parliament will have justified implementing this brave and innovative legislation.

Ian JS McAlpine
Regional Manager
CISWO (Scotland)

SUBMISSION BY BRITISH HOSPITALITY ASSOCIATION SCOTLAND COMMITTEE

1. Introduction

The British Hospitality Association Scotland (BHA) welcomes the opportunity to submit evidence on the Smoking, Health and Social Care (Scotland) Bill. The BHA is also a member of the National Smoke Free Areas Implementation Group established to advise the Scottish Executive on the implementation of smoke free areas.

The BHA has been representing the hotel, restaurant and catering industry for over 90 years. Some 3000 establishments in Scotland, across all sections of the industry, are represented by the BHA – not just group-owned properties, but also hundreds of individually owned hotels and restaurants.

The BHA is a signatory of the Scottish Executive’s Voluntary Charter on Smoking in Public Places and we are a member of the corresponding group in England and Wales. As a member of these groups we have sought to ensure that the hospitality industry recognises that the majority of the
population are non-smokers and that this is reflected in the policies of the industry as a whole. The
overriding aim of the BHA is the creation of an environment where non-smokers are not adversely
affected by the effects of passive smoking.

As stated in evidence on the Prohibition of Smoking in Regulated Areas (Scotland) Bill the BHA
position was that if the Voluntary Charter no longer commanded ministerial or public support, the
only realistic policy option was a total ban on smoking in public places as has been announced by
the Scottish Executive.

2. General Principles

The BHA supported the Voluntary Charter as long as it continued to enjoy industry and government
support. It is the position of the BHA that if the voluntary charter is no longer supported in this way
a total ban on smoking in places of employment is the only logical step open to government.
Therefore, as the voluntary charter is no longer supported by the Scottish Executive we support the
main objective of the Smoking, Health and Social Care (Scotland) Bill in prohibiting smoking in all
enclosed public spaces.

2.1 Detailed Comment

The BHA supports the Bill on the following grounds: -

- It is unambiguous and Scotland-wide making enforcement easier and preventing
  regional discrepancies; if optional powers were devolved to local authorities to set their
  own rules in relation to smoking this would confuse customers, tourists and operators
  and has the potential to distort the market place.

- The legislation is straight forward to implement and enforce unlike the proposed
  legislation in England.

- The Bill as currently drafted splits responsibility and penalties equitably between
  operators and customers. However, consideration should be given to greater penalties
  being placed on those individuals who smoke in areas of employment rather than
  penalising management or more senior employees for the offences of others.

- The Bill is even-handed as it applies equally to hospitality establishments where food
  is served and to other workplaces.

- The Bill as currently drafted provides clear health benefits, which the Prohibition of
  Smoking in Regulated Areas (Scotland) Bill did not.

2.2 Concerns

2.2.1 Hotel Bedrooms

The Bill does not address the issue of hotel rooms which are traditionally viewed as private places
and where if a guest chose to smoke, despite a restriction, it would be impossible for the hotel
management to know that an offence was being committed until after the event and as such wholly
inequitable and inappropriate to penalise management in such circumstances. It would also be
inappropriate for local authority officers to have powers to enter an hotel bedroom, possibly by
force, to check whether an offence was being or had been committed. The BHA is strongly of the
view that an exemption in the case of hotel bedrooms requires, as in the Irish Republic, to be
contained on the ‘face’ of the Bill.

2.2.2 Bodies Corporate etc.

The structure of some BHA member businesses involves premises being leased from them or
managed on their behalf. As currently drafted section 7 appears to suggest that owners or head
landlords may be proceeded against even in circumstances where they are not in day to day
control of the business. This is not compatible with natural justice and should be addressed.
2.2.3 Impact on Recruitment

The hospitality industry is facing well documented recruitment difficulties which we as an industry are working hard to address. However, by making employees liable for prosecution and fines it is possible that the Bill will undermine strenuous efforts to make the hospitality sector a more attractive career option.

SUBMISSION BY COSLA

Introduction
1. COSLA, as the umbrella organisation representing 31 of Scotland’s councils, welcomes this opportunity to submit evidence to the Health Committee on the Smoking, Health and Social Care (Scotland) Bill. This submission will concentrate on the smoking ban elements of the Bill from the local authority perspective.

2. COSLA has already submitted written evidence and given oral evidence on the financial implications of the Bill to the Finance Committee. A copy of the submission to the Finance Committee is annexed as elements in that, although primarily cost focused, are relevant.

COSLA Position
3. COSLA:
   o Supports the introduction of the ban
   o Recognises the health improvement benefits that will follow the ban
   o Is committed to playing its part in implementation
   o Requires full funding for its member councils to cover implementation

Principles
4. COSLA supports the principle of the ban on smoking in enclosed public spaces and regards it as a major step in advancing the health improvement agenda which is one of our member councils’ priorities.

5. Support for the Bill is contingent on the Scottish Executive providing councils with full funding to allow for the successful implementation of the Act. This represents standard COSLA policy in respect of all new legislation and was reiterated as part of our spending review submission in 2004.

Comments
6. COSLA would wish to comment on a range of associated issues:

   Phasing
   While there is an appreciation of the arguments in favour of a phased implementation of a ban, in view of the over-riding health arguments for a ban, and Scotland’s health record as one of the poorest in Western Europe, any phasing arrangements would not be supported. Immediate implementation will help raise awareness, avoid confusion and send the correct, positive message. A phased introduction would lead to practical difficulties with enforcement.

   Possible Exemptions
   COSLA recognises that possible exemptions to the smoking ban is a key area to be debated and one of the most difficult to address. Amongst councils there is a range of views about what should be exempted, with residential homes and day care centres featuring most frequently on the lists of those councils favouring exemptions. It is accepted that an exemption would not represent carte blanche for smoking to continue indefinitely; that it should be subject to review; and that smoking cessation work should continue with people living in any exempted areas.

   Staff working in areas where smoking is permitted
   Councils as employers will be required to consider specifically the position of members of staff required to work in areas where smoking is permitted and where they could be subjected to second hand smoke.
Benefits arising from the Ban
It is accepted that it will take time for the benefits stemming from the ban – as with most health improvement measures - to be evidenced. The step is, however, an important move forward, which will impact positively on the health of Scotland’s people, and is not to be viewed as a ‘quick fix’

Rural areas
The impact of a total ban could be particularly severe in isolated, rural areas both from the economic and socialisation perspectives. The social opportunities offered by pubs should not be underestimated as a means of reducing social isolation which is recognised as having an adverse effect on health.

Smoking Cessation Work
An increased demand for smoking cessation services can be anticipated in the run up to and following the implementation of the ban. While it is recognised that the ban is a ban on smoking in enclosed areas, not a ban on smoking, cessation work is regarded as an extremely important area for councils as employers and will be included in council estimates for the cost of implementation. Councils are often the largest employers in the local authority area and by supporting staff to give up smoking the council may indirectly be influencing others in the wider community to stop, with staff possibly passing on to friends and family members what they have learned through smoking cessation initiatives in the workplace.

Enforcement
The likely shortage in Environmental Health Officers to enforce the legislation has already been highlighted to the Scottish Executive and will the subject of separate discussion. The Committee should, however, be aware that councils are already experiencing difficulties in recruitment – a position that will be exacerbated by the requirements of the new legislation.

3. COSLA would be happy to give oral evidence to supplement this submission if the Committee would find that helpful.

February 2005

• COSLA Submission to the Scottish Parliament Finance Committee

Purpose
The purpose of this paper is to provide the Scottish Parliament’s Finance Committee with an outline estimate of the costs associated with the introduction, implementation and continuing enforcement of a ban on smoking in wholly enclosed public spaces as proposed by the Smoking, Health and Social Care (Scotland) Bill. The Committee is asked to note that these are preliminary costs that COSLA will refine with its member councils. The costs will, in addition, be discussed with the Scottish Executive.

Principles
4. COSLA supports the principle of the ban on smoking in enclosed public spaces and regards it as a major step in advancing the health improvement agenda which is one of our member councils’ priorities.

5. Support for the principles and goals of the Bill is dependent on the Scottish Executive providing full funding to allow for the successful implementation of the Act. This is standard COSLA policy and was reiterated as part of our spending review submission in 2004.

The Financial Memorandum
6. As usual, as required by the Parliamentary process, the Financial Memorandum was published with the Bill itself but in the absence of the detailed Regulations that will accompany the new legislation. This has caused practical problems in costing the implementation of the smoking ban and means that, at best, COSLA’s current estimate can only be an estimate. Costing new legislation is an important part of the legislative process, for all parties involved, but it is particularly
important to ensure the integrity of any new legislation and its efficacy. Against this background COSLA’s member councils have provided the best estimates possible. The Committee is asked to recognise this and also the fact, that, at this stage, the interpretation of costs will vary between authorities. Any inconsistencies in approach will be addressed as estimates are refined.

7. Work with COSLA member councils has produced an initial first year estimate for the implementation of the ban of smoking in public places. Based on figures available, we believe that the total cost in 2005/6 and 2006/7 is in the region of £6 million.

8. With regard to the other elements of the Bill, the financial memorandum states that no major financial implications have been identified for local government at this stage. However, the cost neutral description of the section relating to Joint Ventures should be treated with some caution. It is felt that, in the long term, this could have implications for local authorities and COSLA would wish to reserve its position on this element of the Bill.

9. The commentary in Executive’s Financial Memorandum on the banning of smoking in public places reflects the uncertainty which all parties feel surrounds the financial elements of the Bill. It rightly states that the implementation costs for local authorities have yet to be determined and will be linked to the detail of the Regulations which have yet to be drafted. It also recognises that additional costs in the early years are likely, an open acknowledgement that is welcome. It is therefore against this background that this evidence has been prepared and the Committee will recognise that the figures used are estimates only. However, experience does indicate that where councils have given detailed estimates, the outturn costs are unlikely to vary significantly.

10. The evidence has been prepared within a short timescale to meet the Committee’s deadline and there has been little opportunity for cross checking, either at Council or COSLA level. When the Regulations are available, it is intended to repeat this exercise against the more detailed background the Regulations will provide and COSLA will be happy to make the information from this available to the Committee.

11. As indicated in the introduction to this paper, COSLA will also be working with the Scottish Executive on these financial estimates.

12. One specific point emanating from the Financial Memorandum that COSLA would like to raise relates to the generally held view that enforcement costs will diminish over time. This is accepted, but there are concerns that it may take longer than anticipated for opposition to the ban to fade. To ensure the success of the ban therefore ongoing commitment is needed from all parties involved. The ban is not a ‘quick fix’ but the beginning of what will be a sustained campaign against the damaging effects of smoking on health. The investment of sufficient resources both initially and on an ongoing basis will be essential.

13. What will not be available with the Regulations and in the next year or so with actual experience of implementation is firm evidence of the financial benefits of the legislation. Some of these benefits to health will be long term and COSLA would prefer to leave it to statisticians to attempt to quantify the cost benefits to employers, the NHS and individuals, of living and working in a smoke free environment. What is clear, however, is that there will be real benefits which must be borne in mind when considering the cost of implementing the legislation.

Individual Issues
14. COSLA would wish to comment on and highlight a number of individual issues with financial implications. These are:

Staff
15. There is already an acknowledged shortage of Environmental Health Officers – a situation likely to be exacerbated given the age profile of the profession. This is an issue the Scottish Executive has already agreed to discuss. It is a fact, however, that the enforcement needs of the smoking ban will create further demands and difficulties on council staff with considerable efforts being required for recruitment. It is recognised that fully qualified EHOs will not necessarily be required for all elements of the resulting workload and enforcement officers will be employed too –
typically authorised/technical officers. This will very much be a matter for individual authorities to determine and current staffing arrangements will be a factor.

16. The possibility of combining smoking legislation duties with existing EHO officer work and with enforcement officers to be responsible for liquor license standards work will be considered by individual authorities, but decisions here will be on an individual authority basis. (For example, in one authority it is not envisaged that the Liquor Licence Standard Officer will be involved in the enforcement of the smoking ban in licensed premises. This post is considered to be a liaison and advisory link between the Licensing Board and licensees and accordingly will at most report breaches of licensing conditions to the Board. It is considered that a direct involvement in enforcement would compromise this link.) Discussions are also taking place between COSLA and the HSE regarding respective responsibilities, possible cross over etc but these discussions are at a preliminary stage.

17. There are concerns that the Executive will only fund enforcement for an initial period and that funding will then decrease with revenue consequences for councils.

18. ‘Lone working’ will not be an option given the need for corroboration and the nature of the premises to be visited allied to the police position that they are not able to commit resources to assist in the enforcement of a ban.

19. Much of the work will be of an ‘out of hour’ nature – overtime payments will be the norm.

20. For rural councils, (and notably islands authorities) given the geography of their areas, there will be particular organisational issues to be addressed and extra expenses incurred.

21. The introduction of the new legislation, if the planned timetable is achieved, will more or less co-incide with the introduction of the new EU Food Hygiene Regulations (from 1 January 2006) which will also place significant additional burdens on environmental staff.

Lead in time
22. Assuming the implementation date for the legislation will be 1 April 2006, work will be required prior to that and expenditure incurred in the current financial year. Ideally staff should be in post some months before the legislation goes live. Publicity and consultations with businesses should ideally be allowed a generous timeframe.

Street Cleaning
23. An increase in street cleaning – particularly in city centres – has been identified by elected members as a likely outcome of the ban. At the moment cigarette litter is a particular issue at the entrance to shopping centres and large office complexes and it is a problem that is expected to increase once the legislation is enacted.

24. There are differing views, however, as to the additional burden this will impose on councils and as with many of the issues relating to enforcement of the ban, advance quantification of their impact is not an exact science. Where streets are not swept in the evenings this might need to be reviewed. If cleaning is required in other than city centre areas, any noise caused by the sweepers will be a consideration. Cigarette related litter is difficult to deal with by mechanical sweeping and is labour intensive. What is clear is the view that responsibility for the immediate environs of premises such as pubs, clubs and restaurants should lie with proprietors allied to a licensing condition that licensees provide cigarette disposal facilities and/or local cleaning at licensed premises. Capital costs for the provision of additional litter bins are anticipated by many councils and to this must be added the cost of their installation and servicing.

Training
25. Training will be required not only for all staff involved, but also for elected members. A central training resource (perhaps a bespoke, module-based course) that can be delivered remotely has been suggested.
26. Training should include: enforcement; how to deal with confrontational situations/aggression/assertiveness; court room training; statement taking, record keeping; use of computers and relevant programmes.

Publicity materials
27. These will be required on both a national and local basis and, as usual, in minority languages etc. Clarification is awaited as to how the £2M expenditure identified by the Scottish Executive for ‘communication ahead of implementation’ will be used. It is hoped that a proportion at least will be allocated to the central production of materials that can in turn be individually badged by councils.

Income generated from fines
28. It is not anticipated that income generated from fines will be high, but that income should be retained by councils for use, for example, to:- offset the cost of implementing the legislation, for smoking cessation services or for sports grants in keeping with the public health theme.

Start up Costs
29. These will include: advertising and employment of new staff; the development of enforcement strategies; preparation for training for enforcement and front-line staff, elected members and senior management; briefing of administrative and managerial staff and training of existing and new enforcement staff; promotion/publication of the new law and councils’ approach to enforcement, associated management of Freedom of Information and the provision of information to the public and businesses (recognised that the Scottish Executive could provide some materials centrally for badging by individual councils); use of existing EHO staff to provide advice on the ban in the run up to implementation.

30. Inspections will require to be at a higher level initially, but it is anticipated that the need for these will decline to a lower, constant rate over time.

Exemptions
31. Depending on any exemptions agreed later through Regulations, there could be financial implications for councils’ social work and housing services, eg to upgrade premises, the introduction of transitional arrangements as part of a move towards smoke-free status as well as a need for continuing support to protect workforce and client health in them. Private agencies used by councils as care providers could pass on costs to councils as service users.

Practical Experience
32. Councils’ experience of implementing similar legislation – eg dog fouling – is varied. In one council, 20-25% of fines are unpaid. The cost of pursuing these through Sheriff Officers is not cost effective.

Conclusion
33. The financial comment and estimates contained in this paper have been based on the information available to date, in some cases projected scenarios and best estimates. COSLA would welcome the opportunity to return to the Committee with more detailed financial information once its member councils have had the opportunity to consider the full implications of the new legislation in light of the detailed regulations.

February 2005
<table>
<thead>
<tr>
<th>Council</th>
<th>Estimated Costs</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>114,000</td>
<td>Probably 75k in future years; 5000 premises; 2 FT officers; 24k start up</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>109,100</td>
<td>1 senior officer; 2 authorised officers; admin assst + 10k essential training</td>
</tr>
<tr>
<td>Angus</td>
<td>108,000</td>
<td>Includes start up costs in 05/06; for 05/06 - Senior EHO/EHO on out of hours conditions (33k); links with other enforcement teams – 5k; publicty + comms materials – 2k; for 06/07 – 08/09 – Senior EHO – 45k; 2 PT EOs – 20k; publicty, comms – 5k. 22.7k pa estimate after 06/07</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>145,000</td>
<td>Includes ICT set ups costs of 10K + 4K for publicity materials, assuming central provision of some materials</td>
</tr>
<tr>
<td>Clackmannanshire</td>
<td>52,000</td>
<td>25k staffing (AP3); 15k street cleaning; training 2k publicity etc 10k; admin – 15k</td>
</tr>
<tr>
<td>Comhairle nan Eilean Siar</td>
<td>55,000</td>
<td>Initial recruitment training + indirect costs + possible legal &amp; admin costs</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>159,800</td>
<td>5-6000 premises (includes food premises + other where H &amp; S enforced) 4FT officers (1 co-ordinator + 3 tech officers); for first 18-24 months reducing to 2 (co-ordinator + 1 tech officer) in next 18-24 months.  + admin backup</td>
</tr>
<tr>
<td>Dundee City</td>
<td>95,500</td>
<td>includes1 EHO (37,000); 1 Enforcement Officer – 25,000; Staff, training, overtime, travel, IT, local publicity + 5k initial set up</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>135,000</td>
<td>2 EHOs; Includes oncost; 10k for training + other operational costs + 10K street cleaning, litter bin provision</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>143,500</td>
<td>2 EHOs – 72k. accommodation – 13k; elected member training 1k – 2.5k; publicty; 5k additional street cleaning 50k</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>230,000</td>
<td>17,000 premises currently inspected – a further 3,000 expected to fall within the smoking legislation; 173k for staff (1 EHO; 1 EO; 2 Env Wardens; 2 EOs (night team); 230k - other costs (16k recurring overheads; 1k elected member training; 30k staff communication and signup; 1k publicity.</td>
</tr>
<tr>
<td>Fife</td>
<td>420,000</td>
<td>2 FT EHOs per area, reducing to 1 FTO per area as legislation beds in – 180kv for years 1 and 2. 90k thereafter; includes costs for mechanical sweepers (80k) + additional manpower; + additional litter bins</td>
</tr>
<tr>
<td>Glasgow</td>
<td>896,000</td>
<td>192k of this for first year only; 404k for initial 3 years. Covers additional EHOs – 1 team leaders + 5 enforcement assts + admin support – 250k for 3 years; legal support; technical &amp; admin support; monitoring; publicity &amp; info materials; additional street cleaning – 144k pa.</td>
</tr>
<tr>
<td>Highland</td>
<td>184,000</td>
<td>Staff only costs – 4 additional staff; 4,500 premises, but 1500 estimated to require active regulation. Other costs to be added later - admin, re signage,</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>140,000</td>
<td>Includes 40k in 05/06 for preparatory work</td>
</tr>
<tr>
<td>Moray</td>
<td>126,500</td>
<td>Covers 4 officers (poss qualified technical officers) – 117k; training for new and existing staff and also Licensing Board members – 4k ; implementation in council premises – 1k; printing of fixed penalty notices + establishment of systems – 3.5k. NOT included, but expected to be substantial – additional street cleaning costs and also publicity materials which it is felt should be produced by the Executive.</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>40,000</td>
<td>1 EHO only costed + training</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td></td>
<td>Using Irish experience as model; 8,600 premises – risk assessment required in some form to determine priority for visits; specialist unit will be required, managed by an EHO and initially staffed by at least 6 technical officers on short term contracts; flexible working patterns and out of hours working.</td>
</tr>
<tr>
<td>Orkney</td>
<td>128,000</td>
<td>Based on 2 officers at 30k, including out of hours working, training, mileage and publicity. Pre-implementation costs included cover training, consultations with businesses, training for elected members. NOT included is cost of employing EHOs in lead in period pre-April 06.</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>312,500</td>
<td>5-6 staff at AP3-4; training; staff time + management costs; equipment – mobile phones, laptop PCs, printer etc; hire equipment (2 vans + running costs); publicity; admin (clerical support; job adverts; accommodation etc). Excludes training, street cleaning costs and miscellaneous additional costs</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>196,000</td>
<td>Includes 1 senior warden + 4 wardens + vehicles, training transport, recruitment – 155k; 1 AP111 officer – 35k; training 3.5k; signage 1.5k publicty 1k</td>
</tr>
<tr>
<td>Shetland</td>
<td>75,100</td>
<td>2 EHOs at higher salary point (36,869) assumed; training £600; mileage costs</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>302,200</td>
<td>Covers additional staff + overtime, additional litter warden, training + publicity – 81k; additional street cleaning – 56k; provision of bins and their servicing – 182k</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>470,000</td>
<td>Includes 170,000 for lead in work; costs for years 2 + 3 reducing to 230k; anticipated 6965 premises</td>
</tr>
<tr>
<td>Stirling</td>
<td>132,500</td>
<td>Senior EHO SCP 39-42); 3 EHOs SCP 31-38 Admin support (SCP 13-15); training; office accommodation</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>190,000</td>
<td>76k for start up + 114k in 05/06 covering recruitment, training of 2 EHO + 2 student EHOs, publicity + other misc costs; 113k and 114k in following 2 years; further 20% reduction anticipated in 09/10.</td>
</tr>
<tr>
<td>West Lothian</td>
<td>75,000</td>
<td>Includes staff (AP4), training, promotional work; 5000 premises</td>
</tr>
</tbody>
</table>
comments are summaries only extrapolated from detailed submissions. Where councils have provided low and high estimates of staff costs, these have been averaged.

Notes:
‘Start up’ costs typically include: development of enforcement strategy; training of front-line staff, elected members and senior management; briefing admin and managerial staff; promotion/publication costs- eg staff time, postage, officer time for preparing and presenting seminars, press releases, briefings etc; advance advice provision by EHO staff; recruitment costs; accommodation and equipment costs

Enforcement costs typically include: initial high volume of inspections, decreasing over time; out of hours working; provision of advice; responding to complaints; monitoring; technical and admin support.

SUBMISSION BY THE CITY OF EDINBURGH COUNCIL

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/

If yes, why?

The main objectives in Part 1 of the Smoking, Health and Social Care (Scotland) Bill are strongly supported. Support is based on:

- The Bill providing the opportunity to develop existing policies and strategies of the Council. For example, “Working for a Healthier Edinburgh: Edinburgh Joint Health Improvement Plan 2003-06” which highlights reducing smoking and tobacco-related harm as a priority area for action and notes the risks of exposure to Environmental Tobacco Smoke. Another example is provided by the Education Department’s “Improving Health, Health Strategy 2004-07” which focuses on lifestyle choices for teenage girls where action on smoking is required. This policy will become the responsibility of the Children and Families Department from April 2005.

- The Council promotes workplace-based health improvement via the Scotland’s Health at Work (SHAW) initiative and has implemented specific control of smoking at work policy. These examples are compatible with the objectives of the Bill.

- The legislation provides an opportunity to simplify Council policy on control of smoking at work, particularly in relation to letting of premises for meetings and events.

- The Local Government in Scotland Act which defines a power of “community well-being”. The Council’s work to improve health relates to this power, and the proposed legislation would reinforce these initiatives.

If not, why not?
Not applicable.

Are there any other comments you would like to make?

The Council welcomes the additional clarity provided by the Bill including:

- A statement that those having management of no-smoking premises can only be expected to prevent smoking by lawful and reasonably practicable means.
• Defined responsibilities of managers and/or owners of premises and individual smokers and the associated penalties incurred when the law is infringed.

• A statement on the powers of an authorised officer.

However, it is recognised that detailed discussions will be required in relation to the drafting of regulations, with particular reference to:

• Guidance on signage. The Council has concerns about signage outside listed buildings.

• Exemptions from the requirements to maintain no-smoking premises. There is clearly a need for detailed consultation with local authorities. Previous evidence has identified issues in relation to residential homes, social work day centres, hostels and provision of services within individuals’ homes.

• Definitions need to be clearly stated and understood - for example, the meaning of ‘wholly enclosed public place’.

Further clarity on these issues would be welcome, together with the opportunity to respond to the proposed regulations.

Resourcing must fully meet any additional costs and statutory burdens for local authorities. The City of Edinburgh Council currently has responsibility for health and safety enforcement at 17,000 premises; it is anticipated that a further 3,000 HSE premises will fall within the scope of the legislation.

Detailed costs have been provided to COSLA and evidence provided to the Finance Committee on Tuesday 8 February 2005, in relation to the Financial Memorandum associated with the Bill.

To provide adequate staffing resources, it is estimated that the City of Edinburgh Council will require:

<table>
<thead>
<tr>
<th>Year</th>
<th>2006/07</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>173</td>
<td>178</td>
<td>184</td>
<td>189</td>
</tr>
</tbody>
</table>

Additional resources will also be required for communications, signage and provision of information on smoking cessation help and support.

SUBMISSION BY THE ROYAL ENVIRONMENTAL HEALTH INSTITUTE OF SCOTLAND

Part of Bill:


Main Objective:

Prohibiting smoking in enclosed public places.

Do you agree with the main objective of this part of the bill?

Yes.

If yes, why?

There is overwhelming and robust epidemiological and other medical evidence to prove that smoking and exposure to Environmental Tobacco Smoke (ETS) are harmful to human health.
ETS is known to contain 4,000 chemicals, some of which have irritant properties and some 60 of which are known or suspected carcinogens. The World Health Organisation’s International Agency for Research on Cancer (IARC) identified, ETS as being ‘carcinogenic to humans’¹. ETS has also been labelled a ‘class A human carcinogen’ by the United States of America’s Environmental Protection Agency². In November 2004, the Scientific Committee on Tobacco and Health (SCOTH) Committee summarised additional research that had been published since their initial report in 1998. The Committee concludes that knowledge of the health hazards associated with exposure to ETS has consolidated over the past five years and that more recent evidence strengthens previous estimates of the size of health risks. The Committee also concluded that ETS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to; and that ETS represents a substantial public health hazard.

The medical case alone for a ban on smoking in public places and in the workplace is beyond dispute. In 2003 the Chief Medical Officer for Scotland stated that ‘smoking is the single biggest cause of preventable premature death and ill-health in Scotland³. Over 13,000 people die every year in Scotland from tobacco use⁴.

There is no doubt that if tobacco were now to be subject to the UK’s approval for use process approval would not be granted. There are no safe limits for exposure to carcinogens: only a policy of elimination of ETS from public places and from workplaces will protect and improve public health in Scotland.

Are there any other comments you would like to make?

The Bill mentions that the class of premises to be covered, will be prescribed by regulations, as will the premises that are to be excluded. The Institute believes that only a total ban on smoking in public and work places will be effective. The Health and Safety at Work etc. Act 1974 does not provide adequate protection for workers against tobacco carcinogens present in both mainstream and ETS. The rights of employees and users of the premises should be protected irrespective of the activity. A comprehensive ban will also be fairer to industry, as all sectors will be equally affected, rather than one group being seen to have an unfair disadvantage. Therefore the Institute is strongly against granting exemptions to private clubs, or pubs which do not serve prepared food, and is concerned that establishments could exploit exemptions to circumvent the law. The Institute believes that ideally there should be no exemptions from compliance with any legislation introduced to ban smoking in public and work places.

The Institute welcomes the introduction of the requirement for warning notices in and on no-smoking premises to be conspicuously displayed and recommends that regulations, relating to the format of such notices and referred to in section 3), be introduced.

The Institute welcomes the possible introduction of regulations relating to the definition or elaboration of the expressions listed in section 4 and for the definition or elaboration of ‘premises’ in section 4. The Institute believes that clear and unequivocal definitions must be provided to ensure the proper enforcement of compliance.

The Institute believes that should smoking on public transport become an offence the issues surrounding compliance on cross border (Scotland/England and England/Scotland) public transport will require to be addressed.

The Institute welcomes the introduction of the power to serve Fixed Penalty Notices on individual smokers and on individuals having control of enclosed spaces. The Institute considers that there may be safety implications for Environmental Health Officers and other enforcement staff who may be required to serve Fixed Penalty Notices on individuals, in public houses and clubs, who may be under the influence of alcohol. The Institute would draw the Parliament’s attention to the Irish experience where Environmental Health Officers deal, in the main, with publicans and licensees and require them to ensure compliance. Environmental Health Officers in the Irish Republic undertake inspections incognito and return next day to tackle the publican and/or licensee. This approach removes the problem of Environmental Health Officers serving Fixed Penalty Notices in potentially dangerous situations. An alternative course of action would be for officers to report the matter to the Licensing Board who could then consider the matter as a possible breach of the
conditions of license. The introduction of a phone line in the Irish Republic allowed individuals to make anonymous complaints about non-compliance to a central location. It is believed that this service, known locally as the ‘clipe line’, was largely responsible for the very high compliance rates reported in the Republic of Ireland.

Finally, the Institute believes that the introduction of any legislation should be preceded by a high profile media campaign which would raise awareness of the impending legal requirements. This form of education would, it is hoped, reduce the number of offenders and ensure high levels of compliance from day one.

SUBMISSION BY ASH SCOTLAND

This submission is from ASH Scotland. We understand that the Health Committee has access to, and will be taking account of, evidence submitted to the Scottish Executive as part of their public consultation on smoking in public places last year. On this basis, the current submission makes reference solely to research that has been accessed and/or published since 30th September 2004.

We ask to be called to give oral evidence to the Health committee.

Name: Maureen Moore, Chief Executive, ASH Scotland

Address: ASH Scotland, 8 Frederick Street, Edinburgh EH2 2HB

Part of Bill: Part 1

Main Objective: Prohibiting Smoking in Enclosed Public Places

Do you agree with the main objective of this part of the bill? YES

This is a Bill that will dramatically improve Scotland’s health. It has been estimated that second-hand smoke (SHS) kills up to 1,000 people every year in the UK\(^5\); with some studies suggesting the figure is even higher than this.\(^6\) Introduction of the new legislation for smoke-free enclosed public places in Scotland will benefit everyone.

Do you have any other comments? YES

New research evidence on the health risks associated with exposure to SHS

There is an established body of international medical and scientific evidence that documents the health risks associated with SHS. This evidence continues to accumulate at an alarming rate.

The International Agency for Research on Cancer (IARC) Monograph Working Group on Tobacco Smoke and Involuntary Smoking is a scientific working group of 29 experts from 12 countries convened by the World Health Organisation. This working group have now published the long-awaited 1,500 page review of all published evidence related to passive tobacco smoking and cancer, concluding that second-hand smoke is carcinogenic to humans.\(^7\) As early as 1993, the Philip Morris Tobacco Company made preparations to mount a strenuous and well-funded effort to subvert the IARC monograph and associated IARC studies, as they feared that their findings would lead to increased smoke-free restrictions in Europe.\(^8\) Their attempts to undermine IARC’s work via industry-directed research, mass media and public communication campaigns, and preventing

ASH REFERENCES


increased smoking restrictions, failed. In addition, further scientific research has since been published that reinforces the conclusions of the IARC Monograph Working Group, that second-hand smoke is carcinogenic to humans.9

In 1998, The Scientific Committee on Tobacco and Health (SCOTH) issued a report which concluded that exposure to SHS causes lung cancer and heart disease in adult non-smokers, and a variety of conditions including respiratory disease, cot death and middle ear disease in children. In November 2004, the Committee published an additional report, summarising research that has been published since 1998, to examine whether any further revision to SCOTH’s conclusions is required. This was in response to the tobacco industry and their allies who still deny the health risks associated with SHS. The Committee concludes that knowledge of the health hazards associated with exposure to SHS has consolidated over the past five years; that more recent evidence strengthens earlier estimates of the size of health risks. The evidence published since 1998 continues to point to a causal effect of exposure to SHS on risk of lung cancer – estimated increased relative risk remains at 24%. The weight of evidence regarding a causal effect of exposure to SHS on the risk of ischaemic heart disease is now stronger – increased associated risk is now estimated to be in the order of 25%. Published evidence continues to point to a strong link between exposure to SHS and adverse health effects in children – the committee conclude that smoking in the presence of children is a cause of serious respiratory illness and asthma attacks. Sudden infant death syndrome is also associated with exposure to SHS, and this association is judged to be one of cause and effect. The evidence published since 1998 also points to an association between SHS and respiratory symptoms and reduced lung function in adults. The Committee conclude that SHS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to; and that SHS represents a substantial public health hazard.10

Recent research also suggests that children who are exposed to SHS are at a higher risk of developing lung cancer as adults. In one of the most comprehensive Europe-wide studies into the health effects of second-hand smoke of its kind, researchers have found that children exposed to second-hand smoke on a daily basis, and for many hours, face over three times the risk of lung cancer than those who grow up in smoke-free environments.5

SHS exposure in pregnant women has recently been shown to adversely affect pregnancy by increasing foetal mortality and preterm delivery at higher exposure levels, and slowing foetal growth across all levels of SHS exposure.11 Bronchiolitis is a common cause of hospital admission among babies and young children in Scotland, and severity is increased in those who are exposed to SHS.12 The links between SHS and asthma are well documented. In addition a recent report has demonstrated that children with asthma whose parents smoke at home are at least twice as likely to have asthma symptoms all year compared to children of non-smokers.13 Recent research has also suggested that exposure to SHS may lead to abnormal tissue repair; delaying wound repair, preventing the formation of the healing tissue, and increasing the possibility of fibrosis and excess scarring.14

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Recently discovered tobacco industry documents demonstrate that second-hand smoke may be even more harmful, volume for volume, than directly inhaled cigarette smoke. Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places, and remain equally active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries.

Short-term Positive Impacts of Introducing Smoke-free Legislation: International Evidence

Since the Scottish Executive’s consultation on smoking in enclosed public places ended, a number of studies and reports have been published which suggest that improvements related to health and to indoor air quality can occur within months of policy implementation.

a) Increased Health Benefits: Reduced Tobacco Consumption

Opponents of smoke-free legislation have suggested that smokers in smoke-free workplaces compensate for being without cigarettes whilst at work by smoking more at lunch, during breaks, or after work. However, recent research has shown that employees in workplaces with no smoking restrictions smoke on average three more cigarettes a day than those whose workplaces are smoke-free.

In the Republic of Ireland, renewed commitment to tobacco control – including the introduction of smoke-free public places – has seen smoking rates plummet from 31% to 25% in just four years. In the six months after their legislation was introduced, an estimated 7000 Irish smokers had given up smoking. These figures have not been matched in the North, where smoking rates remain static. Up to 26,000 people rang the national Smoker’s Quitline in the past 14 months, with most calls received in the run up to legislation coming into force. Prior to this, an average of about 6,000 calls a year were received. Some one billion fewer cigarettes were sold in the Republic of Ireland last year, a 15% decrease on 2003. The Department of Finance acknowledges it is to early to say whether all of this decrease can be attributed to smoke-free legislation, but state that smoke-free workplaces and enclosed public places play a significant role. Similarly, although smoke-free legislation in Italy was only introduced on January 10th 2005, Italian cigarette sales are reported to have already fallen by 23%.

Recently published figures show that Scotland now has the highest proportion of smokers in the UK. 31% of Scots are smokers compared to 27% in Wales and 25% in England. It should be recognised that there is a substantial benefit to be gained from smoke-free legislation in terms of the impact it will have on active smoking rates. A recent review of smoke-free workplaces in the USA, Australia and Canada estimated that smoke-free legislation reduces smoking prevalence by 4%, and overall tobacco consumption by 30%. A modest reduction in active smoking rates would have major benefits in terms of reducing numbers of deaths among the Scottish population generally.

The hospitality and tobacco industry continue to voice concerns regarding a “dramatic escalation a possible rise in smoking in the home” as an immediate consequence of the introduction of smoke-free enclosed public places. However, evidence from countries such as the USA, Canada and Australia suggests that the introduction of legislation for smoke-free workplaces and enclosed public places does not lead to an increase in home smoking.

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19 ‘Smokers’ helpline registers 26,000 calls in past 14 months.’ News article printed in the Irish Times (06 January 2005). Message posted online at: http://member.globalink.org/msg/murrell.shtml (Accessed 07/01/05)
20 ‘One billion fewer cigarettes sold last year’ News article printed in the Irish Examiner (06 January 2005). Available online at: http://www.irishexaminer.com (Accessed 07/01/05)
public places may have the effect of enhancing protection from SHS in the home. For example, in Australia, the introduction of legislation for smoke-free workplaces during the 1990's was accompanied by a steep increase in the proportion of adults who avoided exposing children to tobacco smoke at home. Among households with children, the proportion with smoking restrictions increased overall from 25% in 1989 to 59% in 1997. In households where one adult smoked, the proportion with smoking restrictions increased from 17% to 53%, and in households where both adults smoked, the proportion with smoking restrictions increased from 2% to 32%.

Young children are thought to face the highest levels of exposure to second-hand smoke in the home. Increasing the percentage of tobacco-free homes is generally not amenable to legislation, but scientists point out that this can be achieved by a combination of mass media campaigns and smoking restrictions in enclosed public places and the workplace. A recent US survey demonstrated that most US parents still do not have a clear understanding of the adverse health effects of exposure to second-hand smoke on children, despite what has been established in published scientific research literature. Media campaigns are required to increase adults’ awareness of the dangers of secondhand smoke, and should be used in conjunction with smoke-free legislation to ensure the greatest protection for young people from the adverse health effects of second-hand smoke exposure. Smoke-free legislation will clearly support current smokers attempting to quit, and denormalise smoking in society, so that future generations do not get addicted to smoking.

b) Improved Air Quality

Travers et al. assessed changes in air quality that occurred in 20 hospitality venues in western New York where SHS exposure was observed at baseline. The findings indicate that, on average, levels of respirable suspended particles (RSPs – an accepted marker for SHS levels that are known to increase risk of respiratory disease, cancer, heart disease and stroke) decreased 84% in these venues within the first 4 months after the law took effect. Similarly, James Repace measured air quality in eight hospitality venues in Delaware; at baseline under conditions of unrestricted smoking, and again 2 months after the introduction of smoke-free legislation. Before legislation was introduced, all venues were heavily polluted, with indoor RSP levels averaging 20 times that of outdoor background levels. The health of hospitality workers was significantly endangered by second-hand smoke pollution. However, 2 months after the introduction of legislation, indoor air quality levels were indistinguishable from those measured outdoors.  

Recent research claiming to investigate the real effectiveness of ventilation in pubs using field studies has been widely publicised by the Licensed Trade as demonstrating that ventilation IS a solution to SHS. The research, carried out by Dr Andrew Geens (University of Glamorgan) measured levels of carbon dioxide, carbon monoxide and airborne particulates cross a number of UK venues including The Doublet (Glasgow), and the Phoenix (a smoke-free pub in Glasgow). Measurements were taken mostly during busy evenings, with ventilation turned on, and with ventilation turned off. Air quality in the Phoenix pub was monitored over a week, with the ventilation on continuously, in order to provide a comparative indicator of air quality in a non-smoking environment. The study concluded that simple, low-cost ventilation systems can reduce SHS dramatically; and in some areas air quality can be made as good as in a non-smoking pub. The study also concludes that particles and gases are kept well within occupational limits, even at peak times in busy pubs with no smoking restrictions.

However, a number of factors require consideration when interpreting these findings.

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The study is far from independent. Atmosphere Improves Results (AIR) co-ordinated funding from the Scottish Licensed Trade Association (SLTA) for the research. It is common knowledge that AIR is a tobacco industry funded organisation.29 The licensee of the Doublet pub is Alistair Don. He is also President of the Scottish Licensed Trade Association. The Doublet was also the site of the first SLTA sponsored "pub users' ballot" on smoking, and the "Freedom2Choose" press launch. The spokesman for "Freedom2Choose", Rod Bullough works in the head office of Cumbria Vending Services, which supplies cigarette vending machines.

Dr Geens concludes that monitored particles and gases were kept well within occupational limits, even at peak times in busy pubs with no smoking restrictions. However, there are no known safe limits for SHS exposure30, and no UK occupational limits for SHS exposure. The American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) sets standards for ventilation rates. These standards are so widely accepted that they are often written into laws and regulations. They are the industry norms throughout North America and many other parts of the world. Up until 1999, ASHRAE provided ventilation standards to remove the odours from second-hand smoke. However, they then accepted the evidence from other authorities that there is no acceptable level of exposure to the chemicals found in cigarette smoke, and rescinded those standards on health grounds.31

The main marker measures used in Dr Geen’s study were Carbon Monoxide and particulate matter at PM 2.5, with Carbon Dioxide used as a control measure. However, the smaller particulate components and harmful gases in SHS that pose the greatest health concerns were not measured. Recent controlled experiments have shown that the air pollution emitted by cigarettes is 10 times greater than diesel exhaust.32 These experiments have also demonstrated that comparative pollution levels for the tiniest particles – the most dangerous to health, are even greater.

Dr Geen's study suggests that there is no significant difference between particulate matter (PM 2.5) averages between the Doublet pub, when ventilation is switched on, and the smoke-free Phoenix pub. Graphs representing both sets of averages are used to demonstrate that ventilation IS therefore a solution to SHS. However, the graphs use different axis scales to plot the same points, and in doing so, the particulate matter averages appear similar. However, when the same axis scales are used, the supposed ‘similarity’ between particulate measures in the two pubs disappears (see Appendix 1, page 17). In fact, using the same axis scales to plot points, particulate matter averages are actually between 3 and 10 times higher for the ventilated Doublet pub, when compared with the smoke-free Phoenix pub.33

This study, though widely publicised and quoted by the Licensed Trade, has not yet been published, and is currently being peer reviewed. There is a substantial body of published work on ventilation, carried out independently of the hospitality and tobacco industry, which shows how SHS cannot be effectively removed from the air.34 35 36 37 38 39  Whilst ASH Scotland doesn’t have in-

29 The Tobacco Manufacturer’s Association funding of AIR and Dr Geen’s consultancy are documented at http://www.airinitiative.com/press.asp?id=109
house expertise on the subject of ventilation, we are familiar with the independent research conducted in this area, and our comments are based on knowledge of this literature. There are many reputable experts within the field of ventilation, and we suggest the Committee seeks their advice and input should they have questions regarding these issues.

The Scottish Licensed Trade - Proposed Legislation

The licensed trade umbrella group, Against an Outright Ban (AOB) represents the SLTA, the Scottish Beer and Pub Association, and other pub groups based in Scotland. In May 2004 they outlined proposals for implementation of a 5-point plan, across a 3-year period, as an alternative to the comprehensive legislation that the First Minister outlined in November 2004. The SLTA’s Chief Executive, Paul Waterson, believes that the 5-point plan would provide a “major contribution to improve health prospects in Scotland”. This alternative approach proposes that:

1. Smoking be banned at the bar counter in all licensed premises.
2. Smoking be banned in any area where and when hot food is served.
3. Smoking be banned in any area from which the public is excluded.
4. Licensed premises must allocate
   a. 30% of total floor space to a non-smoking area in year one
   b. 40% in year two, and
   c. 50% in year three. This would be followed by a further review
5. Licensed premises must display a smoking policy at the entrance in order that customers can see the facilities available before they enter.

These proposals are very similar to those in the Voluntary Charter, which has failed to deliver significant protection to hospitality workers in Scotland. Even where designated smoking areas are provided, they often continue to expose people in the vicinity to ETS, and they increase the exposure to smoke by concentrating smokers in the one place. Neither the current Voluntary Charter, or the proposed five-point plan are based on evidence on how to protect health, either for staff in the leisure industry, or for the public who use these facilities. Scotland currently has fewer smoke-free workplaces than the rest of the UK: 31% of working women and 21% of working men had been exposed to other people’s smoke at work in the week preceding the most recent Scottish Health Survey. These results confirm that the voluntary approach has not significantly increased protection from ETS. Voluntary agreements have proved ineffective in other areas of tobacco control policy, such as advertising. Voluntary approaches are not relied upon to control any other carcinogen in the workplace. In short, voluntary approaches simply do not work.

ASH Scotland believes that encouraging partial action by businesses in place of comprehensive legislation would be a backward step. Hospitality workers, children and other members of the public would not be adequately protected from the harmful health effects of SHS. Any efforts to provide partial protection from SHS remain flawed, as there is no safe level of exposure to second-hand smoke.

Inherent in the licensed trade proposals is the assumption that ventilation in bars could protect the public from the harmful effects of SHS. Although good ventilation systems can help reduce the irritability of smoke, they do not eliminate its poisonous components. Only 15% of second-hand smoke is in the form of particles that are visible to the eye. Ventilation filters trap these particles, making a room look less smoky and feel more comfortable to be in. However, tobacco smoke contains 4,000 toxins and more than 50 cancer-causing substances. Many of these are odourless, invisible gases, which cannot be removed by ventilation systems. Dr Geens recently stated: “You

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can do what you like with ventilation so long as you are prepared to spend the money”.24 Indeed, many businesses end up installing expensive ventilation systems in the mistaken belief that they are protecting staff and the public from the ill effects of SHS. Scientific evidence has demonstrated that there is no ventilation system that fully removes harmful gases that are present in SHS.45

Research has demonstrated that the current ventilation standards promoted by AIR (Atmosphere Improves Results) are inadequate. They state that a minimum of 12 air changes per hour is required for an average sized room, in order to judge ventilated air as ‘safe’. Based on this recommended ventilation rate for a pub at full occupancy, it is estimated that 5 out of every 100 bar staff will die from job-related passive smoking-induced heart disease or lung cancer during his or her working life.46

Those who continue to advocate ventilation as an appropriate solution to the health hazards of SHS have argued that indoor air pollution could be further reduced through higher ventilation rates. For example, Dr Geens recently stated that “Air changes per hour are virtually unlimited”.24 It is true that ventilation rates may be increased, and that air changes per hour are virtually unlimited. However, efforts to reduce indoor air pollution through higher ventilation rates does not lead to a measurable improvement of indoor air quality, as increased ventilation rates have no significant influence on the air concentration of tobacco components.47 Furthermore, SHS and ventilation expert Prof. James Repace has estimated that it would require in excess of 10,000 air changes per hour to produce levels of risk acceptable to bar staff from SHS.48 This would be equivalent to a tornado-like gale, and this is clearly unachievable.

Enforcement and Implementation
Opponents of smoke-free laws have proclaimed that difficulties with enforcement and implementation make such laws unworkable. The Office of Tobacco Control has recently announced that in the six months since smoke-free legislation was introduced in the Republic of Ireland, on average over 94% of premises inspected were compliant with the law. Compliance levels are reported at 94% in hotels, 99% in restaurants, and 91% in licensed premises.49 These figures demonstrate that smoke-free legislation is both viable and largely self-enforcing.

Maximising Compliance: An International Perspective
The New York State Health Department recently announced the first independent evaluation of New York’s tobacco control programme. The report contains a number of recommendations that Scotland should consider very carefully in order to maximise effectiveness in implementing smoke-free enclosed public places. In order to counter the near limitless marketing resources of the tobacco industry, the report emphasises the need for a pragmatic approach that is solidly based in evidence-based strategies and is consistent with best practices. It highlights the need for a strategic planning process, and for increased resources to expand and improve smoking cessation services. The report also emphasises the necessity of an effective, co-ordinated mass-media marketing and advertising campaign, which should be (in line with best practice) high in emotional impact in order to garner attention among the public.50 ASH Scotland considers that such steps are crucial for the Scottish Parliament to consider in its strategic planning of implementation of the Bill.

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45 British Medical Association (2002). Towards smoke-free public places.
46 A Killer on the Loose. An Action on Smoking and Health special investigation into the threat of passive smoking to the UK workforce. ASH (Action on Smoking and Health), 2003.
The New York City Department of Health and Mental Hygiene is responsible for enforcing the Smoke-Free Air Act. To inform the public and employers of the new law, the Department developed a brochure explaining how to comply with the Act, and met with employers, building owners and operators, restaurant association members and community organisations to provide information about the law. The Department also sent ‘No Smoking’ signs to more than 20,000 establishments. Information on compliance is available and regularly updated on the Department website. These educational efforts have resulted in remarkably high compliance with the new smoke-free workplace law. Of the more than 12,000 establishments inspected in the first three months after the law went into effect, the Department has only issued 177 violations, mostly for failure to have a “No Smoking” sign posted or for the presence of ashtrays. This suggests that businesses are observing smoke-free workplace requirements, and that the law is largely self-enforcing.

To ensure compliance, provision for enforcement must be in place which will identify what the offences are, who enforcement action may be taken against and who the legislation will be enforced by. This legislative provision should be adequately resourced, to ensure the effectiveness of any controls. Another good example of such provision is the Republic of Ireland’s Office of Tobacco Control (OTC). The role of the OTC is to support the Republic’s smoke-free policy by discharging a variety of functions which includes enforcing the tobacco control laws, operating the Smoke-Free Compliance telephone line, conducting research into tobacco and communicating the findings, and organising a national inspection programme. The Republic’s government is quoted as saying they expected a 90% compliance rate with the measure when it was newly introduced. On the 31 May 2004, the OTC published its first report on compliance for one month after the smoke-free workplace legislation was introduced. The report found that 97% of premises inspected were compliant with the new law. In their six-month progress report, 94% of premises inspected were reported to be compliant with the law. The slight decrease in compliance levels from one to six months reflects the concentration of inspections at six months on non-compliant premises, together with enforcement actions requiring repeat inspections.

Time Delays and Exemptions: Learning from International Experience

Very few countries with smoke-free legislation have contemplated the notion of time delays in the process of implementation. Considering the limited evidence that is available from those countries that have, this comes as no surprise.

a) Time Delays: International Evidence

Time delays have caused great confusion in the Saskatchewan province of Canada. Five days after the introduction of Saskatchewan’s law, many bar and restaurant owners are still allowing patrons to light up. Some say they feel they have the right after hearing the province won’t be ticketing offenders for the first 60 days. This ‘grace period’ has encouraged challenges to the law, and misunderstandings concerning how the law works and how it affects business. Time delays also hindered the introduction of legislation in Italy by almost two years.

The option of postponing introduction of new law provides the hospitality trade and tobacco industry with increased ammunition, giving them time to step up attempts to scupper the
introduction of legislation. The tobacco industry has a vested interest in opposing legislation and, as previously experienced in New York and Ireland, they actively support groups attempting to derail smoke-free laws before they are introduced. Restaurant and bar owners continue to argue that custom will fall and the law will be difficult to enforce. Opponents continue to advocate for compromises such as ventilated rooms or designated smoking areas, which we already know to be wholly ineffective measures. An Aberdeen License Trade Official has recently called on pubs to consider introducing a voluntary smoking ban, in order to help stop Scotland-wide legislation being introduced in 2006.69 FOREST, the tobacco industry funded front group, has recently appointed a Scottish spokesman, who is reportedly attempting to combat moves to outlaw smoking in enclosed public places, and trying to persuade MSPs to introduce a system that offers greater choice to smokers.60 Both the Scottish Licensed Trade Association, and the Tobacco Manufacturer's Association, have recently indicated they are examining the possibility of mounting legal challenges against the legislation.61 The threat of legal action is a delaying tactic, intended to overturn the introduction of smoke-free enclosed public places in Scotland.

b) Exempting Private Clubs from Legislation: International Evidence

There are already some deliberations regarding the possible exemption of private clubs from smoke-free legislation. In Idaho, most restaurants and pubs are now smoke-free, but private clubs are exempt from smoke-free legislation. Some establishments have been converted into private clubs, charging drinkers a minimal fee to join. Not only are they exploiting the exemption loophole, they are undoubtedly undermining what would otherwise be an effective piece of legislation.62

In Utah, smoking is prohibited in most indoor locales except private clubs, which were given an exemption as part of a political compromise under the 1995 Utah Clean Air Act. Some 10 years later, residents, governors and members of the general public are still debating whether private clubs should be smoke-free, in advance of the Legislature next year.63

In Delaware, private clubs are exempt from the state's indoor smoke free legislation. Prior to the introduction of legislation, state officials carefully defined what constitutes a private club, and as a result it is almost impossible for pub and bar owners to convert their premises in order to escape legislation.64

In New Zealand, smoke-free provisions apply in all private clubs where the club employs people, serves food, or has a liquor or gambling license.65 This creates a level playing field with other businesses with the same license or employer obligations, and the same potential clientele. In New Zealand, the Health Select Committee recommended the removal of the exemptions that allowed smoking in certain licensed premises, for consistency in protecting all workers from the harmful effects of SHS.61

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59 ‘Pubs urged to consider voluntary smoking ban.’ This is North Scotland news report (07/01/05). Available online at: http://www.thisisnorthscotland.co.uk/displayNode.jsp?nodeId=149235&command=displayContent&sourceNode=149218&contentPK=11613474&moduleName=InternalSearch&keyword=smoke&formname=sidebarsearch (Accessed 07/01/05)
65 Smokefree law in New Zealand. Ministry of Health Website: http://www/moh.govt.nz (Accessed 07/01/05)
Even organisations with strong links to the tobacco industry, such as the Empire State Tavern Association, and the SLTA, state that smoke-free legislation should be applied even-handedly, to bars, pubs and private clubs.\textsuperscript{66} 67

c) ASH Scotland’s Position on Private Clubs
It is much easier for the public to understand a ‘one rule applies to all’ smoke-free provision. A level playing field is considered fairer and easier to implement. Legislation that applies equally to all enclosed public places has the additional advantage of requiring minimal lead time, since no building alterations need to be made nor equipment installed. This is clearly the most effective way to reduce the health risks caused by tobacco and exposure to SHS.

If the issue of private clubs has to be further discussed and debated we suggest that Parliament must consider most carefully the definition of what constitutes a private club that could be exempt from legislation.

The international evidence is clear that comprehensive legislation works most effectively in other countries. In order to effectively reduce the health risks caused by tobacco and exposure to SHS, legislation must be standardised across areas and establishments.

d) Other Possible Exemptions
Other possible exemptions that may be considered include police and prison cells, secure hospitals, hotel and bed-and-breakfast rooms, and hospices.

e) Current Guidelines
Current guidelines for local authorities on tobacco at work state staff should be protected from second-hand smoke, and that each local authority should give serious consideration as how it is going to protect its entire staff, in the variety of settings in which they work. The guidelines identify settings (other than office premises) in which the development and implementation of a comprehensive tobacco policy is important, including schools and youth community centres, residential homes for the elderly, domiciliary care, council vehicles, local authority venues where food and/or alcohol are served, and residential accommodation for young people. The guidelines continue that all organisations should have the goal of becoming completely smoke-free workplaces.\textsuperscript{68}

Current guidelines for effective tobacco policy in the NHS state that health care trusts have a duty to protect the health of staff and patients and not subject them to hazardous environments and materials, and this includes protecting them from second-hand smoke. The guidelines also recommend that a commitment to helping staff and patients to give up smoking is an essential part of an effective tobacco policy, and that any patient or staff member should be able to access an ongoing programme of cessation help if they wish to.\textsuperscript{69}

f) ASH Scotland’s Position on Other Possible Exemptions
Exemptions to any law introduced on smoke-free enclosed public places would result in only partial protection of staff and the general public – smokers and non-smokers – from the health risks of passive smoking. Exemptions may lead to lead to the marginalisation of some sectors of society and parts of the workforce, effectively implying that their health is less important. If legislation is not put in place to protect all workers from SHS then employers risk being exposed to litigation.

If exemptions are to be considered, they should be minimal exemptions for evidence-based reasons, and be time limited or with defined and monitored criteria. For example, in the Republic of Ireland, prisons, nursing homes, psychiatric hospitals and hotel bedrooms are exempt from smoke-
free legislation. This is to accommodate people who would be regarded as ‘dwelling’ in these places. Even though these exempt institutions are not obliged to enforce the legislation, all employers still have the right to enforce it, and are free to do so if they wish. In making any such decisions, it is crucial to remember that a dwelling place for some is a workplace for others. In a recent online survey conducted by irishhealth.com, it was reported that nearly half of the general public (47%) do not support the exemptions listed above.  
ASH Scotland believes that exemptions should only be introduced in exceptional cases, and in such instances employers and service providers should provide all reasonable means for employers and other service users to avoid exposure to second-hand smoke. Any possible exemption should be justified in terms of the acceptability of exposing members of the workforce to a preventable Class A carcinogen.

Economic Impacts
The Scottish Licensed Trade Association has estimated that “the capital cost of compliance with the Bill will be in the region of £85 million, suggesting that “costs may be well in excess of that, depending on the views of the local regulatory authorities on matters such as the provision of fire escapes and facilities for the disabled”. They have also reported that smoke-free legislation will force more than 140 pubs to close, and lead to the loss of 2,300 jobs, and £59 million in tax revenue.

However, there is a wealth of international evidence to demonstrate that smoke-free public places don’t have a negative impact on business. In addition to the evidence we have already submitted to the Scottish Executive in response to their public places consultation, a number of positive economic impacts have recently been reported.

A recently published international review models the likely impacts of moving from the current voluntary code to comprehensive legislation on smoking in public places in Scotland. Modelling procedures utilise existing evidence on the economic impacts that have been measured in other countries with comprehensive smoke-free legislation. The report concludes that conservative estimates of savings in the workplace exceed the ‘worst case scenarios’ for losses in the hospitality industry. The effect on the hotel, restaurant and bar sectors in Scotland is centrally estimated at +£110 million (range –£63 million to +£281 million). The study also suggests that the most sizeable economic impact is a net gain for society in resource terms, which are centrally estimated at £115 million five years post legislation.

The level of turnover in Scotland should also be borne in mind when interpreting any future claims of economic loss; there are around 5,000 openings and closures of businesses over a 3-year period, without attributable effects to policy changes. Predictions of a downturn in business are encountered in every country where legislation has been, or is currently being, introduced. For example, in Ireland, the The Licensed Vintners Association (LVA) recently published research concluding that the economic impact of smoke-free legislation is unfavourable for the licensed trade in the Republic of Ireland. However, a number of factors should be taken into account when interpreting this conclusion. The LVA’s study was based on subjective interviews with over 270 publicans around Dublin. They were asked to describe how they viewed the impact of legislation, to estimate the effects the legislation has had, and to predict the economic future of their business. This material is entirely unreliable as a proper economic assessment as it is not based on hard financial or economic data.

It is interesting to note that the publicans’ estimates of their sales figures are significantly different to the hard data available, such as the drink sale figures produced by the Central Statistics Office (CSO) as well as the drinks manufacturers themselves. According to the latest figures from the

70 http://www.irishhealth.com/poll.html?pollid=174 (Accessed 07/01/05)
71 SLTA response to Stewart Maxwell Bill, page 3, para. 1
72 ‘Smoking ban will cost 2,300 jobs and 140 pubs, report claims.’ Press article in the Scotsman, 05 February 2005, available online at: http://news.scotsman.com/scotland.cfm?id=1410222005 (Accessed 08/02/05)
CSO, bar sales are reported to have picked up sharply, with sales figures rising by 2.3% between September and November 2004. This rise marks a turnaround after two months of declining volumes. Whilst bar sales continued to be down on 2003, falling by around 5.1%, this is dramatically less than the 29% fall in volumes claimed by the LVA, whose figures do not take account of seasonal changes to drinking purchases.

Smoke-free legislation in the Republic of Ireland was introduced in what was already a shrinking bar sales market. Sales reportedly hit their peak in May 2001, and since then, the volume of drink sold in Irish bars has fallen by approximately 15%. Many factors have contributed to this climate, including changing demographics, the price of drink, increased price competition from supermarkets and off-licences, increased excise duty on alcohol, and changing working patterns and lifestyles. Yet the LVA report attributes all of the alleged downturn in the trade to smoke-free legislation. This is simply not credible, and claims to this effect don’t stand up to scrutiny.

The LVA has also claimed that the introduction of smoke-free legislation in the Republic of Ireland has led directly to the loss of 2,000 jobs in Dublin. However, these figures are dubious, as they too are based on subjective interviews with bar managers or owners and not on objective economic information. Mandate Trade Union, the third largest union in the Republic of Ireland, represents almost two thousand bar workers, mainly based in Dublin. The union’s records indicate that job losses in the greater Dublin area have been in the order of a couple of hundred, not the thousands claimed.

In the United States, many hospitality groups have claimed that their business has been detrimentally affected by smoke-free legislation. For example, in Beverly Hills, California, the Restaurant Association said that their businesses had suffered a 30% decline in revenues during the five months after smoke-free regulations were in effect. As a direct result of such opposition, organised by the tobacco industry, Beverly Hills repealed their smoke-free restaurant ordinance. Studies have since shown that, contrary to tobacco industry claims, there was no detectable drop in restaurant sales during the time the ordinances were in effect, nor was the an increase in restaurant sales following reversal of the 100% smoke-free ordinances. In fact, sales increased slightly during the period the smoke-free regulations were first in place.

Anecdotal reports, polls or interviews with business owners concerning economic impacts of smoke-free legislation should be treated with great scepticism. Smoke-free legislation has been passed in every conceivable type of community, from small towns and rural areas to a number of states, and economists have studied the impacts on communities across the spectrum. No objective, peer reviewed study ever conducted has found a significant negative economic impact associated with smoke-free legislation. The reliable evidence, that measures hard numbers from independent sources, remains clear. Legislation on smoke-free enclosed public places will not harm the economy, and will improve Scotland’s appalling rates of cancer, heart and lung disease, both by cutting smoking rates and by reducing people’s exposure to unwanted smoke.

Public Opinion
UK public opinion continues to demonstrate that it is time to put an end to smoking in enclosed public places. Results from key questions in the recent Scottish Executive consultation document demonstrate that 82% of respondents believe that further action needs to be taken to reduce
people’s exposure to second-hand smoke. Eighty percent of respondents support a law to make enclosed public places smoke-free. Fifty-six percent of respondents felt there should not be any exemptions to the law, with only 35% stating they would like to see some form of exemption.

Populus have recently published findings of a survey they claim to be independent, conducted on public attitudes to smoking with 10,000 British respondents (1,000 of whom were Scottish). On the contrary to the findings outlined above, Populus results demonstrate that 72% of Scottish respondents want separate smoking and non-smoking areas in pubs, clubs and bars. Only 22% of Scottish respondents state that they support the notion of completely smoke-free public places. These and other such findings from this poll have been widely quoted by the hospitality trade in their attempts to rebut legislation. However, only 46% of respondents in this survey have never smoked. A further 23% used to smoke, 8% class themselves as occasional smokers, and 24%, nearly one in four, smoke every day. No information is provided concerning the number of individuals in Scotland within each of these four groups. This sample simply does not provide a representative picture of the opinion of the Scottish population, and renders extrapolations to the wider Scottish population meaningless. It would be possible to use statistical procedures that take combined account of nationality and smoking status in order to give true percentages, but Populus does not appear to have done this.

In addition, the Populus poll asks respondents how smoking should be handled specifically in pubs, bars and clubs, rather than phrasing the question to ask about enclosed public places. Research has demonstrated that smoking restrictions in pubs and bars have lower levels of public support than other enclosed public places. However, findings of a poll commissioned by the Office for Tobacco Control demonstrate that public support for smoke-free bars and restaurants in the Republic of Ireland increased once plans for legislation were announced. In June 2003, 67% of the Irish public supported the proposed law for smoke-free bars and restaurants, compared to 59% in favour before legislation was announced in February 2003. A recent survey conducted by Amarach Consulting found that 89% of respondents agreed that the legislation was a great success, and nearly 90% of smokers believed that the smoke-free law was working.

The Populus question is a loaded question, and a useful reminder that opinion polls can be conducted to provide any ‘evidence’ required by those who commission the survey, so long as questions are phrased carefully. Andrew Cooper, Director of Populus, recently stated that the ‘right’ question to ask re: public attitudes to smoking should be “What do the British and Scottish people think is the best approach to the issue of smoking in public places?” Why then, was this not the question asked, and the results reported accordingly? Perhaps the answer in part lies with those who commissioned the research, in this case FOREST, a front group funded by the tobacco industry.

The Tobacco Industry’s Attempts to Rebuke Science

The tobacco industry is renowned for its extensive attempts to fight second-hand smoke issues across Europe. There are now a number of published reports that document tobacco industry projects to recruit scientists in developed countries around the world who would criticise the science on second-hand smoke, cast doubt on whether SHS harms people and “prolong the

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82 Smoking in Public Places A Consultation on Reducing Exposure to Second Hand Smoke. Key Findings of Responses to a Public Consultation. Available online at: http://www.scotland.gov.uk/library5/health/smipp02-02.asp (Accessed 13/01/05)
controversy” about the effects of health effects of SHS. Indeed, documents made public demonstrate Philip Morris’s intention to create a foundation that would "become THE scientific authority on a wide range of human concerns, thus putting itself above WHO, FAO and other organisations who restrict themselves to narrower fields".

There are also published reports that document attempts by the Philip Morris tobacco company to conceal important research that could and should influence government policy. The scientists involved in research that is associated with tobacco manufacturers appear to publish only a small amount of their research, and what is published appears to differ considerably from what is not. In particular, unpublished reports have provided evidence that suggests SHS is more harmful than mainstream smoke, which is most interesting concerning the industry’s continuing denial of the harmful health effects of SHS.

Dr Steven Stotesbury, a scientist from Imperial Tobacco Limited, recently challenged the science on second-hand smoke, in particular questioning the statistical techniques and methodologies that have been used in the body of research on the health hazards of SHS. He claims that even in studies that have claimed associations between SHS and disease, the relative risk is generally low, i.e. between 1.0 and 2.0, and would not normally be regarded as sufficient to prove a causal effect. To support this statement, he uses the following quote from Baroness Jay of Paddington, Health Minister (1998): “A stronger association – of greater than 2 – is more likely to reflect causation than is a weaker association – of less than 2 – as this is more likely to result from methodological biases or reflect indirect associations that are not causal.” On this basis, Stotesbury concludes that the levels of relative risk that are used to substantiate the case of SHS to justify public smoking measures have been officially described as ‘too low to prove a causal effect’.

The National Research Council (2002) states that there is no biological reason for the use of 2.0 standard as opposed to any other standard. They continue “the use of such a hard standard obscures the fact that any risk means that some people could be harmed by the agent in question. For example, the relative risk of passive smoking – is reliably shown to be about 1.2, i.e. the risk of developing lung cancer is elevated about 20% by passive smoking”.

It is generally accepted that in assessing the evidence for a link between a risk factor and a disease, a range of factors need to be taken into account. These factors have been included in lists such as the Austin Bradford-Hill criteria, proposed more than 35 years ago for attributing disease causation to environmental factors. The general principles behind this approach are widely accepted and utilised by epidemiologists, clinical researchers, pharmaco-epidemiologists, and by UK Government Advisory Bodies and Committees in order to establish the robustness, the clinical importance, and the public health significance of possible risk factors for disease.

The Bradford-Hill criteria emphasise that evidence that a risk factor causes a disease should not be based on only one factor, such as the strength of the association. The criteria emphasise the need to examine a range of factors, including the following: strength of the association (i.e. as measured by level of relative risk); consistency of the association (similar results emerging from several studies done in different populations); specificity of the association; temporality (i.e. the cause must have preceded the effect by a sufficient amount of time); and reversibility (i.e. the effect disappears when the cause is removed).

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90 http://tobaccodocuments.org/profiles/whitecoat.html
precede the effect); biological gradient (i.e. increasing dose must lead to increasing disease frequency); plausibility (i.e. the biological plausibility of the observed association); coherence (the knowledge that the association does not conflict with current knowledge about the disease, such as its natural history and biology); experimental evidence; and analogy.

According to advice that ASH Scotland has received from a leading and respected national statistician, it is therefore not reasonable to assess causality solely on the basis of meeting an arbitrary cut-off for relative risk. The argument for the harmful effect of SHS rests not only on the strength of the association with disease but also on the consistency of the evidence, temporality, biological gradient and other factors as outlined above. Dr Stotesbury states: “the case for a smoking ban has often been argued on an emotive and subjective basis”.90 On the contrary, there has now been 50 years worth of research into tobacco, which demonstrates conclusively the damage it does to human health. Nevertheless, the licensed trade and the tobacco industry continues to try and cast doubt on the link between SHS and lung cancer, heart disease, respiratory disease and tobacco.

Scientists representing the tobacco industry have also raised doubts as to the robustness of using meta-analysis as a statistical means of inferring conclusions regarding the science of SHS and disease. Stotesbury, for example, states: “risk estimates that are based on a mathematical combination of different studies, many of which are weak or inconclusive, are extrapolated into the headline claims about specific numbers of deaths due to passive smoking. In other words, the science and statistics have been exaggerated to fit the anti-smoking case”.90

SIGN (Scottish Intercollegiate Guidelines Network) give guidance to the Scottish NHS on effective treatment and are widely accepted and internationally recognised. In general their conclusions do not differ in any important way from other reviews about effective treatments. SIGN rate meta-analysis as the highest level of evidence available about the effectiveness of treatments. If critics believe that meta-analysis is not a legitimate technique, then they should be prepared to say whether they believe meta-analysis when used to assess treatment. For example, SIGN guidelines recommend the use of clot-busting drugs to treat acute myocardial infarction.97 This recommendation is made on the basis of a meta-analysis of 12 trials. Similarly, SIGN guidelines recommend chemotherapy as a treatment for breast cancer, also on the basis of a meta-analysis.98 In fact, meta-analyses are used in almost every SIGN guideline currently published. Would the tobacco industry reject such recommendations on the basis that they are based on meta-analyses?

As Sir Austin Bradford Hill stated92, “All scientific research is by its very nature incomplete, whether it is observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have or postpone the action that it appears to demand at a give time”. Scientific research does have limitations; it produces likely explanations rather than certainty; and when taken out of context it can be misinterpreted. Meta-analysis has an important role to play in causal assessments, although like all science meta-analysis contributes to the weight of evidence rather than offering proof. Meta-analysis provides more precise estimates of the magnitude of the effect than can be obtained from individual studies, but causal inference requires a range of kinds of evidence to be taken into account.99 Making causal claims on the basis of one or two aspects of either method (i.e. on the basis of relative risk values and/or, confidence intervals) clearly does not equate with objective, scientific interpretation of the evidence.

Opponents of smoke-free legislation often cite a study conducted by Enstrom and Kabat100, published in the British Medical Journal in May 2003, which concludes that exposure to SHS does not lead to an increased risk of illness. The publication of this article caused widespread debate

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and controversy, with more than 140 BMJ readers responding to the paper and associated editorial.

Enstrom and Kabat undertook a follow-up examination of a subset of the American Cancer Society Cancer Prevention study cohort (CPSI), comprising 35,651 never smokers who had a spouse who smoked. The cohort, and information on their smoking status, was established in 1959. Additional smoking status information was gathered by the American Cancer Society in 1961, 1963, 1965 and 1972. Extended follow-up research was then carried out up until 1997, by Enstrom and Kabat, which included gathering updated information on smoking status. This extended follow-up phase was conducted with initial support from the Tobacco-Related Disease Research Program (TRDRP), a Californian Research program funded by the Proposition 99 cigarette surtax. After continuing support from the TRDRP was denied, follow up through 1999 and data analysis were conducted at the University of California at Los Angeles with support from the Centre for Indoor Air Research, an organisation that received funding primarily from US tobacco companies.

The results of this follow-up study suggested no significant causal relation between SHS and related mortality, although Enstrom and Kabat didn’t rule out a small effect. Results also suggested that the association between coronary heart disease and lung cancer may be somewhat weaker than generally believed.

The Chief Executive of the Vintners Federation of Ireland, Tadg O’Sullivan, recently spoke out about this paper, stating that “the BMJ would not risk its reputation in publishing this research unless it were absolutely sure of its validity.” It is noteworthy that, in the editorial in the BMJ regarding this paper, a number of points were made regarding interpretation of findings, including the potential for socio-economic confounding to affect results, and the potential key role for misclassification of exposure status in studies of passive smoking.

O’Sullivan also stated that “the American Cancer Society decided that they would not publish (the study) when they discovered what the results were going to be.” However, the American Cancer Society were not directly involved in the Enstrom and Kabat follow up, they merely provided the initial data. The ACS did in fact publish, to coincide with the Enstrom and Kabat publication, concerns regarding a number of flaws in the use of such a small subset (10%) of the CPS-1 database and the potential for misclassification of exposure status when undertaking research with this particular dataset. The ACS also noted that an association between exposure to SHS and lung cancer was demonstrated in studies using the Cancer Prevention Study 11 dataset, which contained substantially more patients than in the Enstrom and Kabat study.

O’Sullivan continues that the Enstrom and Kabat study “simply rubbishes the claims of the pro-ban lobby.” Following publication of the study, the UK Government Advisory Committee on Carcinogenicity of Chemicals (COC) were asked to undertake a review of the evidence presented in this paper. The Committee concluded that no definitive conclusions could be drawn from the Enstrom and Kabat study. They also stated that there was no reason to change the conclusion they had reached in 1997, following a request from the Scientific Committee on Tobacco and Health (SCOTH) to review the evidence regarding exposure to SHS and lung cancer, namely:

“Taking all the supportive data into consideration we conclude that passive smoking in non-smokers exposed over a substantial part of their life is associated with a 10-30% increase in the risk of lung cancer which could account for several hundred lung cancer deaths per annum in the UK.”

O’Sullivan refers to a second study to back up his argument of there being “a vast array of evidence to prove that the issue (of the association between passive smoking and ill health) is grossly exaggerated". The study in question, conducted by researchers at the Oakridge National Laboratory of Tennessee, suggested that exposures to SHS may be lower than previously indicated for bartenders, waiters and waitresses.

Oakridge National Laboratory of Tennessee and its researchers, although part of the U.S Department of Energy’s often highly-classified research establishment, are also for rent to private companies. Roger Jenkins, the lead author of this study, has conducted several other pieces of research commissioned by the tobacco industry, that typically attempt to show that exposure to SHS is not a health hazard. Jenkin’s findings, and Jenkins himself, frequently appear in hearings to oppose local smoke-free measures. As an expert witness for the defence in a lawsuit bought by flight attendants against the tobacco industry over the lung cancer and other diseases they contracted at work, Jenkin’s evidence was excluded by the judge because of his pro-tobacco industry bias.

Without exception, the ‘evidence’ presented by hospitality groups and the tobacco industry suggest no associations between SHS and ill-health is flawed, weak, and lacking in scientific credibility. The WHO International Agency for Research on Cancer’s (IARC) classification of SHS as a human carcinogen is based on the full scope of evidence; observational studies, carcinogenic components of SHS, experimental models, and biomarker studies. The issue of whether exposure to SHS causes ill-health has been resolved scientifically. It is only hospitality groups and the tobacco industry that cynically continue the “debate”.

SHS kills up to 1,000 people every year in the UK, with some studies suggesting the figure is even higher than this. Ventilation does not protect employees and customers from the harmful effects of SHS, and any assertions otherwise are based on flawed science. The Scottish Executive has made their decision regarding legislation on a wealth of robust scientific and medical evidence. The new laws will benefit everyone, and the publication of this Bill will dramatically improve Scotland’s health. A comprehensive law to end smoking in enclosed public places is the only way in which to protect the people of Scotland from the health hazards associated with SHS.

Appendix 1: ASH Scotland Mapping of Figures 7 and 18 from Dr Geen’s unpublished paper, ‘Can ventilation clear ETS?’

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106 Roger Jenkins and Oak Ridge National Laboratory. Available online at: http://www.tobaccoscam.ucsf.edu/vent/vent_hg_internal_4.cfm (Accessed 21/01/05)
SUBMISSION BY AMICUS

Background

Amicus as the UK’s largest private sector union represents a diverse range of interests from our members in the Health sector to those in Food, Drink and Tobacco and those in the Heating and Ventilation industry.

We have smoking and non-smoking members of the union and as such we believe that the interests of all people should be considered.

Sections of the Bill covered by this submission

Whilst this submission relates only to the proposals contained in Part 1 of the Bill (Prohibition of smoking in certain wholly enclosed spaces) it should not be construed that this implies Amicus endorsement or otherwise of the other Sections of this Bill.

Overview of Part 1 of the Bill

The Amicus Food, Drink and Tobacco National Industrial Conference has already declared its opposition to a total ban on smoking in public places believing that solutions can be found by looking at the introduction of greater restrictions rather than total prohibition.

We are more inclined to support the proposition from Dr John Reid, UK Health Secretary suggesting that an outright ban is not the way forward.

Employment Issues

It is our view that, whilst health matters are important, equal consideration should be given to the employment implications of any legislation that may be enacted by the Scottish Parliament.
Evidence from the Central Statistics Office Ireland indicates that employment in the Hospitality sector in Ireland has been severely affected since the advent of the smoking ban that was introduced in 2004.

The latest available figures indicate that between Quarter 3, 2003 and the same Quarter in 2004 employment in this sector fell by 6.1%. This equates to a loss of some 7,600 jobs lost to this particular Sector in a 12-month period.

There is nothing to suggest that the introduction of a total ban in Scotland would produce a different set of results.

In fact if the 2003 figure of 150,000 employed in the Scottish hospitality industry, which is contained in the Bill supporting paperwork, were taken as a guide then extrapolation of the Irish statistics would give an indication of some 9,000 jobs being lost in that Sector.

No doubt the hospitality industry will make its own views known to the Parliament on this particular issue.

Amicus in Scotland has members employed in the food and drinks industries as well as with the tobacco company sales forces and the vending companies whose machines are commonplace in pubs, clubs and restaurants throughout Scotland.

It is our belief that the employment of our members in these sectors could equally be threatened in the event of the introduction of a total ban on smoking in ‘enclosed’ areas.

Alternatives to a Total Ban

To date it would appear to us that the Scottish Executive has dismissed out of hand any propositions suggesting that there are alternatives to a total ban.

Public opinion indicates that there is widespread support for greater restrictions on smoking in public places and an extension of no smoking areas.

However the majority do not support the proposition of total prohibition.

In workplaces partial or total bans on smoking have in the main been introduced as a result of consultation and co-operation between the employer and the representatives of the workforce. As a result enforcement does not appear to be an issue.

Amicus would encourage the voluntary approach suggested by the Hospitality industry which includes:

- the provision of more non-smoking areas
- the banning of smoking at bar counters
- the banning of smoking in areas where hot food is served
- the open displaying of a smoking policy at the entrances to premises.

In addition to the above we would also advocate improved ventilation systems.

Ventilation/Filtration Systems

The Scottish Executive dismisses the idea that adequate ventilation and filtration systems can provide any kind of solution.

Via the Executive web site it is possible to access a site www.smokefreescotland.com/facts/second-hand-smoke) which asserts that ‘research suggests that the air-flows possible with current ventilation systems are not sufficient to eliminate the health risk associated with second-hand smoke.’

There is no indication as to the source (or sources) of that research.
However it appears to be taken as fact by the Executive.

We would refute the sentiments of that statement.

However, there is evidence to suggest that there are adequate ventilation systems available – including research currently being undertaken by the University of Glamorgan.

Additionally we would suggest that organisations such as the Heating and Ventilation Industry and Government Departments such as the Ministry of Defence could be helpful in this area.

We believe that the option of utilising adequate ventilation systems can provide a base for job creation in that industrial sector.

Economic Issues

The Bill, and the supporting paperwork, seeks to outline some of the financial implications in the event of a total ban being introduced.

These tend to concentrate on the projected savings to the Scottish Health Service by highlighting 2 main areas namely:

a) Reduction in the smoking population
b) Reduction in exposure to ETS.

We would acknowledge that the introduction of any restrictions [either in full or in part] on smoking in enclosed spaces is likely to give rise to a reduction in consumption either as a result of individuals cutting down or giving up smoking completely.

However it would seem to us to be imprudent if the only financial impact to be taken into consideration is in relation to savings that may be made in one area namely the cost of health care provision.

We believe that consideration should also be given (and taken in to the overall view of the financial impact) to the areas which have the possibility of creating a negative financial impact.

These areas would include the loss of revenue to the Exchequer and the increase cost of benefits such those arising from unemployment.

It is estimated that there are 1.275 million smokers in Scotland.

Revenue (to the Exchequer from Scotland) from tobacco products is estimated to be in the region of £1.04 billion.

Accepting for a moment the figure of 4% reduction in smokers, which comes from the Wanless Report, it would be logical to assume a similar reduction in revenue.

This would equate to a reduction of £41.6 million to the Exchequer.

It is also some £26 million greater than the estimated savings of £15.7 million that would be saved by the health service.

In addition to loss of taxation revenue consideration should also be given to the likely additional cost of State benefits to those who may find themselves made unemployed as a result of the introduction of the proposals contained in Part 1of the Bill.

This of course may be difficult to quantify in full. However if we take the figure of 9,000 who may loose their jobs in the hospitality industry and assume that 50% of that number may be long term unemployed we can make an estimate of what that cost may be.
That would make 4,500 people claiming Job Seekers Allowance (JSA) for 26 weeks.

Taking an average figure for the weekly level of JSA for persons over the age of 18 years that would mean 4,500 claiming £50/week – a total of £225,000 per week or £5.85 million over a 26 week period.

This figure of £5.85 million when added to the loss of Revenue figure of £41.6 million gives a total [negative] figure of £47.45 million.

When the projected savings to the NHS of £15.7 million are then put in to the equation this would give a net negative impact of £31.75 million as a result of the implementation of this part of the Bill.

[The Bill and its associated paperwork refuses to address what mechanism would be employed to redress this loss of Revenue – would this be through increasing taxes, cutting services or what?]

This figure does not take into consideration any other related benefits to which individuals may be entitled.

The associated paperwork also quantifies to an extent the likely additional costs to the Local Authorities in ‘policing’ the enforcement of Part 1 of the Bill.

It does not however attempt to look at the additional financial impact on Local Authorities of potential loss of revenue in respect of Council Tax or ‘rates’ revenue lost in the event of the closure of premises in the hospitality industry as a result of these measures. [Loss of revenue in this direction would be likely to result in further increases in the Council Tax to compensate for these losses.]

Conclusion

We would urge that co-operation rather than coercion and compulsion should be the way forward.

Both sides of this debate have rights, which should be respected, and that the right to choose should be made available to both smokers and non-smokers alike.

We should not forget that tobacco products are still legal substances in this country and as such should be treated no less favourably than other such products which the adult population is free to purchase and consume.

Amicus

SUBMISSION BY STUC

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

We do agree with the objective behind banning smoking in public places, namely to reduce the risk to the health of those who work in and visit public places.

However, we remain concerned that a number of issues need to be more closely examined if this objective is to be met.

We are of the view that for this piece of legislation needs to be introduced but have reservations at the timescales laid down by the Executive. Our main concern at this time is that, while it is desirable to protect workers in the hospitality industry from environmental tobacco smoke, little research appears to be available or carried out by the Executive as to the numbers of workers in
the industry that have direct exposure to the harmful effects of tobacco through smoking themselves. Anecdotal evidence we have received suggests this could be as high as 70%.

The STUC General Council took the view, outlined in our response to the Scottish Executive, that in order to protect jobs in the short term that a longer lead in time, perhaps three years, was required.

This would have allowed the Scottish Executive to work with the hospitality trade to ensure support was available to those who work in the industry to stop smoking. If the Executive had been willing to work with employers in the hospitality industry there could have been opportunities to investigate innovative approaches to delivering smoking cessation advice at the front line as the ban approached.

Additionally, a more realistic timescale could have allowed employers to put in place transitional arrangements to ensure the lead in period had minimal impact on profitability and possibly, in turn jobs.

It may be that by insisting on implementation in 2006 the opportunity to work with the employers to reach a vast number of smokers assist them to stop smoking and improve their health has been lost.

If not, why not?

Are there any other comments you would like to make?

The STUC although supporting the ban on health grounds is concerned at the effect that this move will have on employment in the hospitality industry throughout the country. The figures that we have seen indicate uncertainty with regard to the accuracy of the financial impact this will have. The detrimental effect that unemployment has on health also needs to be taken into consideration.

It should also be remembered that many individuals work in the hospitality industry not through choice but necessity. This includes students, young parents and those who need to take additional jobs to supplement low pay in their main employment.

The STUC would reiterate that we support the principal of the ban on health grounds but we would have preferred the Executive to have been more cautious in their approach and used the time to ensure all stakeholders bought into, and supported, the ban and worked together to ensure the main objective of improving Scotland’s health is achieved.

We are also concerned in relation to the enforcement of such a ban. There is concern that Local Authority Environmental Health departments are not resourced to take on this extra work. We would also be cautious in relation to positive comments about the ban being self regulating as a result of potential financial sanctions. Scotland, through reserved legislation enjoys some of the best health and safety regulation in Europe. However, many employers still risk the health and lives of their workers despite the threat of financial penalties.

SUBMISSION BY UNISON SCOTLAND

Introduction

UNISON Scotland welcomes the opportunity to respond to the call for evidence from the Scottish Parliament’s Health Committee regarding the above Bill. While welcoming some of the general principles and aims of the Bill, UNISON Scotland would like to comment on some particular issues highlighted in the call for evidence.

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? Yes

UNISON Scotland support a ban on smoking in enclosed public spaces not just in terms of the general health benefits to non-smokers but also with regard to the implications on worker health and safety. With this in mind UNISON Scotland believes that there should be further guidelines for staff who have to work in service users’ homes (home carers and others) regarding their health and safety at work from ETS.

UNISON Scotland believes that under health and safety legislation employers must protect the health of employees and provide a healthy and safe working environment. With today’s level of awareness on passive smoking it would be difficult for any employer to argue that they are not in breach of these duties by not prohibiting smoking at work in all areas except for specifically designated places where non-smokers have no reason to enter.

UNISON Scotland is also concerned about the role of Environmental Health Officers as the enforcement authority for the Bill. There are concerns over the safety of these officers in enforcing this bill and assurances should be given that the legislation provides adequate protection for such officers in the enforcement of their duties.
Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:03

The Deputy Convener: The convener has now arrived, so I will vacate the chair.

The Convener (Roseanna Cunningham): Thanks very much. I am sorry that I am late. Children from a local primary school are visiting the Parliament this afternoon, so I needed at least to go and say hello to them.

We now move on to our evidence-taking sessions on the Smoking, Health and Social Care (Scotland) Bill. The committee papers include submissions from a number of the organisations that are to give evidence this afternoon. Members also have a copy of the draft Smoking, Health and Social Care (Scotland) Bill (Prohibition of Smoking in Certain Premises) Regulations 2005, which the Executive has prepared for us, and a copy of the Scottish Parliament information centre briefing on part 1 of the bill. In addition, we have a note on the committee’s recent fact-finding visit to Ireland.

I welcome the members of our first panel: Paul Waterson, chief executive of the Scottish Licensed Trade Association; Stuart Ross, chief executive of the Belhaven Brewery Company, who also represents the Scottish Licensed Trade Association; Christopher Ogden, director of trade and industry affairs, Tobacco Manufacturers Association; and Steven Stotesbury, senior scientist with Imperial Tobacco, who also represents the Tobacco Manufacturers Association. I ask the panel for two brief introductory statements—one from the Scottish Licensed Trade Association and one from the Tobacco Manufacturers Association—after which we will move on to questions from the committee.

Paul Waterson (Scottish Licensed Trade Association): Thank you for inviting us to the committee today. Our association is totally committed to improving the health, safety and welfare not only of our members, who are the licensees of Scotland, but of our staff and customers. The matter on which our thoughts diverge from those of the Scottish Executive is on the most efficient way of doing that. A total ban will cause our members to lose their livelihoods and our staff to lose their jobs; there would be a significant impact on health if that were to happen.

Managing smoking efficiently has been the aim of the SLTA for a long time. We are one of the founding partners of the Scottish voluntary charter group, which has worked with the Scottish Executive since 1999 to encourage licensed premises to introduce smoke-free areas and so on. Although the group had exceeded all the Executive’s charter targets, except one that related to paperwork, we realised that voluntary action had served its purpose. In May 2004, we asked the Executive to introduce legislation that would have three key elements: a smoking ban at the bar counter in all pubs in Scotland; a smoking ban wherever and whenever hot food is served; and, within three years, a commitment that 50 per cent of the total floor space in all pubs in Scotland should be given over to non-smoking areas. We further suggested that a review be conducted at the end of the third year and appropriate further steps taken.

The proposals are fair and enforceable; they reflect public opinion which, from Executive research, we know favours smoking restrictions. The proposals echo to some extent the thoughts of the committee’s colleagues at Westminster and are in tune with the European Union, which also wants restrictions to be put in place to protect our trade and give choice to our customers.

Good health messages, like good laws, are easily understood, easily enforceable and backed by public opinion. A total ban is none of those things. Evidence from Ireland shows that jobs have been lost and business is down, especially in rural areas. Some research shows, as it does for Norway, that smoking cessation rates are down since the ban. There has also been an increase in drinking and smoking in the home, which does not reduce or eliminate environmental tobacco smoke risks but accentuates them.

Our view is fully supported by Dr John Reid, who gave evidence recently to the Health Committee at the House of Commons. He said that “A complete ban on smoking in public places is not a good thing on health grounds … because you get a displacement of smoking from some public areas to the home … a percentage of people who previously went to the pub to smoke will now get a carry-out and take it home. I think that the figure in Ireland is about 15 per cent.”

Dr Reid went on to say that “80 per cent of people … did not want a complete ban” on smoking in pubs. He gave a second reason for the adoption of the route that Westminster appears to be taking, which is the recognition that ultimately, in a “free society”, men and women have a right within the law to choose their own lifestyle.

We submit that the dictatorial approach of the Scottish Executive has resulted in the presentation of a bill that is predicated on incomplete and, to a great extent, irrelevant research. We also submit that the health outcome of the bill will exacerbate rather than reduce the problems that Scots experience from passive smoking.
The Convener: Thank you. I invite one of the Tobacco Manufacturers Association’s representatives to make an opening statement.

Christopher Ogden (Tobacco Manufacturers Association): Thank you for inviting me to speak on behalf of the Tobacco Manufacturers Association. I am accompanied by Dr Steven Stotesbury, who is a scientist from Imperial Tobacco. Steven will be able to address any questions that arise from those submissions. We will also deal with any additional points that are raised.

The TMA represents British American Tobacco, Gallaher and Imperial Tobacco, which together create a €12 billion a year industry in the United Kingdom. Of that total, some 80 per cent goes to the Treasury in duty and VAT receipts. Tobacco is a legal product, and we take the view that smoking is a matter of informed adult choice. We acknowledge the fact that there are health risks associated with smoking, and it is quite right that public health authorities promote risk awareness programmes. We cannot possibly object to that. What we do object to, however, is the distortion of science to further an anti-tobacco agenda. It is one thing to tell smokers that they are harming themselves, but it is quite another to say that, by smoking, they are harming others. That is the premise on which section 1 of the Smoking, Health and Social Care (Scotland) Bill is based.

The whole issue of environmental tobacco smoke—ETS—is being driven by a strident, determined anti-smoking lobby whose ultimate objective is a tobacco-free world; ETS is a means to that end. Our view is that the scientific evidence—and it is important to understand that the evidence that exists is epidemiological, not medical—does not prove causation between exposure to ETS and death or disease. Nevertheless, that is being posited as a given by the anti-smoking lobby, which is assiduous in extrapolating dubious relative risk figures into absolute numbers of deaths. We are not alone in our view. In 2003, Richard Smith, formerly the editor of the British Medical Journal, said:

“We must be interested in whether passive smoking kills, and the question has not been definitively answered. It’s a hard question, and our methods are inadequate.”

So the medical profession thinks along similar lines.

We are not in denial of ETS to the extent that we do not acknowledge the fact that other people’s smoke can be annoying and, indeed, irritating to non-smokers. Of course, it can be; however, in the interests of common sense, freedom of choice and natural social justice, alternatives to an outright ban on smoking in public places should be considered. It is perfectly possible to create designated smoking areas with proper ventilation in a range of public places, which can accommodate the preferences of both smokers and non-smokers. Opinion polls indicate that that is what the public want, and among the population at large there is a greater degree of tolerance and a greater sense of fair play than those who are implacably opposed to tobacco might wish us to believe.

The Convener: Thank you. Before we move to the question and answer session, I welcome Brian Monteith to the committee. I understand that he does not wish to ask questions, although he may do so. We will try to accommodate that if we have to. Apologies have been received from Kate Maclean, who is unable to attend the meeting.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I am interested to hear the evidence from the Tobacco Manufacturers Association. In your written submission, you acknowledge the fact that tobacco smoke can be irritating to non-smokers, and you just confirmed that you refute the fact that passive smoking kills people. You will be aware that the committee has received other medical evidence—for instance, from Action on Smoking and Health Scotland. ASH Scotland cites the findings of the International Agency for Research on Cancer’s working group

“of 29 experts from 12 countries convened by the World Health Organisation.”

It states:

“This working group have now published the long-awaited 1,500 page review of all published evidence related to passive tobacco smoking and cancer, concluding that secondhand smoke is carcinogenic to humans.”

Do you still refute that evidence?

Christopher Ogden: My colleague will deal with the specific scientific details in a moment. However, in response to your question, I have to say that we refute that evidence. The relative risk figures in some ETS studies do not warrant the claims that have been made about its effect on health. For example, many are spurious smoking studies that rely on recall of exposure to smoke over many years. Indeed, of the five largest studies into ETS, three determined that, statistically, there was no increased risk to health; one determined that there was a slightly increased risk; and one determined that the risk was slightly decreased. That, in a microcosm, exposes the degree of contradiction and discrepancy in the various studies.

14:15

Mike Rumbles: So you refute the evidence of 29 World Health Organisation experts from 12...
countries.

Although the SLTA does not go as far as the Tobacco Manufacturers Association, its submission says:

“We find the claims of hundreds of deaths a year of non-smoking bar workers as a result of ETS … to be incredible from our own observations.”

Does the SLTA accept that ETS is carcinogenic? If you do not accept that ETS causes hundreds of deaths a year, how many deaths do you think there are and how many of them are acceptable?

Paul Waterson: We see the same risk factors as everyone else, and do not think that they are large at all. Indeed, we think that the claims have been grossly exaggerated. For example, we hear that a bar worker dies every week from the effects of passive smoking. I have been in the trade for 30 years and have to say that neither I nor any of my colleagues know of any bar worker who has died in that way. When we asked about these figures, we were told that one bar worker a week died in Scotland, then that one a week died in the UK, then that it was not really one a week. It goes on and on. Where are these figures coming from?

Mike Rumbles: That is exactly what I want to get at. Are you refuting the medical evidence that ETS is carcinogenic? Are you saying that you do not believe that these deaths are happening?

Paul Waterson: As far as smoking is concerned, a comparison of relative risk factors shows that someone who uses a mobile phone has more chance of getting a blood clot in his eardrum.

Mike Rumbles: But how many people have to die from ETS before you think that it is unacceptable?

Stuart Ross (Scottish Licensed Trade Association): We have read the research that was undertaken for the Scottish Executive by the University of Aberdeen, which concluded that of the 865 people who die each year from passive smoking, 120 experienced second-hand smoke in all types of public places. No one knows how many people experience second-hand smoke in licensed premises, because there has been no research into that matter.

The licensed trade gets frustrated by statements such as the one that the First Minister made to Parliament on 10 November when he presented the bill. He said that 1,000 people in Scotland die each year from the impact of second-hand smoke. However, the Executive’s own research mentions 865, more than 700 of whom experience the problem at home. Our argument is predicated on the fact that the Scottish Executive has carried out no research whatever into the question whether an outright ban will solve or shift a health problem. In fact, as Paul Waterson said in his introductory remarks, Dr John Reid made exactly the same point to the House of Commons Health Committee on 25 February 2005.

Mike Rumbles: I understand the Tobacco Manufacturers Association’s position, because it has made it absolutely clear.

Steven Stotesbury (Tobacco Manufacturers Association): Can I come in here?

Mike Rumbles: I want to pursue this question first.

The TMA has said that people do not die from ETS. However, the SLTA has not said that; instead, by refuting the figures, you are playing a numbers game. You are still not answering my question, which is: how many people have to die from passive smoking before you think that it is a problem that we need to solve?

Stuart Ross: We want fewer people to die from it. We have read a lot of research on the subject and we listened to Dr John Reid at Westminster saying that more people will be harmed by an outright ban on smoking than would be harmed by his proposals. There are obviously different views. You must appreciate that we are business people running bars and trying to do our best within our own domain. We are not health experts, but there is clearly a division of opinion on the matter. We cannot answer the question, but we listen to a lot of people.

The crucial point that we want to make to the Health Committee, and the point that we have been making all along in our various submissions, is that the research that has been conducted by the University of Aberdeen, and upon which the bill is predicated, is incomplete and, to a large extent, irrelevant. That is made quite clear in the document that we submitted, which was prepared by the well-respected Moffat centre at Glasgow Caledonian University. It peer-reviewed the University of Aberdeen work and came to the conclusion that it was based on studies of smoking restrictions in countries round the world, not of smoking bans in any countries. Indeed, there has been only one outright ban of smoking, in Ireland, which came into place in April 2004, as members will all know from their trip to Ireland. The Irish ban has not even had a year to run, and there has obviously been no complete research into its health or financial consequences.

Steven Stotesbury: I would like to make a point, because I am afraid that if we go on our position may not be understood. Our position is not to say categorically that no one can die, or has ever died, from exposure to environmental tobacco smoke. Our position is that the science is inconclusive and that the risk factor cited is extremely small. Unfortunately, for both sides in
the debate, the issue remains uncertain. I wish that I could tell you otherwise, but I cannot. Neither can anyone who follows argue legitimately that the risks are proven on scientific grounds; they are not. Therefore, there is uncertainty, and within that uncertainty I believe that there is the space and opportunity for us to find proportionate solutions that will, while minimising involuntary exposure to smoke, enable smokers to enjoy a legal product in a social setting.

Helen Eadie (Dunfermline East) (Lab): I want to ask about the economic impact of a ban. First, how much duty is generated through taxation for the UK Government from tobacco revenue?

Christopher Ogden: Last year, it was in the region of £9.6 billion.

Helen Eadie: How much money is spent by the national health service in Scotland on treating smoking-related disease?

Christopher Ogden: That question is best answered by the health authorities, but I understand that the cost, for the United Kingdom as a whole, of treating what are described as smoking-related diseases is £1.5 billion.

Helen Eadie: It is £200 million in Scotland, according to the Scottish Executive. Do you know the cost of the payment of welfare benefits to those unable to work due to smoking-related illnesses?

Christopher Ogden: No, I do not.

Helen Eadie: You may be interested to know that it is £40 million. What is the loss of total productivity through smoking-related time off work in Scotland?

Christopher Ogden: Again, those are figures that are no doubt familiar to the public health authorities, but I am not in a position to comment on them.

Helen Eadie: You are arguing that there will be a loss of money to the Exchequer, and I am highlighting the fact that there is also a cost to the Exchequer. If your argument is to be persuasive, I want you to be able to quote to me precisely what the pluses and minuses are. I am asking you about the total loss of productivity through smoking-related time off work in Scotland.

Christopher Ogden: I shall answer that by saying that the tobacco industry has always been at pains not to trade figures in that way. We think that it is irrelevant to the argument, which is to do with the consumption of a legally manufactured, legally sold product that is bought by those who wish to purchase and consume it.

Helen Eadie: The premise of your argument is that it would cost the Exchequer more if we allow you to continue to cause smoking-related illnesses. The answer that I was looking for is £450 million.

What is the estimated cost of sickness absence that is related to exposure to environmental tobacco smoke, for those with asthma and chronic bronchitis?

Christopher Ogden: To clarify, in mentioning the size of the United Kingdom tobacco market, my intention was not to juxtapose those figures with the figure with which you have presented us. We have not approached the economic argument about health costs.

Helen Eadie: You will agree that it is important for any Executive in arriving at a policy conclusion to know what the costs and benefits of the policy are. Your argument has been about costs and benefits, but you cannot provide any persuasive thinking on the issue.

Christopher Ogden: I can do that, but by concentrating on the issue that is at stake, which is not active smoking, but second-hand or environmental tobacco smoke. Our argument on that issue is completely different. Our view is based on the fact that the case is simply not proven that exposure to other people's smoke causes death or disease.

Helen Eadie: Are you really saying that all the World Health Organisation reports on the subject and the various other reports from a variety of universities and experts are not telling the truth?

Christopher Ogden: I would not put it quite like that—I am saying that those reports do not give a definitive position. I should add that organisations such as the WHO, the BMA and the Royal College of Physicians have as an ultimate objective a tobacco-free world; for health reasons, they do not wish people to smoke.

Helen Eadie: When did you read the 1998 report of the UK Scientific Committee on Tobacco and Health?

Christopher Ogden: Recently. There is a more recent SCOTH report, which is a meta-analysis of existing studies, but which adds nothing to the 1998 report.

Helen Eadie: What were the conclusions of the report?

Christopher Ogden: It gave a relative risk factor of 1.24 for lung cancer that is related to environmental tobacco smoke.

Helen Eadie: So the increased risk of lung cancer from environmental tobacco smoke is about 20 to 30 per cent.

Christopher Ogden: The use of percentage
terms—

Helen Eadie: Was that what the report said?

Christopher Ogden: With all due respect to the committee, I will explain what that means.

Helen Eadie: The report talked about the risk of exposure to environmental tobacco smoke.

The Convener: Let the witness answer.

Christopher Ogden: The medical community accepts the figure that, among those who do not smoke and who are not exposed to smoke, 10 in 100,000 people per annum die from lung cancer—the norm is 10 in 100,000 people per year. A relative risk of 1.24 that is arrived at as a result of an ETS study means that 12.4 in 100,000 people would contract lung cancer, the extra 2.4 people being those who are exposed to ETS. That translates into a 24 per cent increase. That sort of percentage increase tends to be headlined in the media, but it gives a misleading impression. A man off the street could go into a pub and think, “Oh my goodness, people are smoking in here—I’ve got a 24 per cent chance of contracting lung cancer.” Of course, that is completely wrong.

Helen Eadie: Are you saying that it is acceptable for society to allow that percentage of people to die from exposure to smoke?

Christopher Ogden: I am saying that we take a different view on the percentages that have been arrived at. More than 60 ETS studies have been conducted, which, as a whole, are insufficient to warrant those figures.

14:30

Steven Stotesbury: I have a follow up point on the SCOTH report. The TMA made an oral submission to SCOTH, which is acknowledged in the report, in which we debated and challenged SCOTH’s conclusions. We had an expert who calculated the figures for meta-analysis and who came up with an alternative range of figures that suggested that, perhaps, the risk was not significant. The point was argued and was acknowledged in the report but, unfortunately, that is where the matter stands. SCOTH did not take those conclusions on board and the report did not state what its view of that alternative was; it simply acknowledges the fact that the TMA came to SCOTH, gave a presentation and left. That is unfortunate.

Helen Eadie: Are you saying that it is acceptable for society to allow that percentage of people to die from exposure to smoke?

Christopher Ogden: I am saying that we take a different view on the percentages that have been arrived at. More than 60 ETS studies have been conducted, which, as a whole, are insufficient to warrant those figures.

Steven Stotesbury: I am aware of that conclusion.

Helen Eadie: Do you deny that that figure of 24 per cent is significant?

Steven Stotesbury: Can I explain what I mean by “significant”? I think that we are talking at cross-purposes.

The Convener: Are you using the word “significant” in a specific statistical sense as opposed to its normal use? That might be where some of the difficulty arises.

Steven Stotesbury: Yes, I am using it in a specific sense. In every study—including the IARC study—the headline figure is an average. However, the result is quoted in terms of a range from a lower figure to a higher figure.

In every study, those who conduct the study are comparing populations. In the usual case, they compare a population of non-smokers who are not exposed to smoke with a population of non-smokers who are exposed to smoke either in the workplace or in the home and examine the outcome in terms of health.

By definition, if there is no difference between...
those two groups, the result is quoted as 1. If, within that limit of confidence—which is another statistical term—the result of a study is quoted as 1, that study is defined as being non-significant. That is the particular and precise meaning of “significant” that I am using. I apologise for the fact that we are talking at cross-purposes.

Helen Eadie: Thank you for that clarification.

The SCOTH report also says that
“new studies on SHS exposure and the risk of heart disease have strengthened the findings of the 1998 SCOTH overview which estimated that the excess risk in non smokers exposed to SHS compared to those not exposed was 23%”.

What do you say about the fact that such evidence and statistics are being produced for us?

Steven Stotesbury: It is right to say that evidence continues to be produced. You will find that people who have an anti-tobacco agenda will pick up on the studies that show something sensational. However, the many studies that suggest that there is no increased risk tend to get left out of their reports and consideration. To return to something that Christopher Ogden said, because we are considering an increase in risk that is incredibly small statistically, it is best to focus on the studies that have included the greatest number of cases. If we consider the largest studies that have been conducted, we get a consistent pattern. Of the top 10 such studies, the top seven are inconclusive in that they include the possibility that there is no difference between the risk to an exposed group and to a non-exposed group. Two of the studies conclude that there is a significant increase in the risk and one concludes that there is a significant decrease in the risk. By any analysis, that is uncertain and inconclusive. I would not call it conclusive proof that there is risk; there is a measure of uncertainty.

Shona Robison (Dundee East) (SNP): One of the problems with the debate is that many statistics are produced by both sides and it is important that both sides produce statistics responsibly. I turn to the section in the SLTA’s evidence on the reduction in smoking incidence. You cite statistics from Norway and argue that “In 2003-4, the incidence of smokers aged 16-24 actually increased by 0.9%”.

You do not mention the fact that the incidence of smoking among the same age group increased in the years 1996-97 to 2002-03. You just take the figure from 2003-04 and say that “From these data you could conclude that the smoking ban markedly decreased or reversed the decline in smoking incidence that was being achieved previously.”

How can you come to that conclusion on the basis of one year’s figures, given that previous years’ figures from before the smoking ban show that there was a rising incidence of smoking in the 16-24 age group?

Paul Waterson: Of course, it has taken 12 years to introduce the total ban on smoking in Norway, so there was a cycle there that we will not have.

Shona Robison: With all due respect, that is not the point.

Paul Waterson: The figures also show that although smoking was being reduced by 3.1 per cent among the whole population before the ban, the rate is now down to 0.3 per cent. There is definitely room for debate about the figures. The figures do not tell us that if we introduce a ban we will stop people smoking totally. That is what we in the licensed trade are saying about the introduction of a ban. The figures exist and we can argue about them, but it is surprising that all we hear all the time is, “Introduce the ban—it’ll be the best thing that ever happened. Everybody’s going to stop smoking. The percentages will go up.” That is not happening in Norway.

Stuart Ross: At the Scottish Executive’s conference on smoking last September we heard speakers representing different countries that have adopted a phased approach to banning smoking talk about the success of their reductions in incidence of smoking. Our argument is predicated on considering whether an outright ban or a phased approach is better. The evidence that we heard at the Edinburgh international conference centre in September suggests that the phased approach works.

Shona Robison: I am suggesting to you that you undermine the credibility of your evidence by pulling out one year’s statistics when all the previous years’ statistics show that there had been an increase in smoking rates among young people, which is a trend across Europe. What you did distorts the picture and is selective. Further on, you say of the statistics:

“This suggests that whilst smoking bans may help
“the light and very light social smokers to give up, and probably reduce the tobacco consumption of heavier users, it does little if anything to cause regular users to stop.”

Even if that were true, would you not say that it was a success to reduce tobacco consumption among heavier users and to get

“light and very light social smokers”

to stop smoking? Would not that in itself be a success?

Paul Waterson: We are not saying that we should not do something to stop people smoking; we are saying that we do not need a ban to achieve cessation rates.
Shona Robison: You said in your written evidence that a smoking ban achieved cessation; I am asking whether it would be an achievement in itself if a smoking ban achieved that.

Paul Waterson: Yes—but we do not need a ban to achieve cessation.

Shona Robison: But you said that a smoking ban had achieved it.

Paul Waterson: Yes. We do not want nothing to happen. We appreciate all that you say, but we are saying that we do not need an overall ban to achieve cessation. Other countries are achieving cessation through restrictions, so why do we need a ban—especially a ban that will be introduced overnight? It has taken Norway 12 years or thereabouts to reach that point.

Stuart Ross: In Australia, there was a ban on smoking in restaurants, which was later extended to bars. That has been an exemplary success in raising the cessation rate. Our argument is not based on health grounds; it is about what will improve health best and what will do least financial damage to business interests. Those are the two fundamental arguments that we would like to put forward—and have been putting forward—to the Finance Committee and the Health Committee.

Shona Robison: Your evidence suggests that the result of a smoking ban such as I have just outlined would not be an achievement in itself. Your evidence says that a smoking ban achieving that would not be an achievement. I suggest that it surely would be an achievement.

Finally I want to ask about the Irish situation. You say that there is no evidence from Ireland, but you cite the experience in Ireland in your written submission. Either there is evidence from Ireland or there is not. You say that in Ireland there has been a shift towards people smoking and drinking at home. I would not dispute that. However, do you accept that many other factors could be behind that? When we were in Ireland, we found that as well as the smoking ban’s being enforced, a number of other changes were taking place; for example, the drink-driving laws were being toughened up. You might screw your nose up at that, but members of the licensed trade in Ireland said that that was having a major impact on whether people drink in rural pubs. There was also a general trend towards people drinking at home because cheap booze is available in supermarkets. That was also acknowledged by the members of the licensed trade, who accepted that it was not just the smoking ban that was having an impact on people coming through their doors. Do you accept that those are other factors that might contribute to more people smoking and drinking at home?

Stuart Ross: You asked quite a lot of questions at once. I will try to answer them in order. First, you asked whether or not there is evidence from Ireland. Ireland is the only country that has imposed an outright ban in a sudden—or dictatorial—manner, as the Executive is proposing. We were asked to give our views on the proposals from Holyrood, we had to get research done. All that was available to us at that time was the four or five-month period of the Irish ban. We commissioned the Centre for Economic and Business Research—a well-respected firm in London that has no axe to grind—to examine the Irish situation and to find out what the percentage of displacement was from on-trade or pub trade to take-home trade. That research was carried out independently and was not influenced by our views. Shona Robison would believe that anything we say is tainted by commercial interests. It was independently concluded that, if the Irish position was replicated in Scotland, there would be a loss of revenue of more than £100 million, a loss of profit of £90 million, a negative shift in jobs of 6 per cent; and a decrease of £56 million in the revenue take from the licensed trade.

Not being economists, we asked the CEBR to carry out research, but we accept that people must decide whether or not to accept the CEBR’s view. As I said earlier, the ban in Ireland has been in place for less than a year, so we do not know the true position in Ireland. However, when Diageo announced its results two weeks ago, its chief executive made great play of the fact that Guinness sales were up in the take-home trade but well down in the pub trade; all the evidence points to a shift. We need to remember that there is always a reason for commercial movements, whether that be the weather, the economy or pricing.

Although the health lobby quotes statistics that are claimed to show a reduction in the use of tobacco as a result of anti-smoking legislation such as outright bans and restrictions, people never mention the fact that the number of smokers is decreasing anyway. People who have a commercial axe to grind always put the best slant on their figures. I am sure that politicians also do that at times.

Shona Robison: To be clear for the record, are you saying that the licensed trade accepts that other factors have been at play in Ireland? Do you accept that factors such as drink-driving laws and the lower price of drink in the burgeoning number of supermarket outlets have been a major factor in Ireland’s increased take-home trade?

Stuart Ross: Whether or not I accept that is irrelevant. We asked the CEBR to conduct independent research. We submitted the research
to the committee, although Shona Robison may not have had a chance to read it. The research concluded that assigning the Irish situation to Scotland would result in the statistics that I have just quoted.

**Shona Robison:** Did the study take account of the other factors?

**Stuart Ross:** Yes. The study’s conclusion, if you read it—

**Shona Robison:** How did the researchers know how much of the change was due to other factors and how much was due to the smoking ban?

**Stuart Ross:** You would need to ask that question of the researchers. I am not here to speak on their behalf.

**Shona Robison:** Are you in touch with the trade association in Ireland?

**Stuart Ross:** Yes.

**Shona Robison:** In that case I have no doubt that the Irish licensed trade association will have given you the same information as it gave us. It told us that the other factors at work are just as important, if not more important, in putting pressure on the industry. Do you accept that?

**Paul Waterson:** The smoking ban "greatly accelerated"—those were the words that the Irish used—the downturn in the Irish licensed trade.

We need to remember that the Scottish licensed trade does not have the same stability as the Irish trade. We are talking about two entirely different types of business. Because of the way in which Irish licences are granted, licensed trade businesses in Ireland tend to be handed down from generation to generation and are asset rich. As such, they are far more able than our industry to handle a downturn in business. Most businesses in Scotland are relatively young, with large loans and rented properties. We are in a much more difficult position, because the trade in this country will not be able to withstand a downturn in business such as the Irish trade has handled.

The smoking ban in Ireland has certainly greatly accelerated the move away from the pub to off-sales drinking. As I am sure members will know, all jurisdictions that have big off-sales drinking populations have problems with alcohol abuse. The health problems that are associated with such abuse are exacerbated and get much worse when drink is taken out of the controlled environment.

**Stuart Ross:** Surely the relevant point is whether or not anti-smoking legislation will improve the nation’s overall health. That brings us back to the question whether more people will smoke and drink at home as a result of a ban and the impact that such a development would have on children. ASH Scotland’s written submission points out that children who are exposed to ETS in their early years are three times more likely to contract lung cancer or smoking-related diseases in later life than are children who are not exposed. If the trend towards take-home drinking is exacerbated by legislation, that is not necessarily good news for health promotion. That is surely a crucial issue that needs to be taken into account, but no research is being done on it. In our view, if the bill is the most important bill that has been introduced in the Scottish Parliament—as the First Minister has claimed—the proposals should be properly and fully researched in respect of relevant like situations.

**Mr Duncan McNeil (Greenock and Inverclyde) (Lab):** I will turn to another matter that we will probably never resolve, even though we have spent hours and hours on it. We will have one more attempt. Is smoking a health hazard? Can we agree on that?

**Christopher Ogden:** As I said in my opening statement, we do not disagree that health risks are associated with smoking.

**Mr McNeil:** A yes or no answer would be fine, because there are other people to get in.

**Christopher Ogden:** That was a yes.

**Mr McNeil:** We have just heard ASH being quoted as saying that exposure to passive smoking increases the risk and health hazard. I accept that. Do you agree?

**Christopher Ogden:** No.

**Mr McNeil:** So—a person who is not exposed to passive smoking is at the same risk as someone who is exposed to it seven days a week, eight hours a day.

**Steven Stotesbury:** That is too close to call.

**Mr McNeil:** That is a difficulty. If you are not prepared to concede that, it is difficult for the committee to take seriously your evidence and your claim that you accept fully your duty of care to your staff. If you are not prepared to go from agreeing that smoking poses a health risk to agreeing that passive smoking also poses a risk—

**Stuart Ross:** I think—

**Mr McNeil:** I am coming to my question. I should not have made that comment, but my line of questioning is about—

**The Convener:** It would be fair to let the witnesses respond.

**Stuart Ross:** You cannot lump together the four of us who are on this one panel. Paul Waterson and I represent the Scottish Licensed Trade Association and have no links with the Tobacco
Manufacturers Association. Of course we accept the risk. Our argument is predicated on that, and our submission to Tom McCabe last May was about how we would handle it. We put to him a five-point plan, the main elements of which Paul Waterson outlined. Since 1999, we have been working with the Scottish Executive—through the Scottish voluntary charter on smoking in public places—to encourage more smoke-free areas. Our objective is to restrict the use of tobacco in licensed premises without fundamentally damaging business interests while still providing freedom of choice for the individual, as supported at Westminster by John Reid, whom Paul Waterson quoted.

Mr McNeil: You said that earlier. Does the SLTA accept that smoking is a health hazard and that increased exposure to passive smoking is also a health hazard?

Stuart Ross: Yes, but the relative risk of passive smoking has to be taken into account.

Mr McNeil: Yes or no will be fine.

Stuart Ross: We are saying that the relative risk has to be taken into account, as does the relative risk of shift.

Mr McNeil: That is useful, particularly as far as you attitude to your staff is concerned. On page 2 of your submission, you claim that there is a “low level of staff exposure”.

How have you measured that? What risk assessment has been carried out? What air pollution tests has your industry carried out to establish the bald statement that there is a “low level of staff exposure”?

Paul Waterson: There are building control rules and regulations to which all licence holders must adhere, so the atmosphere must be kept within certain limits. However, we have the problem that we are told that ventilation does not work. We have done research—we are back to the problem of whether you agree with the research that we commissioned—that showed categorically that relatively inexpensive ventilation systems work, but we are told that we need a hurricane blowing through our premises to make the air clean enough. We have a problem with that. Licence holders are under a duty of care under building control regulations and other legislation. That looks after the staff side.

Mr McNeil: So you are not aware of any risk assessment that has been carried out throughout the establishments that you represent to establish whether you can make the claim that there is a “low level of staff exposure”.

Stuart Ross: Although I have worked in the industry for 30 years and have been the boss of Belhaven for 20 years, not once has a member of staff complained to me about passive smoking in the work environment.

Mr McNeil: You came to us today saying that you are responsible employers. Have you carried out a risk assessment in any of, or throughout, the establishments that you represent to allow you to submit that there is a “low level of staff exposure”? How are you able to make that statement without measuring exposure?

Stuart Ross: The Scottish Executive’s own research shows that health problems because of passive smoking are mainly experienced in domestic environments. You need only read the University of Aberdeen research to draw that conclusion. Six sevenths of ETS problems come from domestic sources, not from public places. Licensed premises are only one small part of a vast array of public places, so you can draw the conclusion from that report that the incidence of staff experiencing passive smoking problems in licensed premises is tiny.

Mr McNeil: You have no scientific basis on which to say that. You have not even carried out a risk assessment, as you would be required to do.

Stuart Ross: Could you tell me how to carry out a risk assessment?

Mr McNeil: Yes.

Stuart Ross: How would you do it?

Mr McNeil: You would speak to the Health and Safety Executive and get its chemists to perform air pollution tests in and around bar areas, which you claim—

Stuart Ross: We have done that with ventilation. That is exactly what Paul Waterson said.

Mr McNeil: Not every bar that I go into has ventilation.

Stuart Ross: That is exactly the point. You are right that ventilation has been adopted by Italy as the solution to the health problems. It is just about to be adopted by Germany. It has been adopted by the European Parliament, in which 544 out of 600-odd members of the European Parliament voted in favour of ventilation as a solution to ETS problems. You say that we have not considered ventilation, but we have considered it, and we have encouraged our members to use it. Indeed, in Belhaven, we put ventilation into every unit that we upgrade.

Mr McNeil: You mention the Health and Safety Executive in your submission in defence of some of your claims, but you have not involved the HSE.
in carrying out a risk assessment. There is a well established hierarchy in measuring risk. The first point is that you eliminate the risk, not that you ventilate the cause of the risk and then remove it only subsequently.

Stuart Ross: If you read the University of Glamorgan report you would see that it concluded that a pub in Glasgow that had ventilation systems and in which smoking was allowed had fewer contaminants in the air than a no-smoking pub in the centre of the city that did not have—

Mr McNeil: If you have not—

Stuart Ross: You are not listening.

Mr McNeil: If you have not evaluated the hazard and the risk, how can you evaluate what type of ventilation to use?

Stuart Ross: We are not scientists. We are businessmen.

Mr McNeil: You have not done anything in that regard to protect your staff.

Stuart Ross: That is nonsense—of course we have.

Mr McNeil: Your staff are exposed to passive smoking seven days a week and eight hours a day.

Paul Waterson: So, do you not agree that ventilation does any good at all—you think that it does absolutely no good?

Mr McNeil: Ventilation has to be introduced alongside a proper assessment of the hazards and risk to your employees. You have confirmed today that you have not taken that seriously.

Paul Waterson: That is not the case. Guidelines on clean air have been laid down and we are within those guidelines.

The Convener: Where do the guidelines come from?

Paul Waterson: They are health and safety guidelines.

The Convener: Do you comply with them currently?

Paul Waterson: Research shows that we are well within the guidelines; in fact, the non-smoking pub had more problems than the smoking pub. That is one of the reasons why we have said that we know that it can be uncomfortable for bar staff and that we will ban smoking in bar areas. We have said that openly. To do so is fair and consistent with what you are saying.

Mr McNeil: You mention “substantial control methods” on page 3 of your submission. What scientific basis do you have for using the word “substantial”? Who has validated them? Has the HSE validated them, and how can it do that throughout the pubs that you represent?

Paul Waterson: The methods are “substantial” within the limits that are laid down.

Mrs Nanette Milne (North East Scotland) (Con): I confess that I am beginning to be blinded by science. Do you have any further comments on Professor Hole’s report that was commissioned by the Scottish Executive and NHS Scotland, and on the University of Aberdeen review? Do you have any points to raise that have not been covered? I am slightly unclear as to your concerns with both.

Steven Stotesbury: I want to make two comments. First, I do not want to say too much about Professor Hole’s report, but I feel that it is unfortunate that in presenting his evidence he has taken the position that there is a certain level of risk and has extrapolated figures from that. It is disappointing that he did not begin by examining the balance of evidence in various studies and considering the variability or uncertainty of that risk estimate.

15:00

Mrs Milne: Are you saying that he has plucked the initial figure out of the air?

Steven Stotesbury: No.

Mrs Milne: Then how did he arrive at it?

Steven Stotesbury: He has based the figure on a particular report without verifying it or testing its variability. For instance, using the SCOTH report’s relative risk figure of 1.24 would in all fairness require an examination of SCOTH’s assessment of the uncertainty of that figure and the whole range of variability.

Mrs Milne: And what about the University of Aberdeen review?

Steven Stotesbury: I am not familiar with it, so I will not comment on it.

Mrs Milne: Does the SLTA wish to comment on that review?

Paul Waterson: That review covered areas where smoking was restricted, rather than banned outright. For example, it considered one study on the effects of smoking in Californian hotels and restaurants, but not in pubs. We do not think that that is the right foundation for decision making.

Stuart Ross: I should point out that those researchers had nothing to look at—when the research was commissioned, an outright ban had not been imposed anywhere in the world apart from Ireland, where it had been in place for only a couple of months.

Mrs Milne: So those researchers were not
comparing like with like.

Paul Waterson: Definitely not.

Mrs Milne: We have already been told that ventilation can remove the obvious effects of smoke—that is, the smoky atmosphere—but that unless it creates a tornado it cannot remove carcinogens from the atmosphere. Do you have any scientific comments to make on that claim?

Steven Stotesbury: Yes. First, I should make two comments, because the previous argument that we had on ventilation leads me to think that the committee might be under the false impression that, on the one hand, there is fresh air and, on the other, there is air that is contaminated with ETS. In fact, the air around us and in most indoor environments is full of chemicals. If members want it, I can quote chapter and verse from reports. Suffice it to say that many of the chemicals in environmental tobacco smoke are already around us and come from a variety of sources, such as varnish on wood, and from paint, carpets and the aftershave that we put on in the morning. A chemical examination of that air would show that it was a soup. I am sorry to say that, but that is the reality of the situation.

Measuring the chemical effect of smoking in such a venue would show that its impact on the number of chemicals present would be very minimal. For example, there might be a very small increase in carbon monoxide. There would also be a sudden peak in nicotine, which is a major product of ETS. However, many of those chemicals, which are accepted as carcinogens, are present no matter whether there is ETS. As a result, ventilation is a very good solution; it deals with the chemicals that are present in ETS as well as all the chemicals that are present in a room, and makes the environment more pleasant for us all.

I am familiar with the argument that although ventilation can deal with many chemicals it cannot deal with carcinogens. I do not know where that has come from, but it is not a scientific argument. Everything that diffuses into the air in its vapour phase becomes mixed. That is a physical fact; indeed, it is one of the gas laws. Gases mix. As a result, if they are removed, they are removed together at exactly the same rate. I do not know who argued that carcinogens are left behind and become concentrated, but the claim is completely and utterly false.

Mrs Milne: Are all solid particles removed by ventilation?

Steven Stotesbury: Solid particles behave differently. It can be easier to remove them, because they can be filtered out. They do not behave like pure gases, but they float in the air and can be removed in approximately the same way.

Mrs Milne: Are the carcinogenic substances mainly gases or solids?

Steven Stotesbury: There will be carcinogenic substances in both phases. Some substances will be apportioned between them, but we do not want to go into that level of complexity.

The Convener: I am keeping an eye on the time and I ask members to make their questions questions, rather than speeches.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): We accept that cigarettes are an addiction and all packets carry a message indicating that they kill. You accept that there is a decline in smoking in the population and that probably 70 per cent of people do not smoke. You are catering for the 30 per cent who still smoke. Do you accept that in this country the number of people who smoke is decreasing, but that in other countries, especially in the east, it is increasing? We are selling more cigarettes abroad.

The Convener: What is your question?

Dr Turner: I have asked a question. We can run things quickly. We accept that cigarettes kill—that is stated on every packet.

The Convener: That is not a question—it is a statement. Ask a question.

Dr Turner: I am asking whether the witnesses accept that cigarettes kill, as is stated on the packets. The answer should be a quick yes.

Stuart Ross: We have already answered the question.

Dr Turner: Are you not catering for the 30 per cent of people in this country who still smoke?

Stuart Ross: All the research shows that 60 per cent of people who go to Scottish pubs smoke. We do not cater for smokers; we cater for people who want to eat and drink. Some of them happen to smoke. We do not make a living out of selling tobacco.

Dr Turner: Exactly. You will have a business plan for the future if a ban is introduced. You have probably looked into the benefits of a ban, some of which have been mentioned. Cleaning bills, fire risk and so on would go down.

Stuart Ross: Your point is absolutely valid. There is an opportunity for all public houses to get more business from people who do not like to go into smoke-filled environments. However, 60 per cent of people who currently go to pubs smoke, so there is a big risk that those people will transfer their drinking habits from the on-trade to the take-home trade. My crystal ball is no better than yours. We can examine only the research that is available. We have commissioned research from the CEBR—the research has been presented to
the committee—that shows the evidence from Ireland in the period for which it is available. That is not a guess; it is assigning known information from Ireland to Scotland.

Dr Turner: Public houses in Ireland accepted the situation and changed their business trends. I suppose that you would do the same.

Let me be more scientific and talk about the duty of care. In New York, a decision was made to carry out blood tests. I would like to hear your scientific take on those tests, which measured the levels of cotinine in the blood of staff, rather than particles and carbon monoxide. The tests found that in pubs and restaurants in which there was a ban on smoking, those levels were reduced markedly. What do you have to say about that?

Steven Stotesbury: I am not familiar with the study, but cotinine is a well-known biological marker.

Dr Turner: Do you think that it was sensible to carry out the tests in New York?

Steven Stotesbury: It was a reasonable thing to do. I will be precise—you cannot infer a direct quantitative relationship between levels of cotinine and exposure to tobacco smoke. However, qualitatively you can tell the difference between an exposed and a non-exposed group. Some people try to extrapolate amazing things from cotinine levels—

Dr Turner: Do you accept that that is better than doing nothing? If you had figures from before, during and after exposure, they might be statistically significant over time.

Steven Stotesbury: They would give an indication of exposure or non-exposure.

Dr Turner: If you wanted to look after the people in establishments, you would not look to carry out air tests, because you think that the air is okay. However, we have heard evidence that sometimes people do not turn on the ventilation, because it is too expensive. Would it be a good idea to carry out blood tests?

Steven Stotesbury: Because I am interested in air-quality measures—I hope that I have already made a case for their being a better route to go down—I am more in favour of measuring air quality and air-quality indicators than in an intrusive practice such as taking blood samples from staff.

Dr Turner: Staff might agree to the procedure if they thought that you had their interests at heart.

It has been said that the proposals will result in more smoking at home, but the experience in Australia seems to show that a reduction in smoking in the workplace results in less exposure to smoke for children at home. Do you disagree with that?

Stuart Ross: I agree that the route that Australia took was successful. The tobacco restrictions there were introduced gradually, over a period of time, which meant that people had a chance to get used to the restrictions and so did not switch from going out to socialise to socialising at home.

Dr Turner: We have been aware for more than 35 years—probably 40 years—that cigarettes are not good for us and that even to inhale the smoke of cigarettes may not be good for us. Given that Scotland has the worst health record in the UK, and perhaps in Europe, it is not a surprise that we are trying to do something about cigarette smoking.

Paul Waterson: Yes, but the issue is what we should do about it and what will work. In comparing the Australian licensed trade with ours, we should bear in mind the climate and the other variables. We must consider what will work and have a significant impact here—nobody questions that. We do not believe that a ban on smoking in licensed premises will have the impact that you perhaps think it will have. The point that we are trying to make is that a ban would simply shift the problem somewhere else.

Dr Turner: Do you accept that cigarettes and alcohol go together and that people drink more when they smoke? There might be a cost benefit for you in encouraging people to smoke.

Paul Waterson: As I had the first no-smoking pub in Scotland, I can say that there are different markets. That was in the mid-1980s, so perhaps it was a bit ahead of its time. I know the arguments, but the point is that, at present, people have a choice. Customers should continue to have the choice about where to go. We should increase ventilation levels and ensure that the trade adheres to our proposals, which is why we want legislation on the issue. That is the way in which we should start the process, rather than going straight for a ban that we do not believe will work and that will affect business, as we have heard.

Stuart Ross: That is our view—you might have a contrary view, to which you are entitled, but the fact is that the most important piece of proposed legislation that the Scottish Parliament has introduced is not based on research. There has been no research into whether the proposals will solve, shift or even exacerbate the health problem. You may argue that I say that for reasons of commercial advantage, but it is a fact.

Dr Turner: Given that you agree that environmental tobacco smoke is a health hazard and that you would like a gradual implementation of measures, when do you believe that a ban could be introduced in Scotland?
**Stuart Ross:** Under the proposals that we put to Tom McCabe, there would be no smoking in any premises where food is served and no smoking at the bar counter in any premises. Smoking would be allowed in pubs where no food was served, but that would be restricted to 70 per cent of the airspace, which would be reduced to 60 per cent and then 50 per cent. After three years, the measures would be reviewed, taking account of public opinion shifts and the health of the nation. We put that proposal to Mr McCabe in May last year, but there has been no engagement with us on them. Sure, we had a public consultation, during which we stood on the same platforms as ASH and other pro-health and anti-tobacco lobbies, but at no stage in the consultation process did the Scottish Executive sit down with us to discuss how our proposals would work. As Scottish businessmen with a vested interest in our concerns and in promoting health in Scotland, we are naturally frustrated by that.

**Dr Turner:** The measures would last for only three years, according to your evidence.

**Stuart Ross:** We said that we would review them after three years. I dare say that, if the proposals were not regarded as robust enough, everything would be open to negotiation.

15:15

**Janis Hughes (Glasgow Rutherglen) (Lab):** You mentioned a number of things that you could have done, such as increasing the amount of ventilation. Why did those things not happen during the period of the voluntary charter?

**Stuart Ross:** They did.

**Janis Hughes:** Did they happen on a scale that any of us would have noticed?

**Paul Waterson:** We achieved all the targets that were set by the Scottish Executive—they were not our targets—except one, which was on paperwork. The voluntary charter was successful. We approached it from a standing start and not many resources were put into it, so the fact that we achieved what we achieved showed great commitment from the trade. Furthermore, in our new proposals we said that we agreed that there should be legislation. We said that, at first, the legislation should be based on the elements of the voluntary charter so that we could drive the measures forward quicker. In any trade, there are always people who lag behind others. There are responsible operators in every business, but sometimes there are irresponsible operators. We asked for legislation and we moved on to our new proposals to drive things forward. We were aware that, although we had achieved the targets that were set, things were perhaps not moving quickly enough. We say that openly. That is why we wanted legislation.

**Janis Hughes:** How many pubs implemented the voluntary charter and had an area that was designated as smoke free?

**Paul Waterson:** I do not have the figures in front of me.

**Janis Hughes:** Roughly.

**Paul Waterson:** We certainly achieved the targets that were set.

**Stuart Ross:** I would say that at the moment about 15 to 20 per cent of Scottish pubs have an area that is designated as smoke free.

**Paul Waterson:** We want that to increase to all pubs.

**Janis Hughes:** That is perhaps the problem. The changes did not happen quickly enough.

**Stuart Ross:** Your point is valid. The Scottish licensed trade is definitely not perfect in relation to air quality. One of the problems is that the more responsible operators will invest to improve air quality, whereas others, who are not members of trade associations or are not committed to the issues in the way that we are, will do nothing. That is why we need a level playing field through legislation. However, you must admit that, because of the investment in Scottish pubs in the past 20 years, the condition of air in them is much better than it was. Progress was being made, although it could be made faster. One of our arguments is that such improvements should be made mandatory.

**Janis Hughes:** You mentioned the need for a level playing field and you say in your evidence:

“it was unlikely that ... accelerated uptake could be achieved by voluntary measures, as there were widely perceived commercial disadvantages to those operators restricting or banning smoking”.

In evidence on Stewart Maxwell’s member’s bill, we heard—perhaps from you—that his proposals would not give you a level playing field because they would displace people who wished to smoke from places where food was served; smoking would be banned in such places, so people would move elsewhere. Is the Executive’s proposal a level playing field, in relation to your commercial concerns?

**Stuart Ross:** The Scottish Executive’s proposals obviously represent a level playing field, but our argument is that the bill is not necessarily the best way of achieving the health results that you are looking for, because of the displacement issue. Moreover, the imposition of an outright ban dictatorially against the wishes of 82 per cent of the Scottish public will have a big impact on our businesses and we are naturally concerned about that. Those are our two fundamental concerns.
Janis Hughes: You mentioned earlier that no specific research has been done on the effects of passive smoking in the home, but you claim—

Stuart Ross: I said that no research has been done into whether an outright ban or the phased introduction of tobacco restrictions would result in displacement of the ETS problems from public places to—

Janis Hughes: I may have picked you up incorrectly, but in your submission you say: “85% of health problems caused by Environmental Tobacco Smoke are derived from domestic situations”. Where does that figure come from?

Stuart Ross: The Scottish Executive’s research, which was conducted by the University of Aberdeen, concluded that 865 people die from passive smoking in Scotland each year but that only 120 of them experienced the problem in public places—not just licensed premises, but all public places.

The Convener: We are just about at the end of this session. Could you just clarify one thing? Your submission says that the SLTA “represents the interests of over 1800 self-employed licensees.”

Your evidence also says that those people mainly work in pubs. Do you have a rough figure for how many pubs are not in the SLTA?

Stuart Ross: There are 5,000 public house licences in Scotland. The SLTA is also a member of the against an outright ban group, which has been promoting the phased approach. The SLTA is only one constituent part of the AOB group, which represents 3,500 Scottish public house licences.

The Convener: The SLTA submitted a petition to the Public Petitions Committee and we have just been notified that that petition is being referred to the Health Committee. It will be incorporated into our stage 1 evidence. I thank you for that and I thank you all for coming. The session has been fairly gruelling, but I do not suppose that you expected anything else.

Paddy Crerar (British Hospitality Association Scottish Committee): Although I represent the BHA in Scotland, I am also an independent hotelier with a hotel chain in Scotland. If a ban were to be imposed, the BHA would support it for the reasons that are set out in our submission to the Scottish Executive. However, we require further work to be done on the exemption of hotel bedrooms.

The Convener: May we now hear from CORCA? Mr Ross?

George Ross (Royal British Legion Scotland): I should point out that my organisation is not an executive member or a body of CORCA. I represent the Royal British Legion Scotland.

Ian McAlpine (Coal Industry Social Welfare Organisation): Perhaps I can assist. CORCA is an umbrella body. It is made up of various bodies including the Royal British Legion Scotland, CISWO, the Working Men’s Club and Institute Union, and Conservative and Labour clubs. George Ross and I are here primarily on behalf of our own organisations, but we are also wearing the general CORCA hat.

The Convener: Thank you. We will go straight to questions.

Shona Robison: I have a question of clarification for the British Hospitality Association. What sort of relationship do you have with the Scottish Licensed Trade Association? Do you work closely together?

Paddy Crerar: I believe that we have a very good relationship. We work closely together on most subjects.

Shona Robison: Do you have dual membership?

Paddy Crerar: I personally do not.

Shona Robison: I am sorry; I meant to ask whether your members can also be members of the SLTA.

Paddy Crerar: Yes, they can.

Shona Robison: Okay. Has the fact that the two organisations are taking very different positions on the issue led to a rigorous debate behind the scenes?

Paddy Crerar: The positions that we are taking are not really that different. Our position is that, if a ban were to come into place, we would support it in the form that is proposed. The BHA has accepted, perhaps wrongly, that the ban is a fait accompli and that we should therefore try to ensure that the bill contains proposals that best suit our members.

Shona Robison: That is helpful. My next question is whether your concern about hotel rooms relates to the fact that no mention is made
of them on the face of the bill. I understand that the Executive’s intention is that the bill will not apply to hotel rooms. Is that also your understanding? If so, do you want the exemption to be made explicit in the bill?

**Paddy Crerar:** That intention is not clear in the bill. My understanding is that hotel rooms could be covered, but we think that they should be entirely exempt.

**Shona Robison:** My understanding is that they would not be covered. Obviously, we will have to pursue the point with the Executive. Your clear position is that the exemption should be on the face of the bill. You think that there should be no ambiguity. Is that correct?

**Paddy Crerar:** Yes.

**Shona Robison:** Thank you.

**Dr Turner:** I, too, have a question of clarification about hotel rooms. I am sure that I read somewhere that, although hotel premises are covered by the bill, it may be possible to designate smoking and non-smoking rooms.

**Paddy Crerar:** We would not wish to support that.

**Dr Turner:** So you would rather that all hotel rooms were smoking rooms.

**Paddy Crerar:** Yes. We would rather have them all as smoking rooms. We think that designating certain rooms as smoking rooms and others as non-smoking rooms would be unworkable.

**Dr Turner:** We are talking only about bedrooms.

**Paddy Crerar:** We are talking only about bedrooms.

**Dr Turner:** Are you happy about the provisions as they relate to the downstairs bars and restaurant areas?

**Paddy Crerar:** “Happy” is too strong a word. If the Parliament decides to go ahead with a ban, our submission sets out how we would support it.

**Dr Turner:** You would accept the ban for downstairs but not for the bedrooms, which you would like to be within your jurisdiction. Your proposal has cost implications, however. The bedside rugs and carpets in many hotel bedrooms have cigarette burns. What is the annual cost of repairs and redecoration that result from smoking damage?

**Paddy Crerar:** I am more concerned about the potential loss of business. We have a number of clients from Spain and we are growing business with Poland and Russia—the sort of places that were mentioned earlier where a high percentage of the population smokes. If smoking is not allowed in the bedrooms, those customers would have nowhere to smoke on our premises. The potential loss of business far outweighs the cost of repair and replacement.

**Dr Turner:** That is clear. Thank you. You are also concerned about recruitment. In your submission, you say:

“As currently drafted section 7 appears to suggest that owners or head landlords may be proceeded against even in circumstances where they are not in day to day control of the business. This is not compatible with natural justice and should be addressed.”

**Paddy Crerar:** Under the bill, if someone persists in smoking on our premises despite the fact that we have done all that we can to prevent them from smoking, short of physically throwing them out, I understand that the owner of the business, who may not be the manager of the business, could be acted against in a court of law. The BHA thinks that that is unfair.

**Dr Turner:** On recruitment, do you not think that people would want to work in premises where there was no smoking? Allowing smoking might be a factor in their not wanting to work there.

15:30

**Paddy Crerar:** The truthful answer is that I think that there are probably as many people who would be happy working in a smoking environment as there are those who would be happy working in a non-smoking environment. That is the nature of the trade. A lot of our staff—about 70 per cent in our company—smoke, so I cannot see that there would be a positive or negative effect on recruitment.

**Dr Turner:** Do you think that factors other than a cigarette ban would cause trouble in recruitment?

**Paddy Crerar:** Yes.

**The Convener:** I would like to clarify something. In the past few days, we have received the draft regulations. There is a clear indication in the guidelines that the regulations have been drafted in such a way as to include hotels, guesthouses and bed-and-breakfast accommodation within the scope of the law, but to allow proprietors, if they wish, to designate bedrooms in which smoking may be permitted. Are you saying that you would prefer bedrooms to be clearly excluded from the guidelines?

**Paddy Crerar:** If the guidelines say that the rooms can be designated by the owner, that is effectively the same thing.

**The Convener:** So you would be happy with that.

**Paddy Crerar:** Yes.

**The Convener:** Will you ensure that you make that position clear in the consultation on the
guidelines, just in case there is any dubiety about that?

I would like to ask a question of the two witnesses from the Committee of Registered Clubs Associations. I understand that you each represent a different group within CORCA—one the Royal British Legion clubs, with which all of us will be familiar, and the other the miners welfare clubs, which, for geographical reasons, will not be so familiar to all committee members. I would like each of you to tell us the views of your individual organisations about the ban.

Ian McAlpine: I represent the Coal Industry Social Welfare Organisation Scotland, which is an umbrella body for miners welfare schemes. As you will appreciate, with 53 independent clubs and approximately 50,000 members, there are widely varying views about the bill and its impact, both positive and negative, on registered clubs.

My organisation’s view is that we wholeheartedly support the prohibition in enclosed public places. Our stance is based solely and specifically on the fact that it is a health and safety issue. Any employer has a duty of care to employees, and that duty of care must extend to the membership, user groups and volunteers who are using the facilities.

We are a mining charity and our whole ethos is to promote quality of life, so it would be wholly inappropriate to support a pro-smoking lobby. However, we acknowledge that there are wide and differing views, and there are individual management committees and individual members who would prefer CISWO not to support the bill but to lobby the Parliament to make amendments to align the bill with the more diluted proposals south of the border. There are individuals who are genuinely concerned about the impact of the bill on their way of life. There is also genuine concern about the impact of the bill on the income generation of certain community clubs and the worry is that those borderline clubs might close if income dropped to such an extent that they were no longer viable, because of a perception that smokers would stop using the facilities. There are also individuals who just completely ignore the health risks, who will quite happily ignore the fact that smoking is potentially addictive and harmful and who will happily support the pro-smoking lobby.

In the CISWO miners welfare network there are already management committees that are partnering health professionals and agencies that provide practical support in their premises to their membership and the wider community. With encouragement, they are organising support groups and smoking cessation courses that link in with nicotine replacement initiatives. They are helping deliver the Government’s ambitions in relation to peer education and a healthy lifestyle. Given that the majority of the population are non-smokers and that the bill will allow them to socialise in a smoke-free environment, there is a strong argument that it might ensure a more secure future for many facilities in the medium to long term. However, careful management and support of what will be a radical change will be needed in the short term for obvious reasons. Some people are clearly up for the challenge, but some might never be.

On some of the other agencies that come under the CORCA banner, the general secretary of the Club and Institute Union has intimated to me that there is a general consensus that its members would much prefer to have an arrangement whereby clubs provide smoking areas and separate non-smoking areas; in their view, that would be adequate. I have not had any direct dialogue with either the Conservative or the Labour clubs. I imagine that there is quite a cross-section of opinion there. Perhaps George Ross can pick up on that.

The Convener: Before we hear from George Ross, how did you go about ascertaining the views of the miners welfare clubs? What was the internal process that has enabled you to represent the views of that set of clubs?

Ian McAlpine: In my line of work I support the miners welfare scheme management committees on a variety of initiatives and give advice on best practice. In recent years I have been involved proactively in coalfields community regeneration and assisting in setting up projects to develop facilities and their usage.

The Convener: I appreciate that, but how did you ascertain the views of clubs specifically on the proposed ban?

Ian McAlpine: I have not spoken to all management committees on the ban specifically. That is why I intimated earlier that there was a wide and varying set of views on the subject. I can speak for CISWO and I can highlight to you the differing views on the ban.

George Ross: I am the legal affairs officer of the Royal British Legion Scotland. Although I have responsibility, I have no authority over any of our branches or branch clubs; they are completely separate units. We have 214 branches in Scotland, 87 of which have clubs. Clubs are brought about by members producing a viable plan and presenting it to their branch; if the plan is accepted, a club will be born. In our 214 branches and clubs we have approximately 59,000 members. I have no authority over the branch clubs, but I carried out a small exercise in Edinburgh and the Lothians and in Glasgow and the western counties. I found that the minority—
approximately 20 per cent—were looking for a complete ban. Of the other 80 per cent, 65 per cent did not want a ban and 15 per cent said, “Okay you can have a ban, but please exempt our clubs.” They took the view that a lot of smoking occurred in domestic areas, such as households.

If the ban were to come into being—and it looks as if it will—many of our clubs will have difficulty staying alive. Many of the Royal British Legion clubs, which serve the ex-service community and those who believe in the aims and objectives of the Royal British Legion, will close. They provide the only means within our organisation for members to socialise and enjoy comradeship.

An important historical fact is that in the first and second world wars, cigarettes were issued to soldiers, sailors and airmen by the Government. Following my 23 years in the Army, I moved to the Royal British Legion Scotland, where I became a war pensions appeal officer and presented cases at tribunals. Many of the people whose cases I presented had chest problems due to smoking-related diseases such as heart disease. Their defence was that they caught the diseases from which they suffered through smoking and that the Government had issued them with cigarettes to smoke during the wars. The Government's response, which was relayed through the Veterans Agency and Department of Social Security representatives, was that an individual's decision to smoke was a matter of freedom of choice and that, therefore, the sufferers had brought their conditions on themselves.

Now, however, we are looking at a complete turnaround. The Government, which issued cigarettes to the servicemen at that time, is introducing a complete ban that will mean that the ex-servicemen will have nowhere to go. The Royal British Legion feels that the Government should accept some of the blame.

Let us consider the issue of drugs. Nowadays, the Government issues needles and so on to drug addicts—those who inject drugs, smoke cannabis and take magic mushrooms—in order to help them. I heard that nicotine patches are being issued to younger smokers. If that is the case, I believe that the Government should issue nicotine patches free of charge in every chemist's throughout Scotland. That would help to educate those who smoke that smoking can cause fatal diseases.

I feel strongly that the Government has a responsibility in this area.

**The Convener:** That is a fair point. It is not germane to what we are doing with the bill, but I am sure that every member of the committee will have taken on board what you have said.

**Mike Rumbles:** I am a member of the Royal British Legion and served in the Army for 15 years. I remember saying to the soldiers, “Let's have a smoke break now.” The phrase rattled off the tongue; it was the accepted parlance and it was accepted that people would smoke. However, time has moved on and we are all aware of the medical evidence on smoking and so on.

Mr Ross, you said that some of the clubs would close. I accept that there will be an economic impact and that the evidence from Ireland suggests that a certain number of people would not come to the club or the pub. However, what evidence do you have for your claim that some of the clubs would close?

**George Ross:** Some of our clubs are so small that they survive only due to the money that is put into a particular gambling machine. That is the only income that they have from which to pay the employees who run the bar. If a smoking ban is brought in, our membership will be reduced in more than one way. Under sections 107 and 108 of the Licensing (Scotland) Act 1976, our membership has to be clearly identified and the ordinary member must be the main member. Associate members cannot rise above that level; if they did, we would be breaking the Licensing (Scotland) Act 1976. Under a smoking ban, our low membership—of both ordinary members and associate members—would deplete further and the club would close.

**Mike Rumbles:** You accept the fact that there is a public health argument. We are talking about saving lives, but we are also talking about some of your smaller clubs closing. I know that you are here to protect the interests of your members, but how do you balance the economic argument and the public health argument? You have just told us that you are involved with claims for your members against the Government on public health grounds.

15:45

**George Ross:** For your information, I am a non-smoker, but I understand that it is about the freedom of the individual to smoke or not to smoke. That is what the Government said, regarding our pensions appeal tribunals. It is the individual's choice whether to smoke or not to smoke. Those individuals who smoke need not go to clubs; I am sure that they can go somewhere else to find what they are after, but if they cannot, that is discrimination against the smoker.

More important—I referred to hard drugs being taken—smoking is taking a drug. The Government and the law are moving in and closing the ring on the suppliers. The newsagents and shops, including Tesco, that are supplying cigarettes are supplying drugs. It is exactly the same—there is
no getting away from it. Smoking is taking a drug.

The Convener: One or two members have indicated that they want to ask questions. This always happens: for 15 minutes, nobody wants to ask a question and then everybody wants to ask questions at once.

Mrs Milne: The last time I was in a British Legion club, the atmosphere was extremely smoky and I was not aware of there being ventilation. Do you know how many of your clubs have ventilation, either efficient or otherwise? If, as is proposed in England, ventilation were to become compulsory, how would that impact on your clubs? You have said that a ban would result in some of them closing. What would be the impact on your clubs of their having to provide adequate ventilation?

George Ross: Several clubs in Edinburgh and the Lothians, including the one in Broughton Street, have ventilation systems. The one in Bridge of Weir, near Glasgow, has a ventilation system. Those clubs are successful. You must remember that the club is brought about by the primary unit, or branch. Moneys that are raised from trading for profit within the club are transferred over and go into the branch funds. Our branch is charitable, and we cannot spend that charitable money on the upkeep of the premises of our branch club. The money that is raised becomes charitable money and we can use it only for charitable purposes. It is as simple as that.

Recently, I spoke to the Office of the Scottish Charity Regulator, the new body that has taken over from the Inland Revenue regarding charities. We talked about installing ventilation and a disabled toilet. We discussed the issue with OSCR and the Inland Revenue. It may be that, within the premises, we can install ventilation for the health and safety of employees and those members of the ex-service community who use the premises for benevolent and welfare purposes. That is the only way that we can get round the rules. However, some of our small branches and branch clubs may close because they have insufficient funds. With all the good will in the world, they are transferring the money from the branch club to the branch, and it can be used only for charitable purposes. They cannot spend it on their premises.

Mr McNeil: You have mentioned your experience of challenging employers—the Ministry of Defence or whatever—about their duty of care to service personnel. How seriously do you take your duty of care to your employees who work in the clubs? What choice have they got about working in that hazardous environment?

George Ross: The majority of employees of Royal British Legion Scotland branch clubs will likely be smokers. Obviously, a time may come when clubs—although I do not know which ones—might have employees who do not smoke.

I am not really in a position to answer your question. However, before any employer takes on any employee, they must surely ask, “Do you smoke or not?”

The Convener: It is probably worth remembering that the bill is not being brought in under health and safety or staffing rules.

George Ross: I understand.

The Convener: It was a valid question, but I do not want us to go too far down that road.

Mr McNeil: You mentioned a straw poll that you took the time to carry out, and you said that you had no figures. Did you carry out a straw poll to establish how many of the people working in the clubs smoke? Did you carry out a straw poll to establish what percentage of your members smoke?

George Ross: All I can say is that we are trying to modernise the Royal British Legion Scotland and bring it into the 21st century. You have to realise that the clubs and branches came about after two world wars and that most of our members are of the older generation. We have very few members of the younger generation, but we are seeking to modernise our clubs.

When I say “modernise our clubs”, I mean that I would rather have 10 first-class buildings with all the necessary community facilities—such as crèches, computer networks and pool tables—than have 80 stinking clubs that are full of sawdust and dirty water. We want to take out the old dirty water, throw out the old accordion, and bring in Bacardi Breezers and karaoke. That is modernising. That is moving into the 21st century. However, it takes time to do that. I cannot give you figures, sir, but it takes time. We are in the process of modernising. The legion is a very big beast. It is slow moving and we have to keep kicking it until it moves. It will move, but until then we have to educate it.

I do not think that I have answered your question, but I am asking you to give us time—we are trying to modernise. However, I feel that bringing in a complete ban, all at once, is provocative and is against my members.

Helen Eadie: You have told us about your total membership and you have told us that you held a small consultation exercise. Did you circulate a questionnaire?

George Ross: Yes, it was a formal survey. I kept it to our Edinburgh and Lothians and Glasgow and western counties areas. However, I intend to expand the survey nationally. We have just completed a survey of our declining membership
and a survey of our clubs with disabled access and facilities.

We are being hit. Licensing legislation is being changed, health and safety considerations are coming in, and now we have legislation on smoking. Those will all lead to big objectives. Reaching those objectives will not come about by itself—we will have to generate money, and that money is not available.

Helen Eadie: You are saying that you sent out a questionnaire on a range of issues. Is that right?

George Ross: Yes.

Helen Eadie: So it was not only on smoking.

George Ross: No.

Helen Eadie: But questions on smoking were included among other questions.

George Ross: Yes.

Helen Eadie: Could you give the committee clerk a copy of your questionnaire?

George Ross: Certainly.

The Convener: We would be grateful if you could send that to us.

Helen Eadie: How many copies of the questionnaire did you circulate?

George Ross: We circulated it with the Scottish Legion News to approximately 60,000 members.

Helen Eadie: What was the percentage rate of return?

George Ross: In the two areas where we carried out the survey, the percentage of people looking for a complete ban was 20 per cent.

Helen Eadie: But how many people returned the questionnaire?

George Ross: I think that 54 per cent of people returned it.

Helen Eadie: How many members do you have in the Edinburgh and Lothians area?

George Ross: I am sorry, I do not have the figures in front of me.

The Convener: Thank you for your attendance and for the evidence that you have given to us. Feel free to provide us in writing with the information that we have requested and other points that occur to you and that you wish you had made. We still have a couple of weeks in which to produce a draft report on the bill.

I suspend the meeting until 4 o’clock, to allow members a brief break before we hear from the third panel of witnesses.

15:55

Meeting suspended.

16:00

On resuming—

The Convener: One or two stragglers are yet to return, but we will start. I welcome this afternoon’s third panel, which has four witnesses: Alan McKeown, the health and social care team leader for the Convention of Scottish Local Authorities; Gordon Greenhill, environmental health manager in the regulatory services department of City of Edinburgh Council; Kevin McNamara, president of the Royal Environmental Health Institute of Scotland; and Deputy Chief Constable David Mellor, who represents the Association of Chief Police Officers in Scotland.

I invite each of the four witnesses to make a brief introductory statement. That might be somewhat rash, because what are meant to be brief introductory statements are sometimes not that brief, but I ask people to be as brief as possible. Let us start from the left, with Mr McKeown, and work our way along the table.

Alan McKeown (Convention of Scottish Local Authorities): COSLA supports the introduction of the ban. There is no dissension among our members on that. We recognise the health improvement benefits that will flow from the ban. Our concerns are around ensuring that councils’ ability to play their full part in enforcing the ban is facilitated by the Parliament addressing the resourcing issues, which include staffing as well as cash.

We will answer any questions that the committee wants to ask. Gordon Greenhill will speak wearing not only a COSLA hat but a local authority environmental health officer hat.

Gordon Greenhill (City of Edinburgh Council): I will also speak on behalf of the Society of Chief Officers of Environmental Health in Scotland. We welcome the proposed introduction of a ban and we believe that the enforcement of the ban will effect a cultural change in relation to the nation’s attitude to health.

Keith McNamara (Royal Environmental Health Institute of Scotland): I am the president of the Royal Environmental Health Institute of Scotland. As the professional environmental health body in Scotland, the institute has more than 130 years’ experience of protecting and improving public health. The institute very much welcomes the bill and wants to play its part in securing its success.

David Mellor (Association of Chief Police Officers in Scotland): My colleagues have taken 30 seconds maximum. I have never spoken for such a short period, but I will do my best.
ACPOS is broadly supportive of the bill’s aims, but we are interested in enforcement and the work that might fall the way of the police in Scotland.

The Convener: In this section of our evidence taking we are, of course, concerned principally with enforcement issues.

Helen Eadie: The written submission from the Royal Environmental Health Institute of Scotland states:

“should smoking on public transport become an offence the issues surrounding compliance on cross border … public transport will require to be addressed.”

Will you enlarge on that issue?

Keith McNamara: We understand that the proposed ban in England will not take effect until 2006, whereas the bill will come into force before that. That time lag means that there will be an issue with cross-border travel.

We are also unclear whether the proposed ban in England and Wales will extend to public transport. We could have a scenario in which people can smoke on a bus while it is in England but it is illegal for them to do so as soon as the bus crosses the border. That is the type of issue to which we are referring.

Helen Eadie: Do you propose any solutions to address that issue?

Keith McNamara: We would need to work with the travel organisations. As the bus crossed the border, people would need to be told to stub out their cigarettes. That might be the best solution that we can offer.

Helen Eadie: Finally, your written submission states:

“The Institute believes that clear and unequivocal definitions must be provided”.

Will you expand on your concerns about the definitional issues?

Keith McNamara: Yes. Since we made our submission, the draft regulations that define which premises would be included in the ban and which would not have been issued. Those regulations, which came out last week, have gone a considerable way towards resolving that issue. As enforcement officers, we need to know which premises would be covered by the ban and which would not. In many respects, time has solved that problem for us.

Helen Eadie: What sharing of knowledge about definitions have you had with colleagues from Ireland?

Keith McNamara: One of the speakers at last year’s annual conference was an officer who enforces the ban in Ireland. We have regular contact with my counterpart in Ireland, who is the chairman of the Environmental Health Officers Association. In fact, I spoke to her on the phone before I came to the Parliament; our contact is frequent.

Helen Eadie: Have your colleagues in Ireland given you any pointers about the definitions that have caused difficulties over there? We heard about such difficulties during our evidence gathering. Have you been alerted to them?

Keith McNamara: They have raised several matters with us, but they have not identified definitions as being a problem.

Helen Eadie: Will you tell us about some of the issues that have been raised with you?

Keith McNamara: Our colleagues in Ireland have stressed the need for us to get in our promotion before we introduce the ban. Believe it or not, the ban in Ireland seems to have been widely accepted. That is largely thanks to a major promotional campaign by central Government and because local people who work on the ground visited premises to provide information and an opportunity to ask questions on a one-to-one basis.

One issue that was raised was having to deal with noise disturbance outside premises, but our Irish colleagues said that that was not too much of a problem. There had been a concern that people who went outside for a fly smoke could create a disturbance, but apparently that has not been a problem. Businesses have tried to overcome the ban, for example by setting up beer gardens with open sides. When people congregate in such an environment, it can cause a noise disturbance. Litter has also been mentioned. If more people stand outside premises, there will be more cigarette-related litter. In Ireland, that was not picked up on. Our Irish colleagues feel that that is one lesson to be learned. They would advise anyone else to take that issue into account.

Mr McNeil: Much of the evidence tells us that 70 per cent of people do not smoke. What are the challenges for enforcement? It is estimated that Shona Robison has 21,000 smokers in her constituency. How can we deal with that? How do we get the nearly 40 per cent of people who smoke to comply?

Gordon Greenhill: We start from the premise that most Scots are law abiding and that, if a law is introduced, they will comply with the terms of the act. That has been the experience with other new legislation that the Scottish Executive has brought in, such as that relating to the issuing of fixed-penalty notices for littering. About 90 per cent of the fixed-penalty fines that are imposed are paid, because people accept that they have done something wrong. From the Irish experience and from our experience of serving fixed-penalty
notices, we assume that if someone is asked to put out their cigarette or is issued with a fixed-penalty notice, they will accept that. The fact that someone is smoking does not make them a hardened criminal; they will be breaking the law but, once people in this country know what the law is, the majority of them will comply with it.

Alan McKeown: It is important to remember that we are not banning smoking; we are just banning smoking in public places.

Mr McNeil: It is estimated that there are 21,000 smokers in Shona Robison's constituency, so we are talking about a significant problem. Many of those people will want to smoke in public places.

I will take my point a bit further by considering the estimated cost of the ban. In the Dundee City Council area, which covers both Dundee constituencies, it is estimated that there are 40,000 smokers. The council there estimates that the ban will cost £95,000. The number of smokers in Inverclyde, which is a much smaller area, is estimated to be 17,000, but Inverclyde Council says that the ban will cost £140,000. How seriously can we take the information that we have about preparations for the anticipated implementation of the ban when so much of it is questionable?

Alan McKeown: A number of councils went through their information quite rigorously. There was not a set template; we wrote to councils based on the papers that we had. We heavily qualified our evidence to the Finance Committee by saying that we would go back and re-examine the information once we had the draft regulations. We now have them, so we will go back and re-examine the information. We might consider defining some headings under which every council will do similar things. There is no question about the need to tighten up the costs, and we have not tried to hide from that. We have worked out a cost of about £6 million for this year and next year to make—

Mr McNeil: Did you submit that evidence on the basis that we should take it seriously?

Alan McKeown: Yes, indeed.

Mr McNeil: Are you now saying that we should not take it seriously?

Alan McKeown: No, we are saying that the evidence was submitted on the basis of the information that was available to us at the time, which was incomplete because the draft regulations did not exist. We now have the draft regulations, so we will go back to our members and clarify the costs.

Gordon Greenhill: There will be two elements to enforcement of the bill. In Edinburgh, the City of Edinburgh Council enforces health and safety legislation in 17,000 premises, so we will go into those premises, say “This is a no-smoking area. You have to have signs up here,” and give advice to the owner of the premises. The bill will give us responsibility for another 3,000 premises that the Health and Safety Executive currently regulates, so visits to those premises will be an additional burden.

The second element is officers enforcing the law where breaches are taking place. We will need a small number of officers to do the in-your-face enforcement and a small number to get round premises to ensure that they comply with the legislation.

Mr McNeil: How many visits can an establishment that you regulate expect in a year or two years?

Gordon Greenhill: We visit all the 17,000 premises in a five-year cycle, but it is not as simple as all 17,000 premises being visited once every five years; there is a different inspection rate for different types of premises. There are different categories of risk, so we visit the high-risk premises every year and the medium-risk premises every two years, but we would visit a corner shop only once every five years. We are probably talking about 25,000 inspections being done in a five-year period.

Mr McNeil: So enforcing the bill would be a significant challenge for you.

Gordon Greenhill: No. We would not be doing full health and safety inspections; we would visit only to check that the no-smoking provisions were in place, so the inspections would be quick.

Mr McNeil: Would you just be checking that the premises had signs up?

Gordon Greenhill: It would be more than a matter of signs. We would check that there was no evidence of smoking paraphernalia.

Mr McNeil: No ashtrays.

Gordon Greenhill: Aye—no ashtrays, cigarette burns or other stuff like that.

Mr McNeil: So you do not plan on going into premises at weekends to do spot checks.

Gordon Greenhill: Yes, we do. Most councils have plans to cover the evening and early hours of the morning. It would be naive to say that we would have any impact on smoking in pubs if enforcement were to take place only during the daytime.

The Convener: We went to Ireland for three days to speak to, among others, representatives of the Health Service Executive, western area, who talked about the need for clear overtime allocations and which activities resulted in real
overtime spending. They also talked about there being a concomitant 20 per cent decrease in their food control activities as a result of the increased activity that they were having to undertake because of the introduction of the ban. Have you considered that aspect of the bill’s impact on your work?

Gordon Greenhill: That is a good question, and the answer to it is yes. The last thing that we want is for the bill to have a negative impact on food safety in Scotland, because we have a large number of tourists and a large number of people who go out to wine and dine. There will be no impact on food inspection regimes throughout Scotland if the bill is properly funded when it becomes an act.

The Convener: There will be no impact if the resources are in place.

Gordon Greenhill: Absolutely.

The Convener: So you would try to avoid replicating the situation in Galway, where food control activities have decreased by 20 per cent.

Gordon Greenhill: Absolutely. Implementation of the bill’s provisions on smoking will have no effect on the food hygiene inspections in Scotland if the funding is available.

Dr Turner: I address my questions to Deputy Chief Constable Mellor. There has been a hint that, because people will be forced out of pubs and on to the streets, the police might be busier on the streets. Will you comment on that? It seems from your evidence that you do not expect to be much involved in enforcing the bill, because others will do that. Do you expect problems?

16:15

David Mellor: The law of unintended consequences could apply. Certainly there would be concern about the safety of women and others who fall into more vulnerable categories when they are smoking outside pubs and clubs. Given that we want to prevent crime, there would be concern if people were more exposed to crime and vulnerability by being outside public houses and clubs late at night in circumstances in which there might be a reasonable fear of violence or attack. We will have to keep an eye on that and log it, and make it part of our patrol strategy, to ensure that we address the fact that people are more vulnerable if they are outside premises smoking.

On your second point, we expect our involvement in enforcement to be fairly insignificant. Over the years, we have worked closely with environmental health officers on a range of issues. Clearly, we would be entirely prepared to support environmental health staff, because one can imagine that public order situations might arise. I read with interest about the mass non-compliance campaign at Fibber Magee’s pub in Galway. It would not be surprising for the police to take an interest in such issues.

We are interested to hear what the environmental health staff’s enforcement strategy will be. If it is based on gathering evidence via observation, then going back and confronting people at a later time, that would be less likely to create friction and public order situations, and so it would be less likely that the police would be involved. We support that particular enforcement strategy.

The Convener: I have a follow-up question. I do not know whether this was suggested to other MSPs, but I was invited to hold local surgeries on the smoking ban in licensed premises, and I dutifully did so. A concern that was raised is that, in areas where there is a problem with drugs, it will be much harder for those who run licensed premises to keep an eye on what is happening, because there will constantly be people hanging around outside, so they will not be able to control what happens outside, for example if transactions are taking place. Has that registered on your radar?

David Mellor: It has not. It is an interesting theory. You are saying that people will be coming and going and hanging around outside, which will provide cover for those who are involved in illicit drug dealing and supply. That has not registered with us, but it is an interesting point. Our drugs enforcement staff would take that into account, but we tend to operate on the basis of accumulating evidence carefully by observation or through the use of closed-circuit television and so on. It would be possible to use that evidence to negate someone’s defence if they said, “I was not supplying drugs. I was just outside having a quick smoke.” It is an interesting point, to which we need to pay attention.

The Convener: Does any committee member want to come in specifically on the evidence from the police?

Janis Hughes: I have a question not on the police evidence, but on the displacement of people outside premises. In Ireland, we learned about a large increase in applications to councils for tables and chairs outside licensed premises, particularly in pedestrianised, city-centre areas. Does COSLA expect a rise in such applications? People will want to smoke all year round, so we will experience that situation all year long, not just in the summer, as we do now.

Gordon Greenhill: There is no medical evidence on passive smoking in the open air, so we would welcome that situation. On the issue of applications for licences for beer gardens and so
on, there will probably be a lot of joiners running about putting up gazebos at the back of licensed premises, which is fine, as long as it is done in a properly controlled manner. The many beer gardens that exist in built-up areas do not give cause for concern, as long as they are managed properly.

Janis Hughes: I was thinking more about the issues for councils, who will have to deal with the rise in the number of applications for licences for beer gardens. We heard evidence that people who want to go into business in Ireland should start selling outdoor heaters, which are in high demand. You mentioned gazebos, which might be another idea. In city-centre areas, many premises will probably apply for a licence to have tables and chairs outside, which people will use all year round until fairly late at night. How will that affect those areas?

The Convener: Before the witnesses answer, I refer to our experience in Ireland, where there was evidence that pubs, particularly city-centre pubs, that had no space at the back were renting pavement space at the front from councils, even for just a couple of tables. Will councils take a similar approach here?

Alan McKeown: We must discuss that in the various political groupings in COSLA. The issue is being considered by our health improvement committee and environment committee. We need to take the issue to the planning committee, now that we know exactly what is to be done. Because the measures will cut across all those functions, we must ensure that we take a strategic approach to applications, rather than deal with them one by one. We will take a report to the council leaders as the bill goes through Parliament and our views become more sophisticated. However, we will take a strategic approach rather than a piecemeal one.

Mike Rumbles: The Royal Environmental Health Institute of Scotland’s written submission raises the issue of officers “serving Fixed Penalty Notices in potentially dangerous situations.”

The committee’s experience of enforcement of the ban in Ireland was interesting. We were constantly told that the success of enforcement was linked to the non-confrontational approach and that the ban was largely self-policing. As part 1 of the bill does, the ban in Ireland focuses on the offence of permitting others to smoke in no-smoking premises. Basically, we will focus on the landlord or manager of the premises. To give some anecdotal evidence, when we were doing our research in Galway, someone started to light up and was put out of the pub by the manager like lintie—we hardly noticed it. The focus is on management ensuring that the law is obeyed.

Surely you do not envisage environmental health officers and police officers going round the pubs issuing fixed-penalty notices to anybody they spot smoking. Surely, as in Ireland, the focus will be on a self-policing approach and on enforcing the ban through the managers of premises.

Keith McNamara: You are absolutely spot on. We flagged up the issue because people might see the fixed-penalty notice as the first means of taking action against individuals, whereas there will be a basket of measures that can be applied appropriately. You are right that we need to focus on managers and to deal with issues proactively to target resources in the most effective way. If we went to premises and took action against an individual smoker on one night and then the next night went back and dealt with another individual smoker, that would not be an effective use of resources. Taking action via the management is in line with the general principle that we apply in environmental health, which is that we take action against the person who has the premises and who controls the risks. The same is true of licensing law—the person who has control of the premises has the major responsibility.

We have spoken to our colleagues in Ireland about the issue, who say that they would take action against an individual who was being deliberately obstructive or obstreperous. We need to have enforcement powers against individuals, but we hope that they will be used rarely. The proactive enforcement in Ireland and the fact that enforcement has been taken up by the trade there are examples of good practice.

Alan McKeown: We take a slightly different view. The law is the law and if its integrity is to be protected, it must be enforced. We accept that a mature and sensible approach should be taken throughout, but if the law is to be successful, it has to be implemented.

The Convener: Will you clarify that you will go after individual smokers as opposed to licensees?

Gordon Greenhill: There are two elements. The licensees must take every possible step: they must have signs up, there must be no ashtrays and they must explain the new law to their clientele. The Royal Environmental Health Institute of Scotland is absolutely right; initially, we as an enforcing body would ensure that all those elements were in place. I assume that this august body will do an extensive education and publicity campaign, so that people know what is what.

However, because of the way in which the bill is written, there is no option. If someone is smoking at premises after that education has been done and the implementation date has passed, the only option will be to issue an immediate fixed-penalty notice, which is an effective measure. The Scottish Executive has gradually introduced fixed penalties
and decriminalised things. People are not criminals if they smoke or drop litter, although they are not in keeping with the rest of society. You have introduced those pieces of legislation, and that is what this law before us says. It says—

The Convener: To clarify, we have not introduced this piece of legislation. We are in the process of gathering evidence on it to establish whether there are things in it on which we wish to comment. If there is a slight difference on the issue, it is important that we know about that.

Gordon Greenhill: What you have put out for consultation will be good legislation because it is clear. There is no vagueness and there are no grey areas. If the person who is in charge of the public house, licensed club, shopping mall or whatever has put in place the proper management procedures, the problem will come down to the individual who is contravening the legislation.

David Mellor: Although we do not expect to play anything other than a peripheral role in enforcement, one thing that police officers learn early on is the importance of discretion. The law does not have to be enforced there and then in all cases; it is possible to enforce it by taking action after the event. One has to balance a whole range of issues, including the danger to public order and the risk of making the situation worse. We need a degree of common sense and discretion, although when I heard the comments that were made earlier, I was quite interested in the idea of posting when I heard the comments that were made earlier, I was quite interested in the idea of posting

Mrs Milne: Mr McNamara, you say in your written evidence that the Scientific Committee on Tobacco and Health’s report

“concluded that ETS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to.”

I assume that you accept that there are risks associated with ETS. Do you also accept that children and infants are not likely to be harmed in pubs but that if ETS goes into the home because people smoke there instead of going to pubs, infants and children will be at greater risk as a result of the bill?

Keith McNamara: It is a matter of individual discretion and choice. If I take my child out to a restaurant for a meal, I do not want her to be subjected to ETS. If people choose to smoke in front of their children at home, that is their individual choice.

Mrs Milne: Your submission says that a “high profile media campaign” should precede the introduction of any legislation. The people in Ireland also made that point to us. Given that the provisions in the bill are supposed to come into effect in a year’s time, is there enough time for such a campaign to be run?

Keith McNamara: I would say so, but we need to start planning it now. Gordon Greenhill and I have had discussions about various aspects of the bill, but COSLA, the Society of Chief Officers of Environmental Health in Scotland and the Royal Environmental Health Institute of Scotland need to work closely to assist with the promotional campaign.

Mrs Milne: My impression is that there was a longer run-in period in Ireland.

The Irish said that the definition of closed or non-enclosed spaces caused them problems with enforcing the ban. For example, people constructed shelters that were all but enclosed. Do you have any views on that?

16:30

Keith McNamara: Yes. As I understand it, in Ireland, a space was not enclosed if less than 50 per cent of the enclosure was within walls. However, in Scotland, the recently issued draft regulations stipulate that a space is enclosed if the only openable elements are the doors and windows. It does not matter whether the Irish system or the system that is outlined in the draft regulations is introduced; businesses will still try to get round it by erecting marquees, tents, gazebos, beer gardens and so on.

Mrs Milne: I am sure that they will find ingenious ways of getting round the regulations.

My last question is for Gordon Greenhill. Would you have to recruit additional environmental health officers to enforce the legislation? If so, would that be a problem? I understand that it is quite difficult to recruit qualified EHOs. Indeed, one source of recruitment has been Ireland; I wonder whether that source is likely to dry up now that the Irish are enforcing their legislation.

Gordon Greenhill: Six Irish EHOs are working for me in Edinburgh, and they are very good.

There are problems with recruiting and retaining EHOs in Scotland. We are actively discussing with the Executive and the society ways in which we can speed up training, but we will not overcome those problems in the time span that we are talking about. It takes four years for someone to qualify as an EHO, after which they must undertake a year’s practical training and sit their chartered exams. The situation will not be cured overnight.

I do not think that the sort of enforcement that we are talking about will require an environmental health officer. We will be able to use what is called an enforcement officer. Many people meet that standard of qualification; for example, 12 ex-police
The Convener: I suppose that they have a bit of experience in that respect.

Shona Robison: I am sorry to go back a step, but I think that we are beginning to uncover something quite important. I simply want to be clear in my own mind.

The panel members appear to disagree about enforcement. Earlier, when David Mellor said that it would be better to carry out enforcement post-event, Gordon Greenhill shook his head; I see that he is doing it again now. I want to explore the difference of opinion on this matter and on the question whether we need a lighter touch and more self-policing. The witnesses seem to have different interpretations of what the bill will mean, and we need to clear up any misunderstandings or have some clarity that will allow us to put those differences of opinion to the Executive. Will you help us by identifying where the difference of interpretation lies?

Keith McNamara: I am not sure that there is any disagreement. We do not have any problems with issuing fixed penalty notices. However, as a line manager, I could not ask two officers—who, at that stage, would have no police support—to put themselves in danger by issuing a notice some Saturday night in a pub full of people with a few drinks in them. I should say that, in my career, we have always had the best of police support in tense situations. I need to make that differentiation from the perspective of my staff's health and safety. That said, I do not object to the principle of issuing fixed penalty notices to individuals.

Shona Robison: Do you disagree with that, Mr Greenhill?

Gordon Greenhill: Yes. I would expect my staff to issue fixed penalty notices. They do so already—what else can they do if a Rottweiler fouls in the middle of a public park? More than 3,000 fixed penalty notices have been issued in Edinburgh, all of which have been paid. No one has given Donald Duck as their name and, when a situation has arisen, the police have been fantastic.

The Convener: I suggest that issuing fixed penalty notices to individuals on a Friday or Saturday night in a busy pub is a very different matter. Have you thought through the implications of what you are saying?

Gordon Greenhill: Absolutely. I agree with you entirely. All our officers are trained to use a hefty dose of common sense. They would walk away from a situation of the sort that has been described or call the requisite back-up. However, if people in a public house persist in lighting up after the ban has been in place for six months and we have spoken to the licensee and the clientele a number of times, should we walk away?

Shona Robison: Surely in such a situation action would be taken against the managers of the premises for permitting smoking to take place there. Would you not threaten them with action if they continued to allow smoking? That is the approach that has been successful in Ireland. However, you seem to want to tackle the problem more from the point of view of individuals. I am not sure why that is the case.

Gordon Greenhill: Our approach is based on our experience of the existing fixed penalties. As I have said, the public are law abiding. I do not disagree that, if the managers have done everything that they can, we would expect them to enforce the ban. However, the bill as drafted makes smoking in enclosed public places an absolute offence. You need to revisit that phraseology.

Mike Rumbles: I do not think that we need to revisit the terminology, which is absolutely clear. Section 1 is entitled “Offence of permitting others to smoke in no-smoking premises”. That is the focus of the bill. It also creates an offence of smoking in banned premises. The bill is quite clear. The committee's experience is that the ban in Ireland has been successful because the emphasis of enforcement has been on management allowing people to smoke. If you pursued an individual in the way that you seem to be outlining, would you not end up with what David Mellor suggested—a greater issue of public safety and disturbance? I may be reading the bill wrongly, but surely it is written in such a way as to ensure that management is tackled first and foremost. Is that not the issue on which we must focus?

Gordon Greenhill: I agree. You are saying that the emphasis is on the owner, licensee or shopping mall contractor to have in place management systems to ensure that people do not smoke. That is fundamental. However, ultimately there is an offence if people persistently flout the law.

Mike Rumbles: Yes, but the approach that is taken in Ireland is to issue a penalty notice to the licensee on the following day or to threaten action if he persists in allowing people to smoke on his premises. Action is not necessarily taken against the individual smoker. That is the right way of dealing with the problem. I believe that our bill is framed in the same terms. If I have misunderstood it, we need to sort that out.

Alan McKeown: Whenever we discussed the framing of the legislation, there was a debate about whether the onus should be solely on the
licensee or whether it should be on individuals, too. We are debating how far we should go down the road of placing responsibility on individuals. We would expect the licensee to exercise due diligence. Indeed, the licensing committee should put management systems in place to ensure that licensees put up signage and that their door staff give information to clients as they come in, go round the bar to remind people of the ban and catch them before they start smoking. If all that is done and is seen to be done, but there is a persistent offender, the only way of dealing with their behaviour under the legislation is to fine them.

We take your point about the need to deal with inflammatory situations outwith the immediate environment, so that there is no threat to the environmental health officer and the rest of the clientele in the bar. As Gordon Greenhill said, that is where a hefty dose of common sense comes in. We need to find a mechanism for dealing with such situations without creating conflict in the bar.

Mike Rumbles: I would like to have one more shot at this issue. I do not want sets of officers, uniformed or not, to go round pubs and clubs in Scotland issuing fixed penalty notices to people who are smoking. That is not the right way in which to approach the bill.

Gordon Greenhill: I agree; that is not the concept that I am trying to get across. We have always worked well with the licensed trade and publicans. Let us be honest: the nub of the problem will be in pubs and clubs. If the bill is to be implemented properly, we will ultimately have to tackle what we call the refuseniks. We will probably do that jointly with the police. A hard-core element of people will flout the law and we will have to issue those people with fixed penalty notices.

The Convener: You can understand our concern.

Mr McNeil: Surely the appropriate response of the licensee or publican to someone who insisted on lighting up would be to ask them to leave the premises.


Mr McNeil: If a licensee did not ask the person to leave, or did not eject them from the premises, the focus would be on that licensee.

Alan McKeown: Yes. That would have to be considered. We do not dispute that.

David Mellor: From a policing point of view, we do not agree with the “in-your-face enforcement” strategy that Gordon Greenhill talked about. We are talking about how we solve a problem and the bill offers one way of doing that. Another way is through publicity campaigns, for example. When we try to solve a problem, it is helpful to have the back-up of positive legislation, which we should use judiciously when we need to do so. I will give a parochial example: if we were in consultation with environmental health officers in Fife about a strategy for enforcing the bill, we would have to take a problem-solving rather than a confrontational approach.

The Convener: If no members have further specific questions, I will release the witnesses. You are probably sitting there thinking, “Please release us”. You are free to go.

I welcome the witnesses from ASH Scotland: Dr Rachel Harrison is senior policy and research officer; and Sheila Duffy is head of information and communications. I invite one of the witnesses to give a brief introductory statement.

Sheila Duffy (ASH Scotland): We thank the committee for inviting us to give evidence. ASH Scotland welcomes the bill and the opportunity that it represents to address a known health hazard in Scotland.

We take issue with the statement that was made earlier that the evidence on second-hand smoke is largely epidemiological. There is good medical evidence that second-hand smoke, as a known carcinogen, increases the risk of lung cancer, heart disease and complications during pregnancy and poses particular health risks to children and infants.

Since the committee last took evidence on the health impacts of second-hand smoke—

16:45

The Convener: Ms Duffy, you must speak into the microphone. We are having difficulty hearing you at this end of the room.

Sheila Duffy: My apologies. I was emphasising that the debate is about health. Second-hand smoke is a toxic substance that threatens the health of smokers and non-smokers, and it is preventable.

Ventilation is not a solution to the problem of second-hand smoke, as it cannot effectively clean the air of toxic gases and particles. We believe that people have misrepresented the research by Dr Geens, which compared a pub with ventilation in which smoking was allowed with a smoke-free pub. His research showed that, even with ventilation, particulate levels in the smoking pub were three to 10 times higher, but the measurements were presented in a graph in which the axes differed by a factor of 10 to make it look as if they were the same. There is no known safe level of exposure to second-hand smoke.

Voluntary approaches have been tried in
Scotland but, in line with experience elsewhere, they have failed to increase protection. The Scottish Licensed Trade Association’s proposed five-point plan lacks an evidence base. Such partial policies are costly and, by delaying effective protection, they lead to increases in health inequalities. Comprehensive legislation, such as the proposal in the bill, is the fairest and most effective way forward. Ending smoking in enclosed public places and communicating effectively why such a step is being taken will not only reduce the burden of health and economic inequalities that tobacco places on our most vulnerable communities, but create positive environments for our children and support the majority of smokers who want to stop smoking. We believe that the majority of Scots will welcome the measure.

The Convener: In our evidence taking on a previous bill, we heard evidence that covered most of the public health arguments in respect of environmental tobacco smoke. In this part of the meeting, we will concentrate on any new health evidence that has emerged subsequently rather than go over the same evidence. The SLTA said that there was new evidence, so we want to give ASH Scotland the opportunity to respond to that.

Shona Robison: There is so much information and so many statistics and different interpretations of the same studies that the subject can, in some respects, become almost impenetrable. Both the SLTA and the Tobacco Manufacturers Association said robustly that there was no evidence to suggest that ventilation did not work. They questioned the source of research that made such a suggestion. For our benefit, will you clarify whether such research is independent, where it comes from and when it was produced?

Dr Rachel Harrison (ASH Scotland): A whole host of independent research on ventilation has been conducted. The SLTA likes to respond to the research that was conducted by Dr Geens of the University of Glamorgan, but we know that that was not an independent study. Our submission refers to research by ventilation experts such as Professor Repace, who is based in the States. He has produced a huge amount of valuable and robust evidence that shows that ventilation simply does not work because it does not remove the carcinogenic aspects from the air. Ventilation is not a suitable outcome measure for reducing the health hazards that are associated with exposure to second-hand smoke.

Shona Robison: Are the five references in your written submission all to independent research?

Dr Harrison: Yes.

Mike Rumbles: I wanted to put this question to the Tobacco Manufacturers Association, but we ran out of time. The association took exactly the opposite view from ASH, although it appeared to be in denial of the scientific evidence.

In what year did the Tobacco Manufacturers Association—or its predecessors—recognise that smoking, as opposed to environmental tobacco smoke, causes deaths? The association opposed the scientific evidence for many years, but I understand that it had to accept it eventually. It strikes me that it is now in the same position in opposing the scientific evidence on environmental tobacco smoke. Do you know when it eventually accepted the scientific evidence on smoking? An answer to that question might be helpful.

Sheila Duffy: I do not know whether there is full acceptance in the tobacco industry of the fact that there is a link between active smoking and lung cancer. Even nowadays, Imperial Tobacco gives evidence in court casting doubt on such a link.

Mike Rumbles: The new evidence that the University of Glasgow published in November suggests that up to 2,000 deaths per year in Scotland are related to the ETS exposure of non-smokers—that is, lifelong non-smokers or quitters. As far as you are aware, is that research robust?

Dr Harrison: As far as we are aware, it is. It might be useful to draw the committee’s attention to a newer study, which has been published since we submitted our evidence. The study, which was published recently in the British Medical Journal, says that exposure to second-hand smoke kills more than 11,000 people a year in the United Kingdom. That figure is much higher than it was previously thought to be. The first available figure for people who die as a result of exposure to second-hand smoke in the workplace is given as 600 a year. That figure is very much in line with recent research that was conducted by David Hole, which suggests that approximately 1,000 Scots die every year as a result of second-hand smoke.

Mr McNeil: Does that figure relate to smoking in public places?

Dr Harrison: There are specific figures for exposure to second-hand smoke—

Mr McNeil: On the 1,000 deaths and second-hand smoking in public places, is there a direct—

Dr Harrison: The study does not specifically talk about enclosed public places.

Mr McNeil: Then why is it relevant?

Dr Harrison: It gives a comparison point that is useful to have when one is working with estimates.

Mr McNeil: For the purposes of the argument, we criticised the tobacco lobby earlier for misusing or selectively using statistics. Have you, too, not just done that?
Dr Harrison: I would not go as far as to say that I have. It is useful to consider estimates and studies that are based on estimates in the context of other research that has been conducted, including large-scale research studies such as those that have been done by the World Health Organisation, the International Agency for Research on cancer and the Scientific Committee on Tobacco and Health. When such things are considered in the context of wider research evidence, it is clear that second-hand smoke kills.

Mr McNeil: But what you say is related to the level of exposure to second-hand smoke.

Dr Harrison: Yes.

Dr Turner: Earlier, I tried to point out that blood test studies in New York have proved that breakdown products of nicotine are diminishing in the bloodstream of people who work in premises in which there has been a smoking ban and that such products were proving to be a good indicator. Do you agree?

Sheila Duffy: Yes. There was a huge drop in the cotinine levels of non-smoking bar staff in New York—I think that the figure was 85 per cent.

Dr Turner: Are such studies worth while, or are there other indicators that are easier to measure?

Sheila Duffy: Cotinine is a good indicator of exposure to tobacco smoke.

Dr Turner: Is it a better indicator than carbon monoxide?

Sheila Duffy: Measuring carbon monoxide can work for short-term exposure.

Dr Turner: Did you clarify whether the Geens study proved that the pub that had a ban had better air than the pub that did not have a ban, if like was compared with like on the correct graphs? Forgive me if you have clarified that matter.

Sheila Duffy: It did, despite being located in the city centre next to Queen Street station and major roads.

Dr Turner: It is good to have that clarified.

Mrs Milne: I have a question about enforcement and implementation. You have referred to high compliance rates in Ireland. When we were in Ireland, people were at pains to say that there was a very long run-in to the legislation. Public opinion was carried along with the promotional campaign, so that by the time the legislation was implemented, the public were ready for the legislation and it was timely. People also said that they had been able to get unions and other organisations on board because the ban was introduced in Ireland as a health and safety at work measure. Obviously, we cannot do that here, because health and safety is a reserved matter. Given that the bill is due to come into force next year, is there enough time for the Scottish public to be brought on board to the same level as the Irish public were, so that by the time the legislation is enforced people are ready for it and therefore the compliance rate will be high? Do you have any comments on that? I know that I am asking you to speculate.

Sheila Duffy: We might benefit from the validated results that are emerging from the experience of other countries that have introduced legislation, therefore we may not require such a long lead time to reach the same level in Scotland. However, I agree that we have a busy job ahead to communicate why the bill is being considered and, we hope, implemented.

Mrs Milne: But is it possible to do that in a year?

Sheila Duffy: Yes.

Dr Harrison: Public opinion that some action should be taken has been increasing steadily since about 1996, so although some polls suggest otherwise, a large proportion of the public are behind measures being taken.

Mrs Milne: Does “some action” equate to a complete ban with few exceptions, except on humanitarian grounds?

Dr Harrison: I will answer that question with regard to the Scottish Executive’s opinion poll by Market Research UK, which I know has come under scrutiny by the likes of the SLTA, because it demonstrated that there were lower levels of support for legislation that covered pubs than for legislation that covered other places. There are important points to note, the first of which is that the public’s support for a ban in pubs is generally lower than that for a ban in other places, such as restaurants. However, in places where legislation has been introduced, public regard for the legislation has generally continued to grow.

Mrs Milne: Your submission quotes the UK Government advisory committee—the Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment:

“Taking all the supportive data into consideration we conclude that passive smoking in non-smokers exposed over a substantial part of their life is associated with a 10-30% increase in the risk of lung cancer”. Can you define “a substantial part of their life”?

Dr Harrison: No, because it was not defined in the paper that we looked at to gain that evidence.

Helen Eadie: What do you know about the tobacco company Philip Morris’s attempt to conceal important research that could and should influence Government policy?

Sheila Duffy: We know from documents that have been disclosed in litigation in various places
that the tobacco industry has sought to delay, alter and deny evidence, and to run concerted campaigns to prevent the health evidence from having the obvious effect.

**The Convener:** May I enter a note of caution? I am being reminded that we should be careful where this leads to in terms of privilege.

**Helen Eadie:** I understand that, but I want to ask about litigation in various places.

**The Convener:** Everybody be careful. We do not want to end up in litigation.

**Sheila Duffy:** We have seen evidence in tobacco industry documents of the industry’s own commissioned research being altered following legal advice to remove evidence of harm from smoking.

**Helen Eadie:** Where is litigation taking place or where has it taken place?

**Sheila Duffy:** There has been litigation in America. We can come back to you with further details on that.

**Helen Eadie:** Will you provide details of all the litigation cases of which you are aware?

**Sheila Duffy:** Yes.

**Helen Eadie:** Can you comment on the assertion in your report that second-hand smoke “is more harmful than mainstream smoke”?

**Dr Harrison:** We can provide you with further details on that if you wish.

**Shona Robison:** The SLTA argued that a displacement effect may lead to increased smoking and drinking in the home. Whether or not you accept that, given the trend towards more home drinking because of the availability of cheap alcohol in supermarkets, it is likely that people will drink more at home and therefore there is a danger that people will smoke more at home. Is ASH concerned about that problem and, if so, what measures are required to deal with it?

17:00

**Sheila Duffy:** We have worked for several years with people on low incomes, particularly in areas of deprivation. We are concerned about increased smoking at home because it has obvious impacts through sudden infant death syndrome and respiratory infections among children. It is important that we communicate clearly to people the reason why the bill is under consideration, because people who understand why smoking has ended in enclosed public places in Scotland are unlikely to expose their children to smoke at home.

**Shona Robison:** Must that issue be taken into account in the publicity campaigns that come with the ban?

**Sheila Duffy:** That will be vital. It would also be helpful if some of the disinformation on the issue was robustly refuted in campaigns.

**The Convener:** Do you anticipate that the ban will result in a decline in smoking in the home?

**Sheila Duffy:** The evidence from Australia is that voluntary restrictions increased after legislation on smoking came into place.

**The Convener:** So you anticipate—

**Sheila Duffy:** We anticipate that exposure of children to tobacco smoke at home will decrease if the pattern here follows that in other countries.

**The Convener:** That is what I asked you. Basically, you anticipate a decline in smoking at home.

**Sheila Duffy:** Yes.

**The Convener:** Do you intend to measure that?

**Sheila Duffy:** I believe that the Scottish Executive is considering ways of measuring a baseline.

**Mike Rumbles:** When the committee went to Ireland, we met Sean Power, a minister of state at the Department of Health and Children, who informed us that in 2004 cigarette sales in Ireland decreased by 17 per cent, which led to a decrease of more than €100 million in revenue for the equivalent of the Inland Revenue in Ireland. The evidence is clear that the ban in Ireland has led to a decrease in smoking. It is assumed from the evidence that smoking is decreasing everywhere, but we cannot tell that. To follow up the convener’s question, how can we measure the impact of the ban here? We have heard about the SLTA’s fear that the ban will simply displace smoking, but the evidence from Ireland is that smoking will decrease. The key is how we measure the effects of the ban. Do you have any suggestions as to how the Executive or other organisations can do that?

**Sheila Duffy:** The early indications are encouraging. The number of calls to the smokeline from people expressing an interest in stopping smoking has increased since the discussion about the proposed legislation started. It should be possible to measure the success of smoking cessation services and the number of people who take advantage of the opportunity to stop. Most smokers say that they would like to stop. Beyond that, there is an on-going discussion about measures of the bill’s success, to which we would be happy to contribute.

**Mr McNeil:** Have you done, or do you have available, any research on illegal supply and smuggling of cigarettes and its impact on deprived...
communities?

Sheila Duffy: We have done some work on that, which is available on our website. The issue is a big one for certain communities. For tobacco control to work, effective action is required on a number of fronts.

Mr McNeil: Do you have evidence that illegal supply of cigarettes in Ireland has increased? The news today is that the Irish Republican Army has made that a business for itself. Could that be related in any way to the decrease in cigarettes that are sold legally?

Sheila Duffy: There are concerns about large-scale smuggling because it tends to go with other criminal activity. Action has been taken to hold tobacco companies accountable so that they do not collude with large-scale smuggling activity.

Mr McNeil: I am trying to establish that the 15 per cent reduction in sales of tobacco—

Mike Rumbles: It is 17 per cent.

Mr McNeil: Mike Rumbles reminds me that it is a 17 per cent reduction in legal sales of tobacco. Could that be partly due to smuggling of cigarettes?

Sheila Duffy: I am not aware of evidence to that effect.

Dr Harrison: Neither am I.

Mr McNeil: Could the reduction in legal sales not possibly be because of smuggling? Is the reduction caused only by people stopping smoking?

Dr Harrison: We do not have evidence on that.

The Convener: If there was evidence of large-scale black market trading in cigarettes that is not reflected in official figures, would you accept that that would displace over-the-counter trade?

Dr Harrison: Do you mean evidence from Ireland?

The Convener: I mean any evidence. If there was evidence here of a substantial black market in cigarettes it would not register in the figures for the over-the-counter trade.

Sheila Duffy: That is right.

The Convener: There are no further questions, so you are free to go. Thank you very much for coming in to give evidence.

The next witnesses are from the trade union side. I ask the representatives from Unison, the Scottish Trades Union Congress and Amicus to come to the table. Please check that the nameplates in front of you are the right ones—if they are not we will all get confused.

I welcome you to the meeting. Andy Matson is the regional officer from Amicus, Ian Tasker is assistant secretary of the STUC and Dave Watson is head of policy and information at Unison Scotland.

I ask Ian Tasker from the STUC to make a very brief introductory statement—perhaps he can hold the jackets thereafter.

Ian Tasker (Scottish Trades Union Congress): The STUC represents approximately 630,000 members. The proposed legislation on smoking has been discussed at some length within the trade union movement. If the committee had hoped to hear of consensus among the trade unions, I can tell members that that will not happen today. The STUC's position is that although we broadly support a ban on the basis of the impact on the health of Scottish citizens and workers in general, we have problems with the timescale for implementation.

The Convener: Thank you.

Janis Hughes: I declare an interest as a member of Unison.

I will ask Dave Watson about the evidence that Unison submitted on the role of environmental health officers in enforcement. You probably heard the previous witnesses' evidence—there was some disagreement about the role of environmental health officers and the role that the police may play in enforcement. Can you comment on the remarks that were made by Mr Greenhill about how he sees environmental health officers working to enforce the legislation?

Dave Watson (Unison Scotland): It is important to say that we represent environmental health staff, so our perspective is probably not a high-level policy one but one that reflects discussions with colleagues who work on the ground. It is important to understand that environmental health staff already enforce fixed penalty tickets in a number of areas including littering, dog fouling, emissions and—soon—domestic noise. The key element for a member of staff who seeks to enforce a fixed penalty on an individual is that they need the name and address of the person. In some cases they also need the date of birth, but in essence the name and address is the key information. The view of our members is that there will be difficulties in enforcement—some of them put it more colourfully than that—and we are not hiding from that.

I will comment on what the committee heard from the witness from the City of Edinburgh Council. Edinburgh has a particularly high enforcement rate for fixed penalty tickets, but that is not the experience throughout Scotland. I do not have the precise figure for the enforcement rate in Glasgow, but I understand that it is significantly lower than the 95 per cent rate—I think that is the
There has been great emphasis on pubs and restaurants and 91 per cent in licensed premises. Compliance levels are reported at 94 per cent in hotels, 99 per cent in pharmacies, 99 per cent in domestic dwellings and 99 per cent in workplaces. Proficiency is also evident in areas in which it is well known to everyone that smoking legislation is largely self-enforceable.

Dave Watson: That is probably the case in respect of the history of other fixed penalties, but it would be foolish to say that there are no costs associated with enforcement.

Mr McNeil: We have received evidence from the Republic of Ireland that shows that, on average, 94 per cent of premises that were inspected comply with the law. Compliance levels are reported at 94 per cent in hotels, 99 per cent in restaurants and 91 per cent in licensed premises. Do not those figures demonstrate that anti-smoking legislation is largely self-enforceable?

Dave Watson: No, but that has not been a problem. People give their names and addresses when the consequences of not doing so are brought to their attention.

The Convener: I am still interested in what happens if a person knows that the policeman will not arrive for an hour. In such circumstances must staff wait with the person? There are issues about that.

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Dave Watson: Yes. However, colleagues in Edinburgh tell me that when people are simply told, "I will have to call a police officer to come and enforce the fixed penalty", they tend to provide their names and addresses. We need to acknowledge that there will be a hard core of people who will cause difficulties, but in general, enforcement of fixed penalties has not been a problem.

The Convener: Are enforcement officers empowered to detain a person while they wait for a police officer to arrive?

Dave Watson: No, but that has not been a problem. People give their names and addresses when the consequences of not doing so are brought to their attention.

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The Convener: I am still interested in what happens if a person knows that the policeman will not arrive for an hour. In such circumstances must staff wait with the person? There are issues about that.
In all things, a pragmatic approach must be taken to enforcement. I understand where my colleagues from the Royal Environmental Health Institute of Scotland and the City of Edinburgh Council are coming from. There is no hierarchy of offences in the bill. I accept the fact that section 1 focuses on managerial responsibilities and that the other sections deal with stand-alone offences, but if someone has responsibility for enforcement, they must take that responsibility.

The Convener: The previous panel of witnesses expressed differences of opinion about the kind of enforcement that we might anticipate. Would you be more supportive of the police approach than of the other approach?

Dave Watson: In all things, a pragmatic approach must be taken to enforcement. I understand where my colleagues from the Royal Environmental Health Institute of Scotland and the City of Edinburgh Council are coming from. There is no hierarchy of offences in the bill. I accept the fact that section 1 focuses on managerial responsibilities and that the other sections deal with stand-alone offences, but if someone has responsibility for enforcement, they must take that responsibility.

Shona Robison: I have questions on Amicus’s written submission. To give us some background, can you tell us how many of your members work in the food and drink industry, for tobacco companies and for vending machine companies? What percentage of your members in the food and drink industry work behind bars, where environmental tobacco smoke is a direct issue?

Andy Matson (Amicus): I will deal with the last question first. Not many of our members work behind bars; they tend to work in other sectors of the industry, but that does not mean that we do not have members who do such work part time. Members of other organisations will put in a couple of shifts at a pub or hotel to augment their income, and I am sure that Unison members and members of other unions fall into that category. The bulk of our members in the drinks industry are involved in manufacture, whether of soft drinks such as Coca-Cola, or alcoholic drinks, which are produced by companies such as Diageo. Our members are also involved in food manufacture.

As far as the tobacco industry is concerned, the split between vending and manufacturing is heavily weighted towards those who are employed in manufacture of tobacco products. The industry, like many others, has been in decline, but we reckon that about 4,500 to 5,500 people are employed in the tobacco industry in the UK. That is nothing like the number of people who were employed in the industry in its heyday, primarily because of advances in technology and so forth. Within the tobacco industry, the workforce is split between those who are involved in production, those who are involved in administration and those who are involved in selling. The vast majority are involved in manufacture.

There are no more than 700 vending machine operatives employed in the UK who service and fill the vending machines in pubs, clubs and restaurants. The numbers in tobacco company sales forces in the UK are similar to the numbers of vending engineers.

Shona Robison: Just to be clear, is the biggest proportion of your members in food and drink manufacture, compared with tobacco manufacture and vending? I ask because when you talk about economic impact, you talk about a reduction in alcohol sales, rather than in tobacco sales, impacting economically on your membership through loss of jobs.

Andy Matson: I do not necessarily accept the logic that if a ban were introduced, it would lead to a reduction in either consumption or production of alcohol. If one considers the Irish experience and talks to the licensed trade in Ireland, people will say that, on the one hand, there has been a significant downturn in sales of draught beers—beer that is sold over the counter in pubs—while the sale of canned and bottled beers has increased. The Irish licensed trade has suggested that there has been a shift away from drinking in pubs, clubs and hotels to drinking at home, therefore it is not unnatural that there would be a reduction in sales of draught beer as sales of cans and bottles increase. It would be reasonable to extrapolate that situation to Scotland should similar circumstances exist.

Shona Robison: What I am trying to get at is where you foresee economic impacts on your membership and where they work. It will not be on the bar staff who might lose their jobs because of the proposed legislation. You are saying that it will not impact on manufacture of drinks because there will be an increase in off-sales, so where does Amicus’s concern lie in respect of its membership and the potential loss of jobs?

Andy Matson: There are two areas. First is where we foresee our members being directly affected, but secondly we believe as a union that should any Parliament—Holyrood, Westminster or Cardiff—enact legislation, the economic impact on the community has to be considered. What we have said and included in our written submission is clear.
The convener will recall that when we gave evidence to the committee on Stewart Maxwell’s bill, I said that we felt then that it would be difficult to quantify the number of jobs that could be put at direct risk in the tobacco and food and drink industries. We can draw some analogies with the vending of tobacco products in Ireland. Our information is that the vending machine companies in the Republic of Ireland have shed between 25 per cent and 35 per cent of their labour, depending on the area in which they operate and the nature and size of the company. Any ban in the UK would also have an impact on throughput of products through vending machines. That has been the experience in Ireland. As far as the other areas are concerned, it would be irresponsible for any Parliament to consider legislation in isolation from the grand position as far as employment is concerned.

We believe that it is fair and reasonable to extrapolate from the Irish experience, given that Scotland and Ireland are similar in their rural and urban make-up, although their populations may differ. Extrapolating from the official Irish Government statistics, which are referred to in our written submission, should allow Parliament and the committee at least to consider the position of the hospitality industry, which we believe will be hardest hit by the ban. We need to take things from there. If the impact on the hospitality industry is similar in Scotland to what it was in Ireland, questions must be asked and people must be given assurances about safeguards and retraining. We need to ask where the money that is lost will come from.

Shona Robison: Is it fair to say that your concerns are more about the wider impact on the economy than about the impact on your members?

Andy Matson: Yes.

Shona Robison: I will turn to that issue. Your written evidence focuses on the estimated £41.6 million reduction in revenue for the Exchequer that might result from fewer people smoking. With all due respect, if you were to take that argument to its logical conclusion—I wonder whether you would—you would argue against all smoking cessation policies across the board. Restrictions on tobacco advertising, health warnings on cigarette packets to warn about the dangers of smoking and bans on smoking in public places are all measures that will potentially reduce tobacco revenue to the Exchequer. Surely Amicus would not argue that smoking cessation policies are a bad thing. Are attempts to improve the health of our nation not a more important objective? Where does Amicus stand on that? Do you agree with anti-smoking policies, which try to reduce levels of smoking even though they might have an adverse impact on the amount of money that the Treasury receives?

Andy Matson: Our written submission states clearly that the union’s food, drink and tobacco sector’s national conference has declared our opposition to an all-out ban on smoking in public places. The union’s position accepts the requirement for greater restrictions and controls on smoking and for consideration to be given to alternatives, including ventilation and filtration systems. We have been consistent on that.

I should say that the mathematics in our written submission are not based on figures that we have pulled from the sky. For example, the bill’s accompanying documents mention the Wanless report’s estimate that a reduction in smoking of something in the region of 4 per cent would emanate from the introduction of a ban. Using that figure and other figures that have been produced by Parliament, our submission puts some reasoned and logical economic argument before the committee. We believe that it is important that the proposed ban be considered not narrowly but in the round. We believe that the electorate are entitled to be told what the bill will or will not mean. If it will mean a shortfall either in revenue for Scotland or in resources for local authorities, the electorate are entitled to know where that money will come from.

Shona Robison: Would a 4 per cent reduction in smoking not be a good thing?

Andy Matson: I am not saying that it would be a good thing or a bad thing. In our submission, we say clearly that we intend to concentrate on the economic and employment side of the debate, which we believe has been somewhat swept under the carpet. For example, the financial memorandum that is attached to the bill tends to consider primarily areas in which estimated savings to the health service can be quantified.

The estimated costs to local authorities of implementation and enforcement are slightly underestimated in the financial memorandum, according to COSLA’s written submission, which says that the cost will be about £6 million in the first two years. That money has to be found by the local authorities, and we should be clear that COSLA is saying that its support for the bill is dependent on local authorities’ getting funding for implementation. It is reasonable to ask where that funding will come from.

17:30

Mike Rumbles: On that point, I understand entirely that you are focusing on the economic and employment side, but we have to focus on everything in the round. In your written submission, you say:

“It is our view that … health matters”
should be given

"equal consideration ... to the employment implications."

You equate a possible downturn in business with the deaths of 1,000 to 2,000 people in Scotland every year through passive smoking—that is based on the scientific information that we have received. Are you seriously suggesting to us that the economic argument that you propound should outweigh that?

**Andy Matson:** Not necessarily, but from the economics, which we outline in our paper, it appears to us that to save about £15.5 million we will lose in the region of £50 million. We are not economists, but simple sums suggest to us that that is the case. That seems to me to be the economics of lunacy.

As a trade union, we have always supported and argued for health and safety. We believe that health and safety in the workplace is paramount. The industries in which we have operated over the years are primarily those in which there have been health and safety risks from fumes of one type or another, but those risks have been resolved in industry with the use of improved ventilation systems. There have been problems with fumes from chemicals that are used in certain processes in the electronics industry, but ventilation and filtration systems have been used to resolve some of those issues. In heavy engineering industries such as shipbuilding there have been difficulties with fumes from welding rods and so on, but improved ventilation systems have gone some way towards resolving those problems.

Evidence is available to suggest that ventilation and filtration systems can provide health and safety support to workers in the hospitality trade, if health and safety in the workplace is the issue on which the committee wishes to focus. We have tried to stay out of the health debate on smoking and concentrate on the areas in which we believe our members have some input and we would like to think that the committee is prepared to take that on board.

**The Convener:** You are saying that, whatever the Parliament chooses to do, it should act with full knowledge of all the impacts of its decision.

**Andy Matson:** That is what I am saying. As we say in our written submission, we believe that choice should be available on both sides of the debate. Some pubs and restaurants have already declared their intention to be non-smoking premises within a particular period of time—Pizza Hut is one and J D Wetherspoon has made its declaration. We do not have a difficulty with that. We believe that, if people want to go into a pub and have a pint and a fag, that is a choice that they should be able to make. If they want to go into a pub and have a pint without a cigarette, that is equally a choice that should be made available to them.

**Helen Eadie:** We visited Galway and Dublin and we met Impact, the biggest public sector trade union in the Republic of Ireland. Do you agree with its view that the health and safety of its members should take precedence over the potential economic impact of the policy?

**Ian Tasker:** The STUC’s policy has always been that there should be no economic measure in relation to health and safety improvements. The difference between the situation in Ireland and the proposed legislation in Scotland—this was touched on in a previous evidence session—is the lead-in. We held initial discussions with the hospitality and licensed trades on how the trade union movement could work with them over a prolonged period to examine and perhaps reduce the economic impact. The Transport and General Workers Union, which has members in the hospitality industry, supports an all-out ban in Scotland, England and Wales. There is an opportunity for the trade union movement to work with the hospitality trade, but we are concerned that the wider public debate over the past few months has prevented us from taking that opportunity.

**Helen Eadie:** When we visited Ireland, we heard about the new investment opportunities, which have been mentioned by the deputy convener, such as the manufacture of gazebos and patio heaters. A whole range of construction-related jobs has been created, which it is felt must offset the number of jobs that have been lost in the hospitality sector.

**Ian Tasker:** I am not aware of any figures relating to what those new industries are doing to offset the overall economic cost. We support the view of Amicus that job losses are an important consideration. People who work in the hospitality industry often do not choose to do so; they do it to see themselves through college or as a second job. If jobs in that industry disappear—although we are not wholly convinced that the forecast loss of jobs will materialise—that may lead to increased social exclusion for many people who are already on low wages.

**Helen Eadie:** What is your comment on the potential impact of the ban on those who suffer from smoke-related diseases, especially asthma and chronic bronchitis? Can you even up the balance sheet from what Andy Matson has said and acknowledge that there is a cost to Scotland of £83 million for sickness absence related to exposure to environmental tobacco smoke?

**Ian Tasker:** Environmental tobacco smoke obviously impacts on people who have bronchial conditions. We are considering the health angle and the STUC line has been that it is inevitable that a ban on smoking in public places will bring
overall health improvement. We therefore support the health arguments, but we believe that some smoking cessation initiatives must be provided for the hospitality trade, as various estimates say that between 50 and 70 per cent of the people who work in that industry smoke.

**Helen Eadie:** What is your comment on the cost of the loss of productivity to Scotland through smoking-related diseases causing time off work? That cost is estimated at £450 million.

**Ian Tasker:** If people are suffering from lung cancer or any lung disease, there will be a loss of productivity. However, there is also a loss of productivity through drink-related illnesses. We have to look at the whole picture. Smoking is one issue, but there are a lot of occupational health illnesses.

**Helen Eadie:** We will move on to the subject of alcohol later. Do you know what the cost is of the payment of welfare benefits to those who are unable to work due to smoking-related illnesses? Do you accept—again, evening up the balance sheet with what Andy Matson has said—that that cost is £40 million? That brings the total cost to around four times the amount that Andy Matson has suggested in his submission to the Scottish Parliament.

**Ian Tasker:** I think that Andy Matson would be better placed to comment on those figures. We are looking at the situation and considering what the health benefits will mean, but what is important is how we use the cost savings relating to health to mitigate the situation in relation to job losses and the arguments that Andy Matson has put forward. The trade union movement exists to protect jobs and to protect members’ health and safety, so we are caught between the devil and the deep blue sea.

**Helen Eadie:** Do you accept that all the savings that we have talked about this afternoon—more than £600 million by now—could be channelled into the public sector works that we so desperately need across Scotland? The trade union movement is always bemoaning the fact that there is never enough money to go round to create jobs in the public sector. Could not that money be redirected from the savings back into the health service, which unions represent?

**The Convener:** I should point out that all that we are asking for is a general opinion. It is not really for the individual unions to answer that question. Unfortunately, it will not be a matter for them.

**Helen Eadie:** Okay. I have a specific question. How much money is spent by the national health service in Scotland, and do you agree that that money—£200 million—would generate more jobs?

**The Convener:** I think that we understand the point that Helen Eadie is making. There are two sides to the equation. Money may be lost on one side, but it may be gained on the other. That is the point that needs to be addressed.

**Andy Matson:** It is unfair to become selective about which work-related illnesses one wants to quantify. We might want to extend that to include work-related stress, which is a big issue these days, although I do not know whether anyone has tried to quantify how much it is costing. As far as our submission is concerned, we have certainly not tried to draw anything out of the air. We have looked at papers that have been produced on behalf of the Parliament in supporting the bill. We have not sought to go beyond that to any documentation that is not among the official papers for the committee. If such papers had been appended, each and every one of us would probably have had a tome to read, but we have tried to make a reasonable submission in the light of the official paperwork that was sent out to interested parties when the Parliament issued invitations to comment.

**Dr Turner:** I have a quick question about the heating and ventilation industry. I take it that you will not be expecting to lose many people from that industry, because I understand that there is heating and ventilation in premises anyway. Would you expect to lose anybody in that area?

**Andy Matson:** No. Our view is that, if the Parliament were to consider a voluntary ban, rather than a total ban, and to tie it in with requirements for improved ventilation systems, there would be an opportunity for expanding employment in the heating and ventilating industry, not only in installing upgraded equipment but in on-going maintenance to ensure that the systems work efficiently. That is certainly not an area in which we envisage a downturn in employment.

**Dr Turner:** A large number of people do not accept that ventilation works and there is quite a range of expensive ventilation systems. If we went to go down that pathway to an eventual ban, would we be leading people into expense and eventually putting the ventilation suppliers out of business, not to mention people in other businesses, because they would have spent and borrowed so much money to install useless equipment—or equipment that you may not think is useless but that many people believe is useless?

**Andy Matson:** I accept that some people believe that, no matter how super-efficient the ventilation and filtration system that could be installed, it is irrelevant to the argument. Equally, some people—including us—contend that adequate ventilation and filtration systems can be developed and installed to provide the necessary...
safeguards that the committee and the Executive through the bill seek to put in public places.

17:45

The Convener: Do members have any final, small points?

Mr McNeil: When will we finish?

The Convener: We will finish when we finish. There is time for you to ask more questions.

Mr McNeil: I will follow up Helen Eadie’s questions. There is a big divergence in view from that of the Irish trade unions, which were clearly partners for the greater good of a large group of workers in the hospitality industry. The STUC submission refers to choice in the round and says:

“individuals work in the hospitality industry not through choice but necessity. This includes students, young parents and those who need to take additional jobs to supplement low pay in their main employment.”

Where else would the trade union movement argue that protection that workers deserve should be deferred until others catch up? As trade unionists, when we meet a health hazard, the first principle is to ask whether that hazard can be eliminated. Smoking is a hazard that can be eliminated in the workplace. Only when we cannot eliminate a hazard do we seek to enclose it or replace it with safer materials. We have a hazard that can be eliminated and we should not defer the support that workers in the hospitality industry deserve. I appreciate that that was more of a statement than a question.

The Convener: Indeed.

Ian Tasker: Duncan McNeil has summed up our position. After much debate, we are supporting a ban. We believe that smoking is a hazard and should be treated as a workplace hazard. It is unusual for the Scottish Parliament to consider legislation that will impact on the workplace.

The STUC youth committee discussed the matter and also favours a ban, but we have not had the chance to work in partnership on the matter. That is what we want to achieve, but we will not do that by April next year. We must engage with the anti-smoking lobbies and the SLTA and we must promote partnership to achieve the overall ambition of a ban on smoking in public places.

Dave Watson: I agree with Andy Matson that the Parliament should always consider the economic impact of legislation. When that is clearly measured, just transition arrangements should be put in place to deal with it. However, Unison has discussed the matter with Impact, our sister union in Ireland, and we take the same approach. As always in health and safety, the risks and the economic impact must be balanced. Given the number of deaths that smoking causes, the impact of second-hand environmental tobacco smoke and the fact that 70 per cent of adults do not smoke, the balance is in favour of the ban.

The voluntary arrangements have not worked. Equally, for many of the reasons that Duncan McNeil gave, the ventilation approach is not right. When we can get rid of a risk, the proper health and safety approach is to get rid of it. It is not as though alternatives do not exist. People do not have to smoke in pubs or other buildings. If an employer said that we had to keep that approach in place, we would say, “On yer bike. We’re not having ventilation. Get rid of the risk.” On the balance of health and safety, that is what we would argue.

I say bluntly that we approach the issue from a public health perspective. We represent staff in the health service and social care sector who see the damage that tobacco smoke does daily. If you have had to nurse someone with lung cancer, you tend to take a fairly firm view on the dangers of smoking. We put the bill in the context of the Executive’s wider programmes to reduce smoking and think that it would provide an important benefit by reducing smoking and the associated health risks in Scotland.

Andy Matson: I do not think for a moment that Duncan McNeil was saying that ventilation systems will not solve the problem. He was saying that a hazard has been identified and asking how we should address it. Over the decades, we have identified numerous hazards in the workplace and have put in place measures to address them, while seeking not to impact on employability in certain areas and industries. Our submission seeks to address that issue by saying that a hazard has been identified and that we believe that there are mechanisms available to address it. Stewart Maxwell is not in attendance, but I say to him that we are not suggesting that people wear space suits. The comments that I made on the previous occasion that I gave evidence to the committee in support of filtration systems and the technology that is available in other places and can be utilised were taken a little out of context.

Let me be quite clear. In its written submission on Stewart Maxwell’s member’s bill, Amicus said that it supported some Executive initiatives to reduce the level of smoking but that it did not believe that an all-out ban was the way forward. We do not believe that such a ban is in people’s interests or that the public are asking for one. We believe that choice is essential and that, if Scottish people are presented with a choice, they will sensibly determine whether during their leisure time—which is the primary target of the proposals—they wish to frequent premises where they can smoke or premises where they cannot
smoke. To remove that option is almost to remove a basic right from the population of this country.

The Convener: That concludes the panel’s evidence.

17:53

Meeting continued in private until 18:22.
Thank you for the invitation to submit supplementary evidence to the Committee for consideration. I hope the points outlined below help clarify our position and will aid the Committee’s consideration of the Smoking, Health and Social Care (Scotland) Bill (‘the Bill’).

In the oral evidence session the Committee discussed the British Hospitality Association’s views on the provisions of the Bill in relation to hotel bedrooms. At present the Bill proposes three things by way of sanction in relation to smoking. In summary, these are as follows:

1. Fine on the proprietor, etc. (Section 1)
2. Fine on the smoker (Section 2).
3. Power to enter and require identification (Section 6).

In relation to hotels (outside of bedrooms), and for restaurants, bars, etc. within hotels, we accept all three sets of sanctions as set out in the Bill as these areas are public places. The intention of the Scottish Executive as stated in the Policy Memorandum is to ban smoking in ‘enclosed public places’. We do not accept that a hotel bedroom is a public place it is patently private and the Executive appears to accept this. The main issue is how best to deal with hotel bedrooms in the legislation.

As currently drafted the Regulations allow hoteliers to designate at their discretion which rooms are smoking and non-smoking. Bedrooms designated as smoking would be completely exempt from the Bill, and rooms which are non-smoking would be subject to the Bill. Therefore, the draft Regulations would exclude bedrooms from all three sanctions if the hotelier specifically allowed guests to smoke, but perversely all three sanctions would apply in non-smoking rooms and that is not equitable.

Our main concern relates to the difficulties of enforcing a ban on smoking in hotel bedrooms which are by their very nature private places, and not ‘public places’. It would clearly be impossible for a hotelier to reasonably detect whether an individual is smoking in a bedroom. Random checks by enforcement officers would interfere with privacy and clearly be unacceptable without a warrant. Logically it would be unworkable for them practically to enforce a ban on smoking in hotel bedrooms.

The situation created by the Regulations if introduced as currently drafted would create a clear anomaly with the ‘general principles’ of the Bill, so it would be in the hoteliers interests to designate a room as a ‘smoking room’ as they would not then run the risk of prosecution.

The BHA believe that the most effective way of dealing with hotel bedrooms would be to exempt them completely from the legislation either on the ‘face’ of the Bill as suggested in our original submission or via the Regulations. This would allow hoteliers to continue as at present to define their own policy on smoking in bedrooms, including imposing a ban without risking a fine as a result of doing so.

I hope this additional clarification and information will be helpful in assisting the Committee draft its Stage 1 Report.

Yours sincerely

Paddy Crerar
Chair BHA Scotland Committee
1. Recommendations for baseline and post legislation research to measure success of legislation, and on implementation issues.

a. Health Outcome Measures

- We recommend measuring cotinine levels in non-smoking bar staff (before and after implementation) as a proxy for exposure to SHS. Cotinine can be measured by urine or salivary tests.

- In order to measure air quality in pubs – taking into account methodological issues around air quality measurements – we recommend assessing levels of respirable suspended particles (RSP), an accepted marker for levels that are known to increase risk of respiratory disease, cancer, heart disease and stroke. Measurements would need to be taken before and after implementation.

- We recommend assessing exposure of young (i.e. preschool) children to second-hand smoke. It may be possible to base research around routine health visitor annual checks of 1-3 year olds, possibly using salivary cotinine measures as a proxy for second-hand smoke exposure. Extent of exposure may also be measured using hair samples – this provides an accurate depiction of average exposure over a long period, as each 1cm of hair accumulates a reading over a whole month. The study numbers could be contained by a geographical selection – including several areas where smoking rates are known to be high.

- We recommend that hospital admission rates for asthma, bronchiolitis and other respiratory conditions in children are recorded pre-and post implementation.

b. Economic Outcome Measures

- We recommend that economic trends in the hospitality sector are validated by business tax receipts – ideally for 3 years before legislation is implemented. Should cover a range of areas especially rural.

- We recommend data is collected regarding the numbers of bars closing and opening, at least a year before, and possibly drink sales figures.

- We recommend collecting cigarette sales data (pre-and post implementation) and bar sales data.

- We recommend measurement of employment rates in the hospitality sector, pre-and post legislation implementation.

- We recommend data be collected on tourism and travel as an indicator of number of visitors in Scotland pre-and post legislation implementation.

c. Public Opinion Measures

- We recommend revisiting some of the consultation questions one year after implementation

- We recommend measuring increased interest/update of Smokeline/Smoking cessation services, and the number of individuals successfully quitting through smoking cessation services. This data should include information on specific health inequalities target groups (pregnant women, young people, disadvantaged communities)
We recommend that surveys be conducted to measure levels of knowledge and awareness of the dangers of tobacco and second-hand smoke (pre-and post implementation). Data should be collected to show differences across region, age, gender, ethnicity and social class. Implementation will succeed through targeted communications. Surveys such as these will show where and how those communications need to be targeted.

d. Implementation Issues

- We recommend that data be collected on smoking cessation service waiting lists and throughput (pre-and post implementation).
- We recommend that data be collected on compliance with legislation – to include data from EHO’s, data on prosecutions etc, and calls to report violations.
- Intensive and strategic media campaigns are required pre-legislation to increase adults’ awareness of the dangers of secondhand smoke & inadequacy of ventilation to remove these. These campaigns will ensure maximum effect in protecting young people from the adverse health effects of secondhand smoke exposure.

2. The Tobacco Industry: Further Insights

a. Imperial Tobacco

The ongoing (McTear vs Imperial) court case in Scotland has not produced public access to tobacco documents. Imperial's Chief Executive, Gareth Davis, testified in court in 2003 that Imperial did not know whether smoking cigarettes causes lung cancer, citing doubts about the basis of scientific methodology. A similar argument was made about secondhand smoke by Steve Stotesbury, Imperial Tobacco’s Industry Affairs Manager European Union, when presenting at the Scottish Licensed Trade Association’s seminar in Edinburgh on 13th January 2005.

Imperial Tobacco was previously singled out for criticism by members of the House of Commons Select Committee on Public Accounts in 2002. Gareth Davis was accused of being 'positively parsimonious with the truth as far as this Committee is concerned' by Rt Hon Alan Williams MP (Labour, Swansea West), and all three witnesses for Imperial Tobacco were overtly accused of lying to the committee by Mr George Osborne MP (Conservative, Tatton) and by Mr Barry Gardiner MP (Labour, Brent North) - who added 'I believe you are the least credible witnesses that I have ever seen come before the Committee of Public Accounts'.

b. Tobacco Document Depositories

The 1998 Minnesota Consent Judgement was the outcome of legal action by the State of Minnesota and Blue Cross and Blue Shield of Minnesota against Philip Morris and several other tobacco companies, seeking to recover smoking related-health care costs. Under the terms of the judgement several tobacco companies were ordered to make public internal documents produced during the discovery process. These were deposited at two sites, in Guildford and Minnesota.

The Guildford Depository, England, holds an estimated 6-7 million internal corporate documents from the British American Tobacco Company (BAT) produced during the discovery process. It opened in February 1999 and will remain open until 2009. In contrast to the Minnesota archive (see


109 Further details of the Minnesota Consent Judgement are available online at: [http://news.corporate.findlaw.com/hdocs/docs/tobacco/consent.html](http://news.corporate.findlaw.com/hdocs/docs/tobacco/consent.html) (Accessed 01/04/05)

The depository at Guildford is managed by BAT itself. From the outset, the efforts of researchers to investigate the contents of the documents housed there have been severely hampered. Recently published reports describe how some industry documents held here have been altered, how database searches conducted by visitors are tracked internally, and that BAT refuse to supply some documents requested. These reports suggest minimal compliance with the letter of the Minnesota agreement.\textsuperscript{111}

The British American Tobacco Documents Archive is a joint undertaking by the London School of Hygiene & Tropical Medicine University of California, San Francisco (UCSF) and Mayo Clinic. It aims to expand access to the BAT documents held in the Guildford Depository by scanning the entire collection and hosting them on a website.\textsuperscript{112} It is anticipated that all documents will be available on the website in 2007.

The Minnesota Depository, United States\textsuperscript{113}, holds approximately 26 million pages of tobacco industry documents produced in the discovery process from Philip Morris Incorporated, Brown and Williamson Tobacco Corporation, Lorillard Tobacco Company, American Tobacco Company, RJ Reynolds Tobacco Company, The Council for Tobacco Research and The Tobacco Institute. It opened in 1998 and will remain open until 2008. It is operated by an independent paralegal firm Smart Legal Assistance. The collection is continually growing as the depository receives documents produced in other litigation cases as a result of the 1998 Master Settlement Agreement.

The Master Settlement Agreement was made on 23rd November 1998 between the five largest US tobacco companies (Brown & Williamson Tobacco corporation, Lorillard Tobacco Company, Philip Morris Incorporated, R.J. Reynolds Tobacco Company, Commonwealth Tobacco, and Liggett & Myers) and 46 states' attorney generals. Among other provisions it stipulated that the tobacco industry is to make public all documents produced in US lawsuits, at their own expense set up and maintain, until 30th June 2010, a website to include all these documents and to add all documents produced in all future US lawsuits.\textsuperscript{114} The Master Settlement Agreement does not apply to the UK based BAT.

c. What have the Collections Revealed to Date?

- Tobacco Industry Efforts to Undermine the World Health Organisation

A key finding from the Guildford documents has been the extent to which the tobacco industry has engaged in efforts to undermine tobacco control worldwide. In 2000, the World Health Organisation (WHO) published a detailed report of the industry's efforts to infiltrate and undermine their organisation, for example by placing industry-paid staff within the organisation.\textsuperscript{115}

- Tobacco Industry Research Strategies

In the late 1980s, the international tobacco industry assisted in the establishment of the International Society of the Built Environment, which published the journal Indoor and Built Environment. A research article recently published in the Lancet examines the industry associations of the Society's executive, the journal's editor and board, and the extent to which the journal published papers on environmental tobacco smoke that would be deemed favourable to the tobacco industry. It concludes that the tobacco industry's aim was to dominate the organisation and the content of its academic journal, pushing the view that SHS posed little risk to those exposed to it. In fact, some 90% of articles which were published in this journal that were positive to the

\textsuperscript{111} Muggli, M.E. et al. (2004). Big tobacco is watching: British American Tobacco's surveillance and information concealment at the Guildford Depository. The Lancet, 29 May.

\textsuperscript{112} British American Tobacco Document Archives. Available online at: \url{http://bat.library.ucsf.edu/}. (Accessed 01/04/05).

\textsuperscript{113} Further information on the Minnesota Depository is available online at: \url{http://www.tobaccoarchives.com/doc.html} (Accessed 01/04/05)

\textsuperscript{114} For further details see \url{http://www.tobaccoarchives.com/}. (Accessed 01/04/05).

tobacco industry were written by people with a history of association with them. When article quality, peer review status, article topic, and year of publication were statistically controlled for, the only factor associated with the conclusion that passive smoking was not harmful was whether an author was affiliated with the tobacco industry.116

Documents have also revealed how the industry built up networks of scientists sympathetic to its position that SHS is an insignificant health risk. The industry funded independent organisations to produce research that appeared separate from the industry and would boost its credibility. Unfavourable research conducted or proposed by industry was prevented from becoming public.117

- Tobacco Industry Evidence that Second-hand Smoke may be more Dangerous than Directly Inhaled Tobacco Smoke
A extremely significant example of such activity was highlighted in recently discovered tobacco industry documents demonstrating that second-hand smoke may be even more harmful than directly inhaled tobacco smoke. As stated in our main submission to the Health Committee (Feb 2005):

“Recently discovered tobacco industry documents demonstrate that second-hand smoke may be even more harmful, volume for volume, than directly inhaled cigarette smoke.”118 Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places, and remain equally active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries.”

The tobacco industry maintained, for many years, that is was unaware of research about the toxic effects of smoking. However, a recent report in the Lancet119 documents the way in which one company, Philip Morris, acquired a research facility, INBIFO, in Germany, in order to privately determine for themselves whether smoking had hazardous health impacts. INBIFO appears to have published only a small amount of its research and what has been published appears to differ considerably from what has not. In particular, the unpublished reports provide evidence of the greater toxicity of sidestream smoke compared to mainstream smoke. By contrast, much of its published work comprises papers that cast doubt on methods used to assess the effects of second-hand smoke.

In the 1980’s INFIBO conducted a large number of animal experiments on sidestream smoke. One INFIBO report120 sent to Philip Morris in 1982 describes in great details the results of exposure of rats to sidestream smoke. The report states that secondhand smoke exposure was more irritating than mainstream smoke, and most particularly to the upper airways (nasal cavities and olfactory membranes). Sidestream exposure induced more frequent and more severe lesions in the nasal cavity than mainstream of equal concentration. An accompanying letter to the report concludes that the extent of cornification observed in these animals had “never been seen before.”121
These internal documents clearly demonstrate that Philip Morris was, contrary to its contemporary public statements, aware of the greater health risks posed by second-hand smoke from the early 1980s. However, as recently as April 2002, Philip Morris, in an American court, rejected the statement that second-hand smoke causes disease. This public statement is clearly at odds with its own research findings concerning the consequences of exposure to second-hand smoke, and highlights the extremely selective nature of what is eventually published by some scientists with links to the industry.

- Tobacco Industry Efforts to Prevent Legislation on Smoking in Public Places
Documents have also revealed further insights into the tobacco industry’s efforts to prevent legislation on smoking in public places across a number of countries and regions. In a recently published internal document from the Tobacco Institute, vice-president Peter Sparber states, “the tobacco industry has faced more than 1,000 public smoking bills, and has defeated more than 90% of them... By in large, these bills have attempted to restrict smoking in public places.” Those they have defeated are more typically reintroduced year after year, often redrafted to accommodate legislators’ objections.” Sparber continues: “We cannot say that ambient smoke doesn’t harm non-smokers... and in fact the best we can say is that it is not proven that cigarette smoke in the air harms normal, healthy non-smokers”.

- Tobacco Industry Evidence that Second-hand Smoke Exposure Increases the Risk of Sudden Infant Death Syndrome (Cot Death)
A recently published report reveals that in 1997, Phillip Morris commissioned a review article on Sudden Infant Death Syndrome (SIDS), in response to company concerns about the possible adverse effects of SHS on maternal and child health. The draft review concluded that prenatal and postnatal smoking exposures are both independent risk factors for SIDS. However, the final draft was modified following exchanges with Phillip Morris and tobacco company scientists, to conclude that postnatal SHS effects were “less well established” than those associated with prenatal maternal smoking. The review paper was published in 2001 in the UK journal Paediatric and Perinatal Epidemiology, stating that the relationship between SIDS and exposure to SHS was ‘difficult to quantify’. The tobacco industry has long fought to counteract scientific evidence that SHS is dangerous to health. By Philip Morris’ own admission, ‘there is perhaps no other issue as powerful facing the industry’ as SHS and maternal and child health issues. Three years after its publication, the SIDS review had been cited at least 19 times in the medical literature. This suggests that Phillip Morris succeeded in manipulating the content and presentation of scientific results, to create a review that, until now, has been seen as authoritative and credible.

3. Additional research published since our written submission to the Health Committee

a. Adult Health Risks
A recent study published in the British Medical Journal highlights that exposure to second-hand smoke kills more than 11,000 people a year in the UK – a much higher figure than previously thought. This study also gives the first available figure for people dying from second-hand smoke in the workplace – 600 lives are year are lost because of exposure to SHS at work. The study found

2,700 deaths among people aged 20 to 64 could be attributed to second-hand smoke and 8,000 in 65-year-olds and over. A further 617 deaths are thought to be caused by workplace passive smoking, including 54 in the hospitality industry. This is in line with recent research that suggests around 1000 Scots die as a result of exposure to second-hand smoke every year.127

b. Benefits of Going Smoke-Free

The SLTA128 continue to argue that the evidence shows that there is little or no effect on smoking incidence among regular users following the introduction of smoke-free legislation. They argue that, in Ireland, according to research Agency Millward Brown, the incidence of smoking 5-plus cigarettes a day, among adults aged 18-64 has increased for both men (by 4%) and for women (by 2%). This is not in accordance with any other estimates of incidence that have been drawn from Ireland (see our main submission). On Tuesday 29th March 2005, the Republic of Ireland celebrated one year of smoke-free success. According to the Irish Finance Minister, cigarette sales have declined by 18%, and it is reported that an estimated 7000 smokers have quit smoking since legislation was introduced one year ago.129 A team of researchers from the Royal College of Surgeons in Ireland have reported that smoking is on the decline among older people in Ireland; with prevalence rates falling between 2-3% over the past 4 years; from 20% to 18% in the east, and from 21% to 17% in the west. By comparison, smoking rates among older people in Northern Ireland have remained stable, at around 19% both in 2000 and 2004.130

In a recent independently conducted poll, an overwhelming 98% of the Irish public responded that workplaces are healthier since the introduction of the smoke-free law, including 94% of smokers. 93% of respondents think the law was a good idea, and 96% of respondents feel that the law is successful.131 A recent survey by the trade union Mandate has found that people working in public houses across the Republic of Ireland believe that smoke-free legislation has yielded huge benefits for their health. 87% of respondents believed that the law had already had a positive impact on their health, with 82% stating that they now found it easier to breathe at work, and 68% reporting that they coughed less.132 A study by the Office of Tobacco Control has found that since the introduction of smoke-free legislation, carbon monoxide levels in non-smoking workers have fallen by 45%, and levels in ex-smokers have fallen by 36%. Average levels of the smaller airborne particles in SHS, which are known to be particularly harmful to health, have been reduced by 87.6%.24

c. Ventilation

ASH Scotland’s evidence-based research briefing on ventilation is available online at:

http://www.ashscotland.org.uk/ash/downloads/Ventilation.doc

127 Hole, D.J. (2004). Passive Smoking and Associated Causes of Death in Adults in Scotland. NHS Health Scotland. Available online at:
http://www.hebs.com/researchcentre/pdf/MortalityStudy.pdf (Accessed 05/01/05)

128 Health Committee Smoking, Health and Social Care Bill. Part 1: Prohibition of smoking in certain wholly enclosed places. Written submission to the Scottish Parliament Health Committee from the Scottish Licensed Trade Association. Available online at:
http://www.scottish.parliament.uk/business/committees/health/inquiries/shsc/Part1/35%20SUBMISSION%20BY%20SLTA.pdf (Accessed 09/03/05)

129 ‘One year on for Irish Smoking ban’. BBC news report available online at: http://news.bbc.co.uk/1/hi/northern_ireland/4388507.stm (Accessed 29/03/05)

130 ‘Smoking rates among older people fall’. Irish Health news report available online at: http://irishhealth.com/?level=4&id=7199 (Accessed 29/03/05)


132 ‘Bar staff experiencing benefits of smoking ban – ireland.com’. News article available online at:
http://home.eircom.net/content/irelandcom/breaking/5266131?view=Eircomnet (Accessed 29/03/05).
This briefing contains further details of the evidence submitted to the Health Committee, and additional research that clearly demonstrates that ventilation systems are not able to remove the hazardous gases that are present in SHS.

The SLTA\textsuperscript{21} recently stated that ETS contamination is subject to exponential decay, and use a chart prepared by Building Services Research and Information Association (BSRIA) to illustrate this point. They argue that most pubs have a natural leakage rate of 1 or more air changes per hour, with air seeping through the fabric of the building. This means that the equivalent of all the air in the room is replaced once each hour with fresh outside air. At even a low rate of ventilation such as 5 air changes per hour, the contamination would reduce by about 85% in about 30 minutes, and effectively to zero within an hour.

BSRIA are far from independent. They have in the past conducted testing on ventilation equipment performance sponsored by Honeywell and other air cleaner manufacturers, under the umbrella of the AIR (Atmosphere Improves Results) initiative. Interestingly, at the time AIR published the results of this testing, relatively few manufacturers agreed that their test results could be published.\textsuperscript{133}

BSRIA has also worked with the Air Cleaner Manufacturers Association (ACMA), which was set up specifically to counter arguments regarding the inadequacy of ventilation systems, and to prove the effectiveness of its members’ equipment to potential purchasers and Regulators. This led to the launch of BSRIA’s certified rating scheme “to clearly show the real performance, rather than the claimed performance of an air cleaning product.”\textsuperscript{26} BSRIA are also a member of the AOB group, the same group that is dedicated to opposing the Smoking, Health and Social Care Bill and in partnership with companies such as Imperial Tobacco.\textsuperscript{26}

The SLTA\textsuperscript{21} continue to refer to the published “Black Dog study,”\textsuperscript{134} which they state clearly demonstrates that well-managed ventilation airflow can prevent ETS drifting from a smoking area to a non-smoking area. The researchers conclude that ventilation techniques for restaurants/pubs with separate smoking and non-smoking areas are capable of achieving non-smoking areas ETS concentrations that are comparable to those of similar facilities that prohibit smoking outright.

The SLTA fail to mention that this piece of research was led by Roger Jenkins, of the Oakridge National Laboratory of Tennessee. Although part of the U.S Department of Energy’s often highly-classified research establishment, Oakridge National Laboratory researchers are also for rent to private companies. Roger Jenkins has conducted several other pieces of research that have been commissioned by the tobacco industry, that typically attempt to show that exposure to SHS is not a health hazard.\textsuperscript{135} Jenkins’ findings, and Jenkins himself, frequently appear in hearings to oppose local smoke-free measures. As an expert witness for the defence in a lawsuit bought by flight attendants against the tobacco industry over the lung cancer and other diseases they contracted at work, Jenkins’ evidence was excluded by the judge because of his pro-tobacco industry bias.\textsuperscript{136}

It is also noteworthy that the research was published in the Journal of Regulatory Toxicology and Pharmacology, which is sponsored by the International Society for Regulatory Toxicology and Pharmacology (ISRTP). In turn, ISPRT are part sponsored by RJ Reynolds Tobacco Company.\textsuperscript{137}

\textsuperscript{133} Honeywell Online Noticeboard: http://content.honeywell.com/uk/air-quality/notice_board/archive/notice_board_archive.html#Anchor5 (Accessed 09/03/05)
\textsuperscript{136} Roger Jenkins and Oak Ridge National Laboratory. Available online at: http://www.tobaccoscam.ucsf.edu/vent/vent_hg_internal_4.cfm (Accessed 21/01/05)
\textsuperscript{137} ISPRT website, at: http://www.cspinet.org/integrity/nonprofits/international_society_for_regulatory_toxicology_and_pharmacology.html (Accessed 09/03/05)
d. Voluntary Agreements

A recently published European multi-centre study has demonstrated that introducing non-smoking and smoking areas in public places fails to create a completely smoke-free environment. The researchers measured SHS exposure in a range of public places, including transport, educational settings, and bars and restaurants. The researchers measured levels of environmental tobacco smoke in Vienna, Paris, Athens, Florence, Oporto in Portugal, Barcelona and Orebro in Sweden. Whilst there was some variability among cities, the study demonstrates that co-existing smoking and non-smoking areas are not an effective means of controlling the health hazards associated with SHS. Nicotine levels in many of the areas tested that had smoking restrictions were not dissimilar in concentrations to areas where smoking was permitted. The highest nicotine concentrations were found in bars and discos, followed by restaurants. The researchers state that “A person dancing for four hours in a disco with the median concentration found in cities like Vienna or Barcelona is exposed to a similar amount of tobacco smoke as someone living with a smoker for a month.” 138

Recent reports139 outline that the city council in Paris have now acknowledged that a voluntary scheme launched three months ago has failed. The scheme aimed at encouraging Paris’s 12,452 cafes, bistros and brasseries to declare themselves smoke-free zones had been adopted by barely thirty. Here is another example of voluntary smoke-free plans failing to work.

e. Economic Impacts

There have been several attempts by the SLTA, TMA and AOB to undermine the International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places that was recently undertaken by Aberdeen University. The Scottish Beer and Pub Association140 state that the study makes no attempt to analyse the macroeconomic impact of smoke-free legislation on the Scottish economy, that the study is not robust, and that it relies on analyses of incomplete and non-transferable studies.

Firstly, the author of the study acknowledges that the model for Scotland was estimated on the basis of the best available evidence and using expert judgement where the evidence does not exist. The majority of studies that have been undertaken cover both bars and restaurants, as very few existing studies separate out the economic effects for these two sectors.

Secondly, to acknowledge the limited number of existing studies available, the authors combined a literature review with the modelling exercise to place the likely impacts of restrictions on smoking in public places in a Scottish context. The literature review covered a number of distinct areas, including economic impacts of restrictions on the hospitality sector, costs of workplace smoking, and the costs of smoking related diseases.

The model was based upon evidence relating to smoke-free public places, which include workplaces and the leisure and hospitality sector. Smoke-free legislation was modelled, rather than lesser restrictions, because the nature of health effects relating to partial smoke-free restrictions remain unclear. In order to provide as complete an overview of the impacts of smoke-free legislation as possible, some impacts have been modelled on the basis of only limited information.

138 Nebot, M. et al. (2005). Environmental tobacco smoke exposure in public places of European cities. Tobacco Control, 14, 60-63. Abstract available online at: http://tc.bmjournals.com/cgi/content/abstract/14/1/60 (Accessed 04/03/05)
139 “Voluntary smoke-free plan not working in Paris”. News article in the Guardian, 16/02/05. Available online at: http://www.guardian.co.uk/france/story/0,11882,1415452,00.html (Accessed 04/03/05)
Therefore, to reflect this uncertainty, a range of estimates has been produced; central, low and high.

There are a number of challenges inherent in research of this kind. Some of the problems in research design are unavoidable given that the impact of restrictions can only be evaluated where they have been implemented.

Looking at the hard evidence from New York, Ireland, and California, there is not a negative impact on business. The only studies that suggest that there is are funded by the tobacco industry and are of poor quality.

Going smoke-free can offer many business opportunities – around 70% of the Scottish population don’t smoke; smoke-free is popular (especially after it’s been legislated for) and smoky pubs are unpopular. The only industry we know will be hurt by progress on this issue is the tobacco industry.

SUPPLEMENTARY SUBMISSION BY COSLA

You will recall I agreed to clarify COSLA’s position on enforcement of the smoking ban following our oral evidence session with the Health Committee at its 15 March meeting and I hope the following paragraphs will provide that clarification.

There is in fact no substantial difference of opinion between ACPOS and COSLA on the issue of enforcement and it was unfortunate that the context of our evidence session did not give that clear message with much of the debate focussing on the operational aspects of the draft legislation.

We did not intend to give the impression that as soon as the Act is live that we go out and take a robust approach to enforcement. What we do believe is that:

~ the legislation, as currently drafted, is enforceable;

~ there needs to be a mature and stepped approach to the enforcement of the ban;

~ the licensee should be responsible for the behaviours of his or her customers whilst they are in licensed premises; and

~ non-invasive enforcement is the preferred and most likely route to success.

We hope that the situation in Scotland will replicate that in Ireland and that the legislation will be largely self-enforcing. We have to be prepared, however, for any instances where a self- enforcing approach, and steps taken by the licensee are not successful and it is here I think that the confusion arose with the evidence to the Committee. COSLA supports the legislation as you know but, if it is to be effective, it must be enforced. We therefore need to be prepared to deal with instances where the low key approach does not work, otherwise there is the danger that the law will be ignored and so be ineffective. It may be that when the legislation is first enacted, some high action/convictions will be necessary to convey the appropriate messages. If it is not clear from the outset that the legislation will be enforced, then the wrong message will have been sent and the legislation will fail. Both the police and local authorities need to be clear about the approach to be adopted in any instances of persistent flouting of the law.

COSLA is clear, as currently drafted, the legislation is enforceable. There are no grey areas in the draft and from the enforcement point of view there can be no argument. Our point is that, if and when enforcement action is required, the draft legislation is clear on the course of action that can be taken. We either take action against the licensees if they have done all they can to prevent the breach (or indeed remove the individual from the premises), take action against the perpetrator or take action against both.

Against that background COSLA and ACPOS are arranging a meeting to discuss these issues and the possibility of developing enforcement guidelines, jointly badged, by ACPOS and COSLA to ensure a consistent approach from Police and Local Authorities across Scotland. The Scottish
Executive is aware of this intention and will be given the opportunity to be represented at the meeting.
I hope this is helpful. If further information is required, please do not hesitate to contact me. Yours sincerely,
Alan McKeown
COSLA

cc Gordon Greenhill
City of Edinburgh Council
I would like to thank you for giving the officials the opportunity to present the contents of the Smoking, Health and Social Care (Scotland) Bill to the Health Committee on the 11th January 2005. I hope that the members of the Committee found this a useful exercise.

There were a number of points raised where officials undertook to provide additional information or felt that further clarification would be of help. Please find attached a paper that provides this information. Again, I hope that this is helpful.

Andy Kerr

Annex A

Proposed Amendments to Part 5 of the Adults with Incapacity (Scotland) Act 2000

1. At the meeting of the Health Committee on 11 January, when Scottish Executive officials provided a briefing on the provisions of the Bill, some issues were raised about the amendments proposed to the Adults with Incapacity (Scotland) Act 2000. It may therefore be useful to the Committee to have this further background to the amendments proposed in the Bill and the rationale for them.

2. Part 5 of the 2000 Act came into operation on 1 July 2002. It gives a general authority to medical practitioners to treat patients who are incapable of consenting to the treatment in question. The authority is conferred by a certificate of incapacity, which can only be issued by a registered medical practitioner. Medical treatment is defined in the 2000 Act as "any procedure or treatment designed to safeguard or promote physical or mental health". It could therefore range from fundamental healthcare procedures, (including relief of pain and discomfort, eyesight, skin care, and oral hygiene), and nursing care to major surgical operations. Emergency treatment to preserve life or prevent deterioration in a person’s condition can be given without the need for a certificate of incapacity. Other excepted treatments – such as electro-convulsive therapy or sterilisation – specified in The Adults with Incapacity (Specified Medical Treatments) (Scotland) Regulations 2002, are not authorised by a certificate of incapacity but are subject to an approval regime set out in the regulations.

3. A Code of Practice, which had been the subject of extensive consultation, also came into effect on 1 July 2002.

4. The Code gives guidance on the operation of Part 5. It sets out the assessment process, which should be undertaken before a certificate of incapacity is issued. It makes clear that adults must not be labelled as incapable because of some other circumstance or condition. Rather the assessment of capacity must be made in relation to the particular matter or matters about which a decision or action is required. Thus doctors, in assessing capacity, should bear in mind that they are assessing capacity in relation to a decision about the medical treatment in question. In assessing capacity, it is a statutory requirement to take account of the present and past wishes of the adult, so far as this can be ascertained by any means appropriate to the adult, including communication by human communication or by mechanical aid. It would be reasonable, in this regard, to use the help of the adult’s relatives, friends, social work, clergy or others, who may be in a position to assist. The practitioner’s own knowledge of the patient will also be relevant to the assessment process, as will the experiences of other health professionals - in particular nurses from their (often) close ongoing contact with the patient. The doctor should also ascertain whether it would be reasonable and practicable to seek the views of any existing proxy with welfare powers.

5. The Act currently provides for certificates of incapacity to last for a maximum of 1 year, from the date of examination on which it is based.

6. The Code was due for revision in July 2003, but, in the light of concerns expressed about the operation of Part 5, the Executive agreed to advance the review. In particular, general
practitioners were concerned about the workload implications of the procedure recommended to be followed in the Code of Practice, especially the processes connected with the completion of certificates under Section 47. Dental practitioners were concerned that treatment for an adult with incapacity presenting at their surgeries could be delayed until a certificate of incapacity could be issued by a doctor. This is especially frustrating in the community dental service, where patients – and their capacity to consent or refuse – are often already well known to the dental practitioner.

7. A consultation exercise on the implementation of Part 5 was accordingly launched on 31 March 2003. This sought the views of a wide range of stakeholders on changes or improvements that might be made to the Code of Practice, and whether consideration ought to be given to amending the terms of Part 5 to assist its effective operation including (a) whether health professionals other than registered medical practitioners should be allowed to sign certificates of incapacity and (b) whether the maximum duration of certificates of incapacity should be extended.

8. A qualitative study of the implementation and early operation of Part 5 was also commissioned by the Executive in July 2003. A 3-stage process of data collection was employed across four case study areas of Scotland to focus on the experiences of those who had come into contact with Part 5. This process included a postal questionnaire with health and social care practitioners; 52 interviews with practitioners and representatives of relevant stakeholder organisations; and 4 interviews with carers of adults who had experienced the operation of Part 5 of the Act.

9. An analysis of the responses to these 2 initiatives was placed in the Scottish Parliament Reference Centre, with Bib.Nos.31350 and 32709 respectively. In addition, Executive officials met key stakeholders in February 2004, including the British Medical Association, Alzheimer’s Scotland, the Law Society of Scotland, the Scottish General Practitioners Committee, ENABLE, the Mental Welfare Commission, the Association of Directors of Social Work, CARE, the Society for the Protection of Unborn Child and the Scottish Council on Human Bioethics.

Extending the Range of Health Professionals Who Can Issue Certificates of Incapacity

10. As the analysis of written submissions to the consultation records, the general consensus among respondents was that health professionals other than registered medical practitioners should be allowed to sign certificates of incapacity, subject to various qualifications including the need to ensure that health professionals are equipped with sufficient skills. This was also the view of the meeting with stakeholders in February 2004.

11. Accordingly, the Bill provides that, in addition to the medical practitioner primarily responsible for the medical treatment of the adult, the following may issue certificates of incapacity:

A person who is;

- a dental practitioner
- an ophthalmic optician
- a registered nurse
- or a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfy such requirements as may be so prescribed,

and who is primarily responsible for medical treatment of the kind in question.

12. The rationale for adding dental practitioners is based on their concerns that the need to obtain a certificate from a doctor before a dental intervention could be carried out was time consuming and could delay the administration of appropriate treatment. This was of particular concern when a patient was in pain, or had a potentially serious infection, which might not fall within the category of emergency treatment.

13. Similar considerations can arise in the case of ophthalmic opticians, where the ability to issue a certificate could facilitate the service given to patients unable to consent. For example, opticians could find themselves with a patient presenting with red eye or a foreign body sensation in their eye which need not necessarily be regarded as an emergency. In cases of incapacity and
in which a certificate has not been issued, the optician at present would need to request and await
the issue of a certificate from the medical practitioner primarily responsible, thus potentially
prolonging the adult’s discomfort.

14. In respect of nurses, the case has a number of strands including –

(a) in the multi-disciplinary team working, which is now being encouraged as the way
ahead for NHS Scotland, the lead clinician may be a consultant nurse with particular
responsibilities for the person’s care and treatment. In the evolving primary care sphere,
team leaders need not always be general practitioners but rather the professional with the
skills most appropriate for the procedure or aspect of care concerned. This does not,
however, diminish the key role of general practitioners, who will remain as the central focus
in primary care, with the improved modes of communication among health professionals,
enabling them to be kept fully informed about their patients.

(b) in care homes, nurses need to carry out a broad range of duties, which come
within the wide definition of medical treatment in the 2000 Act, including basic nursing care
and changing or applying surgical dressings. It is desirable that they should be able to
carry out these tasks without the threat of legal challenge and that, where necessary, and
in cases where a certificate has not already been issued by a medical practitioner, they
should be able to issue a certificate at their own hand, providing they have the necessary
expertise to carry out the required assessment.

(c) in general, it is envisaged that nurse practitioners, practice nurses and nurse
consultants are the groups most likely to use these powers.

15. It is envisaged that the Code of Practice will set out the circumstances in which it would be
appropriate for nurses and other proposed signatories to issue certificates.

16. It is important to note that these additional categories of potential signatories could only
authorise treatment within their specialism. Thus, a dentist could only authorise dental treatment
and a nurse could only authorise or carry out treatment, which was within his or her professional
competence. Before issuing a certificate of incapacity, they would need to carry out the
assessment procedure set out in the Act and the accompanying Code of Practice.

17. The responses to the consultation stressed the need for professionals issuing certificates
of incapacity to have the training and expertise to assess capacity. Already, for example, dentists
receive general training on issues of consent and some specific training on the 2000 Act. Such
training is offered at 3 key stages: through the undergraduate curriculum; and following vocational
training, a range of post graduate courses are offered by NES Scotland. But the Executive
attaches particular importance to the need for professionals issuing certificates to have the
necessary competence to assess capacity and, in consequence, it is discussing with NHS
Education Scotland the introduction of training packages and protocols for health professionals
involved in the issue of certificates and in assessment procedures.

18. The Bill also makes provision for other groups of health professionals to given the authority
to issue certificates, subject to such requirements as may be prescribed in regulations. There is no
immediate intention to increase the range of signatories but, if in the future, any such need
emerged, any proposed addition would be the subject of consultation and the regulations, would, of
course, be laid before the Parliament.

Extending Duration of Certificates of Incapacity

19. In relation to increasing the duration of certificates of incapacity, again the general
consensus among respondents to the consultation was that the maximum length of certificates of
incapacity could be extended, subject to various qualifications. For example, a number of
respondents expressed reservations about extending the duration for adults, where capacity might
fluctuate. Accordingly, the Bill proposes that the certificate should be for one year or, if in the
opinion of the person issuing the certificate, any of the conditions or circumstances prescribed by
Scottish Ministers applies as respects the adult, for up to 3 years. It is envisaged that the
regulations which will prescribe the circumstances in which the certificate can be extended beyond a year would focus on, for example, conditions in which there is progressive deterioration and from which the adult is unlikely to recover. Again, there would be full consultation on the terms of the regulations which would thereafter be laid before the Parliament.

Conclusion

20. In proposing these amendments to the Act, the Executive’s aim has been to find ways to help improve the operation of this important legislation, while at the same time maintaining its principles and ensuring the continuing benefits and protection it provides for this vulnerable group of adults.

SUBMISSION BY MINISTER FOR HEALTH AND COMMUNITY CARE 16.03.05

I am writing to you in response to your letter of 8 March and 9 March following the Health Committee oral evidence sessions on March 1 and 8 March 2005.

The annex to this letter addresses the specific questions asked on hepatitis C, joint ventures and adults with incapacity. It also provides additional information arising from the three oral sessions to date, including 22 February 2005.

Hard copies of HDL (2004)31 (the service alert on the Skipton Fund) and an application pack are also enclosed for your information.

I hope you find this information helpful.

Andy Kerr

ANNEX : SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL
Additional Information for the Health Committee

Hepatitis C

1. The justification for the exclusion from the scheme of those who died before 29 August 2003 (section 24(1)(c));

29 August 2003 is the date that all Health Ministers in the UK announced that a UK scheme would be established and was therefore chosen as the eligibility date for the scheme. The Executive has great sympathy for the relatives and dependants of those who died before the eligibility date for the scheme, but has always made it clear that it has to consider the effects of the financial outlay on this scheme on ability to provide treatment for other patients. For that reason the scheme focuses on those who are currently suffering.

2. Progress in relation to the establishment of a Skipton Fund appeal procedure, including the date on which such a procedure will be operational and the scope for including a haematologist (as well as a GP) on any appeals panel;

The Haemophilia Groups Forum was consulted in October 2004 on an initial draft proposal for the composition of the Appeals panel and the Appeals process. All of the comments submitted in November 2004 are currently under consideration by officials of the four administrations. Officials met on 28 February to progress various issues in relation to the Skipton Fund and are due to meet again on 17 March to discuss these further. I am not currently in a position to give a definite date by which the Appeals panel will be operational but hope to be able to confirm this soon.

3. The justification for including an applicant’s place of residence when the claim is made or at time of their death as an eligibility criterion (section 24(2)(b)), rather than the applicant’s place of residence when that person was infected by hepatitis C as a result of NHS treatment;
For the purposes of the Bill, a person seeking to make a claim under the payment scheme in Scotland, must be resident in Scotland at the time of making the claim. This requirement enables more efficient administration of the scheme in the UK and merely determines which of the four administrations should meet the costs of the claim. The application process is the same for all claimants.

Consequently, if a person infected in Scotland moves elsewhere in the UK and had not yet made a claim to Scottish Ministers, they would be eligible to make a claim as a resident of England, Wales or Northern Ireland instead of Scotland.

4. The extent to which you are aware of problems faced by certain applicants in receiving assistance from clinicians, and particularly consultants, in completing application forms for Skipton Fund payments.

I am aware, from correspondence, of some cases where delays have been experienced. Where specific details have been given officials have been able to make enquiries of the NHS Board involved and to ensure they were taken forward. Where concerns have been raised I have indicated that officials would be willing to make enquiries if individual details were provided.

In the course of enquiries officials became aware that approximately 28 claims may have been delayed awaiting completion by consultants in the NHS Glasgow Board area. I understand that action has been taken by the Board to expedite completion and submission to the Skipton Fund.

5. The justification for decision to establish the Skipton Fund as a private company.

Legal advice on the setting up of the Skipton Fund advised that it could not be a charitable trust because of the nature of the one-off payments. In order to give the Skipton Fund legal status it was necessary to register it as a Limited Company. This was also important in terms of requiring the Fund to be a legal entity so that it could be referred to in the Department of Works and Pensions Regulations allowing a social security disregard.

6. Clarify whether section 24(3)(b) - which appears to allow for Skipton Fund payments to be taken into account in any other proceedings an applicant may undertake – is a departure from the current arrangement.

During his evidence Mr Maguire suggested that there should be an amendment to 3(b) to make it clear that a person can receive a payment from other schemes in addition to a Skipton payment. Clearly this section must properly reflect what has previously been said by Scottish Ministers. I will consider this section and amend as appropriate.

Joint Ventures

7. How will public finance and public service delivery be safeguarded should a joint venture company or initiative fail?

The risk exposure of a joint venture will depend on the structure that it takes. For a company limited by share capital the risk of failure is limited to the share investment. For companies limited by guarantee the exposure will be dependent on the extent of guarantees given to underwrite losses and support the rights of creditors.
As with any contract between parties, terms covering the default by either party to a contract will be covered. There are a number of events that could trigger a default including breach of the contract by a party or failure to perform and deliver specified services specified in the contract.

With public private joint venture structures there is a real incentive for both the public and private partners to make the joint venture a success as both parties are sharing risk in the form of their investment in the company and the returns that both parties expect over the duration of the partnering agreement.

We will ensure, through standardised documentation, that any partnering agreement between the public and private sectors requires a joint venture to perform its obligations at its own risk and without recourse to Government or public funds.

8. Will the Scottish PPP staffing protocol apply to joint venture companies established under these provisions?

The STUC Protocol with Scottish Ministers and subsequent guidance clearly indicates that it applies to all Public Private Partnerships (PPP). Public Private JV’s are a form of PPP and therefore the protocol would apply in such cases.

9. To what extent has discussion taken place with CoSLA and the NHS Confederation about the policy intentions behind these provisions and their implementation?

In 2003, COSLA officers and nominees participated in and contributed to the original Short Life Working Group on Joint Premises Development which produced the report which recommended that:

• Recommendation 20 - Public Private Partnerships: The Scottish Executive should introduce legislation that will enable Scottish Ministers, NHS bodies and contractors, local authorities and private sector providers to enter into Joint Venture agreements in order to make available another vehicle to support joint premises development. The first stage would be to consult on proposals.

• Recommendation 21 - LIFT (Local Improvement Finance Trusts): The Scottish Executive should consult within its proposals for Joint Venture Organisations such as LIFT on the basis that such arrangements offer flexibility for joint premises developments in community care under the umbrella of community planning partnership(s).“

As part of the SLWG consideration of whether to recommend consultation on Joint Ventures, COSLA representatives attended detailed presentations on NHS LIFT and were involved in a visit to a LIFT project in Newcastle and North Tyneside.

In 2004, COSLA responded to the subsequent Scottish Executive consultation on Joint Ventures and attended events that contributed to the consultation report. At the same time, East Ayrshire Council and NHS Ayrshire and Arran participated in the development of a good practice toolkit for Joint Premises development which was published by the Scottish Executive as part of the report recommendations.

In 2005, following the Joint Venture consultation, Ministers approved the establishment of a Joint Premises Project Board to oversee the implementation of the report recommendations and consultation findings. The Board is remitted, amongst other things, to scope the detailed options for Joint Venture models.

COSLA have provided co-chairmanship for this Board and have nominated representatives from an estates and policy perspective. Social work are represented on the Board by a member of the Association of Directors of Social Work. The Project Board held its first meeting on 21 January 2005 and is currently in its set up phase.

The NHS Confederation has been invited to take a place on the Stakeholders Forum with which the JPPB will have ongoing dialogue.
10 What consideration has been given to the possibility of conflict of interest in relation to governance arrangements given that NHS and other public sector representatives are likely to play a role in joint venture company boards?

The issue of conflict of interest is not unique to joint ventures but applies to all corporate bodies, both public and private. In the context of joint ventures this issue being considered both from an employee and organisational governance standpoint.

The Civil Service Code covers the requirements on civil servants, including those of propriety, honesty and use of public funds. The terms and conditions of other staff groups will generally incorporate reference to conflicts of interest and general probity issues.

Detailed guidance has been prepared for Government Departments and Public Bodies thinking of forming joint ventures which includes issues around governance and conflict of interest within joint venture companies. This guidance will be fully considered in the development of joint venture models developed as a result of the provisions within the Bill.

The structure of a company is framed within the Articles of Association and Shareholders Agreement.

All corporate bodies whether public or private have to recognise the possibility of conflicts of interests and make appropriate arrangements to deal with such events. In such cases Board members are required to declare such conflicts of interest. Whilst individual integrity is the basis of such a position we would wish to protect the interests of individuals and the organisations that they represent. The Executive is committed to ensuring appropriate guidance is produced to support the operation of joint venture companies at a local level to deal with such issues.

In general terms the governance arrangements for any joint venture company will be compliant with The Combined Code on Corporate Governance issued in July 2003 by the Financial Reporting Council.

It assists greatly if the joint venture is established to deliver a common agenda with public sector participants. Given the participation of the public sector in the first place there has to be a commonality of interest. The objects of the joint venture can be constructed in such a way to ally interests and minimise conflicts of interest. The NHS LIFT initiative is a working example of how this approach can and has been put into practice.

11. What consideration has been given to alternatives to the Bill; for example, extending prudential borrowing rights to Health Boards?

Westminster legislation provides Local Authorities with the powers to raise funds through borrowing. These arrangements have been well established over many years. The prudential borrowing regime which was recently introduced has provided greater flexibility to Local Authorities in terms of increasing borrowing to fund projects with identified income to repay the borrowed funds and their costs.

The use of prudential borrowing arrangements is already available to local partnerships as a method to fund the development of joint schemes. The local authority raising funds where the income for the scheme is identified by the partnership from their respective resources. As with all funding methods, local partnerships are expected to consider the delivery of Value for Money in whatever funding method is chosen.

The extension of borrowing powers to individual NHS Boards in Scotland has not been considered since the Scottish Ministers have no powers to raise extra resources by borrowing or sanctioning borrowing. Capital funding in the NHS is controlled by rules issued by HM Treasury, the Scottish Executive has no power to change these rules which are a reserved matter for Westminster.

The powers in the Bill pave the way for new methods of funding for joint premises to be developed which are intended to be additional to these traditional routes and which are aimed at providing improved value for money.
12. What guarantees can be offered that joint ventures will prioritise health services and facilities, rather than commercial development?

The influence on the direction taken and prioritisation of schemes would be achieved through the governance arrangements established for the joint venture company.

In the context of a LIFT type development, the Strategic Partnering Board (SPB) fulfils this role via the Strategic Service Development Plan (SSDP).

The SSDP is a whole system approach to service planning intended to be a tool to co-ordinate the plans and aspirations of all users and carers, of health, social care and other identified services in the local area. It is complementary to existing planning processes and is the document which brings all relevant strands together.

It is a useful performance management tool for local teams, NHS Boards, Community Health Partnerships, Local Authorities, and the Scottish Executive etc. and will enable measurement of change by identifying a baseline from which to work and considering the delivery of the vision as further SSDP’s are developed in the coming years.

It will be the document that gives stakeholder approval for the development of a LIFT company. It is expected that should this model be adopted it would be a pre-requisite for Scottish Executive approval. It would explicitly give stakeholder undertaking to commit to the revenue consequences of the first wave of schemes to be delivered by the local LIFT company.

The SSDP is also the basis on which a LIFT partner would be procured and would form the main elements of the Memorandum of Information issued to all parties who respond to the OJEU notice.

It will be specific about the first schemes to be delivered by the LIFT company and therefore the basis of capital investment approval by the stakeholders.

The Strategic Partnering Board (SPB), which is made up of representatives of local public sector partners, will agree the needs of the local community and determine the requirements for local services and facilities to be provided by the LIFT Company. It enables the NHS Boards and local authorities to come together with representatives of other interests (e.g. medical and dental practitioners, voluntary groups, patient representatives etc.) to agree priorities for service development and improvement. The Strategic Partnering Board would approve the SSDP, which is updated annually. The LIFT Company is invited to develop proposals for improvements to facilities and/or services to meet the requirements of the SSDP.

The role and rights of the public sector can be adequately defined and protected within the rights of minority shareholders within the Articles of Association of the Joint Venture.

In Scotland, consideration is being given to how Community Planning Partnerships and Community Health Partnerships can fulfil this role.

13. Is it intended that joint venture companies in Scotland will mirror or differ from the operation of NHS LIFT projects in England?

The LIFT model is one model that could be applied in Scotland. The decision to seek powers for the creation of joint ventures in a health context was taken by Ministers on recommendation of the Short Life Working Group on Joint Premises which reported in July 2003 and which contained members from the Scottish Executive, COSLA, and Local Authority together with other contributors from NHSScotland and local government.

The role of the Joint Premises Project Board, established in December 2004, is to take these issues forward in an inclusive way. The JPPB involves the Scottish Executive, NHSScotland, COSLA, Staff Partnership Representatives and Partnerships UK.
On the basis of work undertaken to date on the application of possible models we are of the view that the NHS LIFT model would be capable of adaptation for use in Scotland but we are committed to the development of a model that meets the service needs of communities within Scotland. We are aware that the National Audit Office is due to issue a report in April on the NHS LIFT initiative in England and we will be informed by the findings of that report.

It is, and will be, possible for alternative models to be developed. But there are cost and time implications in doing so both nationally and for local partners. Cost implications will include the actual costs of developing alternative models together with the impact on financing terms of an untried and untested model. The powers we are seeking are generic and do not restrict either Scottish Ministers or NHS Boards to one particular model.

14. In PFI projects, the assets revert to the health service at the end of the period of the contract. What will happen to assets and the land on which they are built at the end of the project, under the joint venture provisions?

There are a number of points to consider:

Where contracts require the property to revert to the Public Sector Organisation (PSO) at the end of the concessionary period the payments made to the Company will reflect this fact, i.e. the PSO would be paying for both the serviced facility over the period and also the value of the property at the end of period, spread across the payments. It will be less costly if the option to own remains open.

In public private joint ventures envisaged there could be a wide range of public and private sector users involved (e.g. Social Work, Benefits Agency, Health Board, GP’s, Pharmacists etc.) and it would be difficult to spread the ownership across them all in a meaningful way. There would also be more flexibility for users individually or collectively at the end of the period. For example by having the right to buy the premises at market value, extend the lease or walk away it will be possible for users to make a decision that will fit in to the way services have developed by that point in time and not be tied in to a potentially unfit building for modern services.

It should also be noted that the lease of premises for use as Local Authority premises, GP facilities, NHS offices etc is not unusual and it is only in PFI that ownership transfers at the end of the period.

Adults with Incapacity

15. When will the regulations associated with section 30 of the Bill be available for review by the Committee?

The Executive anticipates being able to put forward to the Committee in June, regulations on the extension of the period of a certificate of incapacity.

Disclosure of Information

16. Executive officials agreed to provide supplementary information on whether the Bill requires individuals currently listed as dental, ophthalmic or pharmaceutical practitioners to disclose information for inclusion in the proposed extended lists.

17. There is nothing in the Bill that would prevent there being a requirement on those currently listed as dental, ophthalmic or pharmaceutical practitioners to disclose information. Currently listed dental and ophthalmic practitioners would be listed in the future in the first part of the new extended lists. In relation to pharmacists, those that will be performing pharmaceutical care services would be listed in the new list of pharmaceutical care service performers.

18. There are powers to make transitional provision between the existing listing arrangements and those introduced by the Bill. It should be noted that regulations in relation to the extended lists under what will be section 17W, 25(2), and 26(2) of the National Health Service (Scotland) Act 1978 may make provision to both applications for inclusion to the lists and requirements with which a person included in the lists must comply.
19. In relation to enhanced criminal records certificates, the amendments to the Police Act 1997 made by Schedule 2 of the Bill will not prevent such certificates being obtained in relation to those applying to or already included on the extended lists.

Pharmaceutical Care Services Regulations

20. Skeletal drafts of the regulations arising from Part 3 of the Bill will be available for Stage 2 but much of the detail will be dependent on negotiations and discussions that will be taking place between the Executive and the Scottish Pharmaceutical General Council (SPGC) over and beyond the summer.

21. Part 3 of the Bill contains regulation provisions in four main areas. The following lists those areas and summarises what should be available. In all cases we are committed to consulting SPGC throughout the drafting process.

Health Boards’ duty to plan and secure, and publish information about, pharmaceutical care service provision.

22. It will not be possible to provide a draft for this area. Development work is currently in hand to establish model criteria for both the planning and administrative processes. Prior to drafting regulations, we plan to test out the recommended arrangements in two or three Health Board areas. We do not expect to be in a position to commence drafting in detail until around September or October of this year.

Describing pharmaceutical care services

23. The draft will define the services to be regarded as 'essential' and additional and provide a broad outline of what they will comprise, e.g. dispensing services. Descriptions of the clinical and professional requirements for the services will be in directions, the detail of which will not be available at Stage 2 as the subject matter is for continuing negotiations.

Pharmaceutical Care Contracts

24. The draft will provide the framework with the sections on some of the contract operation issues populated but still subject to discussions with SPGC.

25. The Bill also contains powers of direction for the remuneration/reimbursement elements of the contract. These will not be finalised until close to contract implementation in April 2006 and, therefore, will not be available until that time.

Persons performing pharmaceutical care services - including 'listing' of performers.

26. The draft is likely to be at a stage that gives a reasonably clear picture of how the listing of performers of PCS will be regulated.

NHS Tribunal

27. In serious cases a referral to the NHS Tribunal can be made but where the allegation against the practitioner is of lesser importance a health board may refer the case to a discipline committee.

28. Discipline committees are established by each health board for each of the primary care/family health service professions. They have a legally qualified chair and equal numbers of lay and professional members. To ensure impartiality, cases are considered by a discipline committee established by a separate health board to the one which makes the referral. The sanctions available to a health board when one of its practitioners has been found in breach of their terms of service are to give a warning or order a recovery of remuneration. In the case of dentists they may be required for a period to obtain prior approval of certain work.
29 The table below shows the number of complaints made concerning NHS primary care/family health services, the number of Health Board Discipline Committees held and the number of NHS Tribunals held for the last four years. As officials advised the Committee, there are currently 2 NHS Tribunal cases under consideration (year ending March 2005).

<table>
<thead>
<tr>
<th>Year ended March</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
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<tr>
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<td>Discipline Committees</td>
<td>29</td>
<td>7</td>
<td>21</td>
<td>30</td>
</tr>
<tr>
<td>Tribunal</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Application of Bill discipline provisions to NHS 24

30. All health care professionals (contracted and directly) employed who provide general medical services can be referred to the NHS Tribunal.

31. NHS 24 employees do not provide general medical services. Individual health professionals employed by NHS 24, including nurse advisers, general practitioners and pharmacists are governed by the disciplinary proceedings by NHS 24 insofar as any acts or omissions that may arise while carrying out duties for NHS 24.

32. As with all health professionals, these individuals will also be accountable to their respective regulatory bodies, for example the Royal College of Nursing.

I am writing to you in advance of my giving evidence to the Health Committee on the Smoking, Health and Social Care (Scotland) Bill. I feel it would be helpful to the Committees consideration of the Bill if I give an indication of the additional topics that the Executive is considering introducing as amendments at Stage 2 of the Bill process. These topics are within the scope of the Bill.

The attached annex lists those areas where the Executive is currently bringing forward Stage 2 amendments, subject to clearance through the Executive’s internal processes. It is possible that there may be a number of amendments in addition to these which are not sufficiently advanced for me to provide a description.

In addition I am anticipating that there will be a number of Executive amendments to the existing provisions in the Bill to provide clarification or correction, or that are amendments consequential to the provisions within the Bill.

I trust you find this information helpful

Andy Kerr

ANNEX : SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

Topics for Stage 2 Amendments by Scottish Executive.

1. Section 25 Regulation of Care (Scotland) Act 2001. Amendment to enable Ministers by order to vary (below but not above current statutory levels) the minimum frequency of inspection of care services by the Care Commission. Power to be capable of being exercised in different ways in respect of different categories of care. Power to be exercised only after consultation. Orders to be subject affirmative resolution.

2. The Care Commission has a statutory duty to inspect care services under Section 25 of the Regulation of Care (Scotland) Act 2001 ("the Act"). There are 2 sub-sections which specify the frequency of inspection which must be met by the Commission:-

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• Sub-section (3) requires at least 2 inspections a year of any of the care services set out in 
sub-section (4) - broadly speaking, all care services which offer overnight accommodation - 
and that at least one of those inspections is done without prior notification to the providers.

• Sub-section (5) requires the Care Commission to inspect all other care services at least 
once a year.

3. By requiring minimum inspection frequencies, the 2001 Act inhibits the ability of the Care 
Commission to target its resources where they will have the most effect in improving users’ 
experience of care services. The proposed amendment would address this.

4. Mental Health (Care and Treatment) (Scotland) Act 2003. Mental Health Tribunal for Scotland: 
Recruitment of Members. The purpose of this amendment is the removal of the upper age limit for 
members of the Mental Health Tribunal for Scotland. The recruitment of 300 Tribunal members is 
esential if the Tribunal is to successfully carry out its functions and removal of the age limit would 
greatly assist in the recruitment and retention of all members. The amendment will delete 
paragraphs 4(3)(b) and 4(6)(b) of Schedule 2 of the Mental Health (Care and Treatment) (Scotland) 

5. Section 157 Public Health (Scotland) Act 1897. The amendment will provide a right of appeal 
against the removal to hospital. detention or continuing detention in hospital for persons suffering 
from an infectious disease. Section 157 of the 1897 Act has the effect of denying any appeal or 
review of orders under Sections 54, 55 and 96. These orders cover the removal to hospital. the 
detention or continuing detention in hospital for persons suffering from an infectious disease. The 
absence of appeal provision means this Act is incompatible with the European Convention on 
Human Rights.
Smoking, Health and Social Care (Scotland) Bill: Stage 1

14:03

The Convener: Item 2 is consideration of the Smoking, Health and Social Care (Scotland) Bill. I welcome to the committee the Minister for Health and Community Care. Members have received copies of the committee papers, which include submissions from the minister in letters dated 31 January, 16 March and 18 March, draft regulations that were circulated for last week’s meeting and the Finance Committee’s report. The Subordinate Legislation Committee’s report will be available after the Easter recess. We will go through the various parts of the bill in turn. It is inescapable that this will be a long evidence session, although it will perhaps be more gruelling for the minister than for any member of the committee. I understand that the minister will be accompanied by different officials depending on which parts of the bill we are discussing. We will try to allow space for folk to move about when discussion on the part with which they are dealing is over.

Part 1 of the bill is on the prohibition of smoking in certain wholly enclosed spaces. For this part of the bill the minister is accompanied by Roderick Duncan, bill team leader, tobacco control division; Sarah Davidson, head of tobacco control division; and Joanna Keating, solicitor in the office of the solicitor to the Scottish Executive. I ask members of the committee to indicate questions that they want to ask about this part of the bill. Sorry, I am being hissed at that the minister will make a brief introductory statement. Sorry, minister.

The Minister for Health and Community Care (Mr Andy Kerr): Thank you. You can rest assured that my statement will be brief. It is good to be back before the committee and to have the opportunity to explain more of what the bill is about.

As you know, the bill is wide-ranging, so there will be occasional reshuffles at this end of the table of the officials who are here to support me. The bill is an important health measure and one that I think will deliver a significant change in the health of the Scottish people.

The bill has three main purposes. The first is the restriction of smoking by prohibiting smoking in certain enclosed places. The second relates to the provision of services by the national health service and, in particular, continuing the NHS modernisation programme. Within that broad area, the bill contains provisions for dental, ophthalmic and community pharmacy services as well as measures relating to discipline and measures that aim to impact on the operation of the NHS—for
example, to allow the NHS to participate in joint ventures to support the delivery of facilities and services. The third area comes under the theme of social care, and the bill incorporates a small number of provisions including amendments to the Regulation of Care (Scotland) Act 2001.

As we are all aware, the keynote provision of the bill is that which relates to smoke-free public places. I have said before that I consider the bill to be the most important piece of public health legislation in a generation. The decision to legislate on smoking was not taken lightly, but we believe that it is the right thing for Scotland.

First and foremost, as we are improving the health of the people of Scotland, we can no longer tolerate Scotland’s reputation as the sick man—or, indeed, sick woman—of Europe. Action on tackling smoking will, undoubtedly, help us to improve our health record. The supporting papers that we have submitted highlight the health risks that are associated with passive smoking. Those risks are now clear and irrefutable, as is the potential health gain from reduced exposure to environmental tobacco smoke and smoking itself. I have monitored the work of the committee and I am pleased that the committee accepts that the health risks exist. I hope that you will be equally convinced of the potential health benefits that the bill will bring. As are other aspects of the bill, the smoking provisions are firmly embedded in health and, as such, lie clearly within the competence of the Scottish Parliament.

Although I am convinced of the benefits that will flow from a smoking ban, I am aware of the fears of business interests, particularly the licensed trade, of the possible adverse impact of the bill. I understand those fears but, as is clear in the regulatory impact assessment that accompanies the regulations, they are not borne out by international evidence and experience. Overall, as you are aware, we expect the bill to have a nil or a positive economic impact. I am also working with businesses, through the smoke-free areas implementation group, to involve them in the process of delivering the policy in terms of how we will make the bill work if it is passed by the Parliament in due course. We cannot allow one area of business to dictate the health of the nation; hence, we want to ensure that the bill is comprehensive in its scope and properly enforced.

We have driven for a bill that can be clearly understood and that will be simple to enforce. There are those who have questioned whether the comprehensive nature of the bill is compatible with individuals’ rights and freedom to choose, and the issue of the European convention on human rights has been raised. However, as I have said in the past, just as smokers have rights, so non-smokers have a right to clean air.

Although, as the Minister for Health and Community Care, I would prefer people not to smoke for their own sake, nothing in the bill impinges on their right to do so. Nevertheless, it is clear that we want to provide the 70 per cent of Scots who do not smoke with a proper environment in which to partake of life, whether socially, through the workforce, through recreation or in any other way. We feel that the imposition of a comprehensive ban is the best way to protect the public’s health; therefore, the draft regulations propose very few exemptions from the ban and for humanitarian reasons only.

The bill is an important step forward for the health of Scotland. I look forward to our discussion this afternoon and commend the bill to the committee.

The Convener: Thank you, minister. I welcome Stewart Maxwell MSP to the meeting.

Kate Maclean (Dundee West) (Lab): I have a question on the final point that you covered: exemptions. In a controversial bill, exemptions will probably be the most hotly disputed issue, once the principles have been agreed. What criteria were used when the list of premises that will be exempt from the smoking ban was compiled?

Mr Kerr: The approach was largely humanitarian and involved common sense, in my view. Residential homes are where people live and have their home. We felt that, as long as there was a smoking policy in such places, people would have the right to smoke where it was deemed to be their home, just as others in the community have that right. That applies to adult care homes, but not to children’s homes.

Adult hospices are on the list of exempt premises for obvious humanitarian reasons. Psychiatric hospitals and units are included on the list because clinicians and others told us that that would be appropriate, if individuals’ overall mental health and well-being were to be looked after. There were obvious humanitarian and other reasons for that exemption. An exemption was sought for police rooms because it has the potential to help the police with investigations and interrogations.

The ban is not so comprehensive when it comes to hotel bedrooms. Although all public areas within hotels will be smoke free, it is felt that if an hotelier opts to have smoking rooms within an hotel, an exemption would be appropriate in those circumstances, because those rooms would be clients’ homes for the night or nights for which they stayed at the hotel.

I argue that there is clarity with the vast majority of public enclosed spaces. That will allow us to legislate effectively and to monitor and control smokers in those environments.
Kate Maclean: Hotel rooms will be treated flexibly on the ground that they are people’s homes for the evening, but one could argue that if an adult cannot stay in their house on their own and must attend a day care centre, that centre is their daytime home for five days a week. Why have the same humanitarian criteria that have been applied to adult residential homes, or other places that could be deemed to be people’s homes while they are staying there, not been applied to adult day care centres?

Mr Kerr: The reason for that is that adult day care centres are not the homes of the adults who attend them. I would argue that it is quite unusual for someone to attend such a centre five days a week, although that does happen, but regardless of how long they spend there, it is a place that they visit only temporarily; they still have their own home, in which they can smoke.

Kate Maclean: Does the same logic not apply to hotel rooms?

Mr Kerr: No, because guests hire hotel rooms for entire evenings; indeed, they could be in their room 24 hours a day for seven or 14 days. The situation is different for people who attend day care centres. They might spend just the morning or half a day there; how long someone spends in a day care centre is very much down to their individual circumstances.

Our approach has been to say that we want a ban that is as comprehensive as possible. To enhance public health, we want to provide as few opportunities as possible for people to smoke in public places. To all intents and purposes, a care home is the home of its residents; the same is not true of a day care centre. That has been the key determinant in our approach.

The Convener: I want to follow that up. Will you monitor that? If you found that, in a year’s time, the number of people who were accessing day care centres was dropping because of the ban while they are staying there, not been applied to adult day care centres?

Kate Maclean: Yes, we would. If any good evidence came to us that would fail them if we made it easy for them to smoke at that time.

Mr Kerr: Our intention is to ensure that environments that are used by non-smokers are smoke free. A day care centre fits that bill and, further, is also a place of employment for people who we would want to protect.

Having spoken to a number of people who work in cessation services, I would say no to your second point. When people are in hospital and have had a big scare, making it easy for them to smoke by providing a smoking facility undermines our cessation efforts. People who buddy such patients—either voluntarily or through the provision of health care services—would be aghast if we were to make that concession. When people experience a health scare, that is the time to harness their willpower and support them in their efforts to stop smoking. That is what the cessation services do. Having visited Wishaw hospital, where the smoking cessation team work in the critical care parts of the hospital that deal with coronary heart disease and respiratory illness, I know that that period of a patient’s recovery period is key and I think that we would fail them if we made it easy for them to smoke at that time.

Further, we have to send a message to the public about public health. We should recognise
what Greater Glasgow NHS Board has done to make all of its health environments non-smoking. That sends the right message.

**Kate Maclean:** I support the legislation, but I think that I would find it difficult to justify allowing someone to smoke in a hotel bedroom—a room in which they might be spending only one night, mostly asleep—and not allowing someone to smoke who is being picked up at 8 o’clock in the morning to go to an adult day care centre and is dropped off at 6 o’clock at night. I am not saying that people should be allowed to smoke in adult day care centres; I am saying that, if they are not, it makes it hard to justify allowing someone to smoke in a hotel bedroom, even though they are capable of walking out to the street to have a cigarette.

I welcome the fact that private clubs will not be exempt from the legislation. Have any private clubs made a plea for support to be put in place? Does the Executive intend to make available to private clubs any support that would not be available to public houses or other licensed premises?

**Mr Kerr:** I am unaware of any special pleading on behalf of private clubs. My officials might be able to say whether there has been any. I understand the point that you made in the first part of your question but, again, I would point out that our policy is about the provision of smoke-free areas for members of the public who do not smoke. A hotel room is not a public area; an adult day care centre is. That is one of the key differences that we are talking about.

**The Convener:** The question about private clubs arises from evidence that we took last week from a representative of the Royal British Legion in Scotland who indicated that many of its clubs’ finances are marginal and that they are liable to close as a result of the proposal. I do not know whether that representation has been made directly to you.

**Sarah Davidson (Scottish Executive Health Department):** The Royal British Legion might have made representations at the time of the initial consultation exercise, but I am not aware of that. No such representations have been made to us in recent weeks, but we are aware of the concerns that were expressed to this committee.

**The Convener:** Right, but your approach would be—

**Mr Kerr:** Our approach remains the same. This is not an economic issue; it is a health issue. While I am sympathetic to the concerns of private clubs and seek to work with them in relation to how we can best implement the measures, the issue relates to public health, the number of deaths that are caused by smoking, the number of non-smokers in Scotland and their right to fresh air. I appreciate the point that you make. We will do everything that we can to assist with implementation. We can try to support clubs—for example, we could change their very nature with cessation services and other work—but I stick to the principle that we want to create as many smoke-free places as possible in Scotland and the bill is the best way to achieve that.

**The Convener:** The British Legion made the point that its rules and regulations do not allow it to apply money that it raises to the work that it would need to do on its premises. I wonder whether that issue, which was raised last week, needs to be resolved.

**Mr Kerr:** I am more than happy to look at that. We will make arrangements to get in touch with them.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** I move on to enforcement. One of the things that struck the committee when it went to Ireland was how the Irish bill has been successfully implemented and enforced. There is a non-confrontational approach to enforcement and the system is very much self-policing. Often, if a public health inspector finds that smoking is taking place in an establishment he will visit it the next day and the matter will be sorted out without a public confrontation.

During our evidence-taking session last week, some of us were more than slightly alarmed by the approach of the City of Edinburgh Council, as opposed to the approach of the police. The council seemed to take the view that the law is the law and that section 1, which creates the

“Offence of permitting others to smoke in no-smoking premises”

is of equal measure with section 2, which creates the

“Offence of smoking in no-smoking premises”
on an individual basis. The council gave the impression that there could be a situation, say on a Friday or Saturday night in Edinburgh, of officials going out and slapping fixed-penalty notices on individuals who were breaking the law. We wonder whether that would be counterproductive to the enforcement of the law. Surely the best approach is the non-confrontational one that has been adopted in Ireland.

**Mr Kerr:** I certainly hear your view that the handling of the matter is critical, and I share your view of the need for a sensible, non-confrontational approach and I give due credit to professionals in the field. That is how they should be working and I am sure that that is what will happen. As I am sure you discovered in Ireland, people are generally law-abiding. That is an
important point; we should not forget that people want to obey the law and that they will invariably do so.

How environmental health officers apply the legislation is important. I have spoken to the Royal Environmental Health Institute of Scotland more than once and what struck me was that very point about the need for a sensible approach. Through the smoke-free areas implementation group’s work with the licensed trade we want to ensure that everyone knows their role, understands how we will enforce the provisions and can handle any situations that arise. As long as the person who manages a bar has done what they need to do in relation to the legislation, we will understand the efforts that they have made. We expect certain things of bar owners in ensuring that they meet their end of the smoke-free bargain: to put up signage, to manage their clientele as best they can, and to ensure that ashtrays are not provided. We want to ensure that we work sensibly with bar owners and their staff as well as with the public.

I support the view that implementation and enforcement should be sensible. If observations are made in the evening, particularly on a Friday or Saturday night, it should perhaps be the next day when environmental health officers visit the bar owner and say, “You need to get a grip on this.” Professionals have appropriate ways in which to approach members of the public whom they encounter and I am sure that they will continue to act in that way in the future. That also applies to provisions in other pieces of legislation, such as fixed-penalty fines for parking offences and—dare I say it—the provisions in the dog-fouling legislation. In handling such situations, professionals aim to reduce confrontation and tension, and I am sure that the enforcement of this bill’s provisions will be no different.

Mike Rumbles: I am delighted to hear that the Executive’s view is the same as the committee’s view. However, when we put our questions to the people who will enforce the legislation, their view seemed to be that there is no hierarchy of offences in sections 1 and 2 and that the offences that are created in those sections will give them the authority to go out on a Friday or Saturday night and issue fixed-penalty notices. Can the sensible enforcement method that you have described be achieved by issuing guidance to local authorities, or should section 2 be amended? Should the bill be changed or should a direction or advice to local authorities be sufficient?

Mr Kerr: First, I will raise the subject at the next meeting of the smoke-free areas implementation group, so that we have an agreed commonsense approach on the right way to proceed. Guidance would be appropriate. I see no reason to change the bill. However, as I said in response to previous questions, if we find evidence that leads us to conclude that we need to amend the bill, we will do so, although I do not think that that is the case in this instance. We might come back to the issue at a later stage, following discussions with REHIS and others on implementation. However, I am sure that the approach that we have identified with REHIS is the best one, therefore I hope that we will simply produce guidance, rather than amend the bill.

The Convener: Our concerns arise out of last week’s evidence, because what we heard from the City of Edinburgh Council was distinctly different.

Mr Kerr: I heard about that.

The Convener: There was general concern that if that one approach was pursued throughout Scotland, we would be in a different kettle of fish to that which we envisaged.

Mr McNeil: We saw at first hand in Ireland the positive implementation of the law and the high level of compliance with it. You mentioned that we have to send a clear message. Our observation as a committee was that a broad-brush approach was taken in Ireland. Will the integrity or enforcement of the bill be harmed by the contradictions that will arise, given the lax enforcement of the law against the underage purchasing of cigarettes, and the openly illegal sale of tobacco products that can be witnessed at any market week in, week out? People also smoke in and around schools and nurseries—as they drop kids off in the morning—and in and around NHS premises. At the same time, we are embarking on legislation that will take action against people for smoking in public places. I worry about that contradiction, and whether it will affect compliance and enforcement. What influence or powers can you bring to bear to address those issues with other ministers, directly or indirectly, even in the short term during the progress of the bill?

Mr Kerr: The package is bigger than the bill that we are discussing today. For example, our considerable additional investment in cessation services will go a long way towards supporting smokers. We are not out to get the smoker, we are out to help the smoker get off tobacco. That is why we have substantially increased those resources. In terms of the health service, we are getting cuter about smoking cessation teams and the work that they do, by intervening at the right point in people’s lives, giving them long-term support, and providing the different tools to help them to quit cigarettes.

There is a balance to be struck. There is also a balance to be struck around the Executive’s media work, in terms of health education. Our “smoke snakes” adverts, the message that we are trying to get across particularly to young girls, and the work
that we are doing to denormalise smoking, are all part of that package. Also raised was the enforcement of current legislation—which I am happy to consider with other ministers—and our powers on the age at which people can buy cigarettes. It is a balanced package, and I argue that we have it in hand at the moment.

The bill is not all about the ban; we are trying to achieve a balance of measures. We are trying to convince young people that to embark on smoking is not the right thing to do. We are also assisting smokers to give up smoking through cessation measures and denormalising cigarette smoking through the work that we are doing in the media. However, if other legislation is to be introduced—such as the Lord Advocate signing off the use of test-purchasing—it can all become part of the package. I accept that there are other things that we can do. We are taking a rounded approach to trying to denormalise and restrict smoking.

14:30

Mr McNeil: Do you accept the point that we must avoid giving smokers victim status? I am thinking of the people who would say, “I’m an adult and I am being prevented from smoking in a public place, when at the same time a 16-year-old can buy cigarettes or an under-age person can be provided with them. Why should I, as an adult, be fined for smoking in a public place—mainly down the pub—while other people are openly selling tobacco products illegally and not being prosecuted?” Surely that is what those people will say.

Mr Kerr: People who are selling products in that way are breaking the law and I hope that we would hammer them for their conduct, which is reprehensible. If people are doing that, we should use test purchasing to detect it and we should enforce consumer and trading standards. The police should enforce the law on illegal sales.

You raised the issue of 16-year-olds smoking, but that is the current age at which someone can buy cigarettes. I accept that one way in which we could try to change young people’s attitudes to smoking is through increasing the age at which people can purchase tobacco. I suggest that the issue is more one of denormalising smoking. We need to make smoking untrendy; we need to make it clear that it affects young people’s lifestyles and choices. An age barrier could make smoking sexier for young people—prohibition can do that—but I am happy to have a debate on the issue.

The Convener: We are in danger of going off-bill and I want to bring us back to its provisions. We have a lot of work to get through this afternoon. I call Helen Eadie.

Helen Eadie (Dunfermline East) (Lab): I want to address the issue of penalties. As you said, minister, we need to begin to hammer people for not obeying the law. What provisions are there for ensuring that the penalties address the issue?

Mr Kerr: I am sorry, but did you say, “What measures”?

Helen Eadie: I asked about the provisions. What provisions are being made for penalties to increase over time? Let us return to the example of parking fines. If someone does not pay the fine, they are given the option of paying £30; if they do not pay that fine, they have to pay £60; and if they continue not to pay, the fine rises to £90. The issue of penalties came up last week in our evidence taking. The committee took the view that some landlords could arrive at a considered view each year on fines. They could add a sum of, say, £10,000 into their balance sheet for the year as the amount that they are prepared to write off for fines.

Mr Kerr: As you know, fine levels are set out in regulations; they will be £200 for an owner and £50 for the individual. The fines that we are putting in place are set at what we think is an appropriate level. Again, our proposals will be consulted on and views will be gathered.

Speaking bluntly, I believe that it is easy to spot cases in which someone is taking an economic gamble by saying that they can afford to get caught X number of times. In cases in which a landlord is deliberately buying their way out of their obligations under the legislation by simply paying fines, the ultimate sanction of licence removal should prevail.

The levels of fines, which are the subject of consultation at the moment, must be appropriate. We are clever enough, as are our enforcement officers, to detect such practice. As I said, if we detect it, we will impose the most drastic of sanctions, which is the removal of the licence.

Helen Eadie: The Finance Committee report says:

“the costs of enforcement are largely unknown.”

How will the Executive ensure that the funding to meet the costs is made available? Is the Executive committed to funding additional enforcement costs?

Mr Kerr: I appreciate the point that the Finance Committee made. I am also aware of what the Convention of Scottish Local Authorities has said about its expectations of the bill. The financial memorandum to the bill shows a figure of £6 million, which we think is the upper level of the costs.
Given that Ireland has about 50-odd enforcement officers, we thought that we should have 70-odd officers. We think that that is the appropriate number, based on the fact that, if enforcement has worked in Ireland with 50-odd officers, we should add an appropriate number of officers to the Irish total. We tried to work through the methodologies that the Irish had employed. The numbers have not been plucked out of the air, but they are up for discussion with the people on the front line—COSLA and REHIS people, and others. However, we think that we have made a fair assessment of the costs of enforcement and the number of people whom we would require for that job.

As committee members will be aware—from your visits and other work—we think that the costs will tail off fairly sharply. That has been the experience elsewhere, once legislation has been put in place and has become normal. In a few years’ time, I genuinely think that people will look back and say, “What was all that about? You mean that people used to smoke in pubs here?” I think that we will get to that position fairly quickly and that the costs of enforcement will drop dramatically.

Mr McNeil: You said that an important objective of the bill was to reduce smoking overall. I agree with that objective; it is the big challenge to us all. You recently announced £12 million or so for cessation policies. How did you arrive at that figure? How will that £12 million be used? Is it sufficient? Will it target communities such as Shona Robison’s, with 18,000 smokers? Will such communities gain more benefit than, for example, Mike Rumbles’s communities, with fewer smokers? Will there be effective targeting?

Mr Kerr: Money will be distributed to the health boards in the normal way. Going into the details of that would probably be unhelpful, but we can consider different routes to cessation. Some are more expensive than others. If I remember correctly, £350 buys nicotine-reduction therapy plus some counselling. Other cessation tools can cost less.

We have a set of possible interventions. We are dealing with individuals, so we will allow the smoking cessation teams in the health service to tailor the package for each individual. Some innovative work is going on. We will consider the available tools, such as chewing gum, patches and therapy; we will consider the individuals, who are all different; and we will then decide what will work best for each individual. It is therefore difficult to say that 30,000 or 25,000 people will receive treatment. It is horses for courses.

Mr McNeil: Surely the £12 million will not be distributed equally to each health board.
reported in local and national newspapers. As people know all about it, I see no reason to stall or phase implementation. We need to get this done and start improving health; indeed, we must remember that, as soon as people stop smoking, their lungs begin to recover.

Mrs Milne: It was made plain to us that there had to be awareness-raising campaigns to let the public know what was happening. What smoking cessation campaigns are proposed in the run-up to and beyond the ban?

Mr Kerr: That is precisely what is being discussed by the smoke-free areas implementation group, which includes representatives of the Scottish licensed trade and club owners, for example. As a result, we are working with the people on the front line.

We are also recruiting advertising agencies to help us in the substantial task of putting together a comprehensive set of public awareness and information campaigns that, in the build-up to implementation, will inform people about our smoke-free Scotland policy and, after that, will inform them about their rights and responsibilities. Again, convener, in the interests of time, I am happy to forward an outline of those measures to you.

The Convener: That would be very useful.

We have pretty much reached the end of our questions about smoking. However, before we move off the subject, I wonder whether, given his background, Stewart Maxwell wants to raise any questions.

Mr Stewart Maxwell (West of Scotland) (SNP): I have one small question for clarification.

The Convener: Could you ask it very quickly?

Mr Maxwell: Yes. Has the minister thought to and beyond the ban?

Mr Kerr: It stated in its report:

The issue is different from that of sight tests, to which I referred to the ophthalmic side; it is about an examination to be.

What we are seeking is health improvement. The issue is different from that of sight tests, to which I referred to the ophthalmic side; it is about an examination to be.

Shona Robison: I am not clear about where that leaves the financial memorandum. As you have said, the figure of £9 million to £12 million for dental checks will change as negotiations continue on the extent and cost of oral health assessments. With respect to the parliamentary process, when will we get a true figure in relation to the financial memorandum? We surely cannot be expected to sign blank cheques. The Parliament must know what the costs will be before it can approve the financial resolution.

Mr Kerr: To be fair, the existing financial memorandum is based on the cost of the existing
check. My understanding is that the memorandum is accurate with respect to the proposed legislation. What is now required, as a result of Rhona Brankin’s statement last week, is a discussion with the profession around the enhanced check. I am confident about the financial memorandum with regard to the current check and the £7.05 figure.

That does not reflect what we now envisage in the action plan on modernising dentistry, in which we have said that we are taking a—I was going to say “holistic” approach, but I hate that word—health improvement approach to dental examination. In our minds, we have costed some of the impacts of that, but we need to have a negotiation with the profession around what the examination is and what it will cost the taxpayer.

Shona Robison: I am not clear about what you are saying. I understood that the free dental check, which is referred to in the financial memorandum, would effectively cease to exist, as it would be replaced by the new oral health assessment. I thought that that was what the bill was introducing. Are you now saying that the free dental check will be a basic check and that the oral health assessment will be something different?

Mr Kerr: The financial memorandum reflects the old form of the dental check. Hamish Wilson can add further light to that.

Dr Hamish Wilson (Scottish Executive Health Department): I can confirm that that was the basis on which the financial memorandum was drawn up. We intend to discuss with the dental profession the nature and frequency of the oral health assessment and the effect that that might have on the existing dental check. An oral health assessment might be carried out as an initial assessment; a dental check will be an updating of that assessment on an on-going basis. It might be that both will exist in the future. The financial memorandum was based on the existing set of arrangements.

Shona Robison: I am not entirely clear about the distinction. I take it that you will be keeping the committee abreast of any further financial implications as the negotiations proceed. That would certainly be helpful.

I turn to the 25 per cent increase in the cost of checks as a result of people being more likely to take up the free dental checks and/or oral health assessment, depending on what we are talking about. What was the basis of that figure of 25 per cent? How was it calculated?

Mr Kerr: I will deal first with the point about the check. It is an enhanced check and it will cost more because it does a different job. You would be right to criticise us if we did not engage with the profession on what that check should be and how much it should cost the taxpayer. It is correct that we should come back to the committee when we can to talk about those issues.

The 25 per cent increase is based on our experience of the change in the public’s behaviour when we introduced the free sight check for the over-60s. That was the only sound piece of evidence that showed how people behaved once a check became free.

Dr Wilson: That is absolutely right. We were trying to make the memorandum as helpful as possible by explaining that the best evidence for what might happen came from our experience of extending free sight checks to the over-60s. In that case, uptake increased by about 25 per cent. We thought that it would be helpful to put that into the financial memorandum to show the scale of the possible increase.

Shona Robison: I take it that you will have room for manoeuvre if the uptake is significantly more than that.

Let us move on to consider the workforce that will be needed to deliver the checks and oral health assessment. How likely is it that there will be a sufficient number of dentists to deliver the proposals? How have you calculated what you require?

Mr Kerr: This is almost “Groundhog Day”, as a lot of these issues were discussed last week in the statement on the modernising dentistry action plan. We have already increased the number of students who are in training; we are increasing the number of allied professionals; and we are seeking to support the education of our dentists via the Aberdeen facility. A range of measures has been put in place that will allow us to be confident that we can fill the gap in dental services. The increased use of allied dental professionals will ensure that dentists can focus on the work that they are required to do. I have every confidence that the substantial investment that we announced last week will deliver that. Training and qualification take time, but we are sure that we can meet the target number of dentists who have to be in training to make the system work.

Mr McNeil: You have referred to the importance of professionals who are allied to dentistry. I am sure that you are aware of the recent study that highlighted the importance of those professionals and of an increase in dentists’ productivity. It also highlighted the shortage of dental nurses. What incentives have you put in place to recruit and retain those professionals?

The Convener: Can you be brief please, minister?
Mr Kerr: The incentives largely relate to the announcements made last week for support for training, particularly for people in rural areas, through training grants, facilities, information technology equipment and premises. We will also give support for the provision of places in our education system to attract people into the field. We have a basket of supporting measures.

In addition, we are trying to ensure that dentists who are tempted by the private sector will stay with us by reducing from 450 to 50 the number of item-of-service payments. That will reduce the red tape around dentistry and incentivise the process much more effectively. We hope to work with dentists to help young people to see dentistry as a career opportunity as well as using additional incentives to persuade dentists to stay with us.

Mr McNeil: How do we ensure that the dental nurses and hygienists also benefit from that process?

Mr Kerr: It is all part of our workforce planning measures.

Mr McNeil: Are you talking about pay and conditions?

Mr Kerr: Yes. Those are the additional incentives that we put in place to encourage people to enter dentistry. The package applies to them as well.

Shona Robison: I come back to “Groundhog Day”. I do not know whether you are aware that Stewart Stevenson has just received an answer to a question that he asked about the percentage of dentists in Scotland who accept NHS patients. The reply was that that information is not held centrally. It seems strange that you would not have that information if you were trying to gauge what is required to meet the commitments in the bill. You do not know your starting point, which is how many dentists carry out the work.

Mr Kerr: Those matters are dealt with through the health boards, which is where the information lies.

Shona Robison: Yes, but you need to know the numbers, because you are sitting here telling us what you think is required in terms of the workforce to meet your legislative commitments. Surely you need to have the information to make an assessment.

Mr Kerr: We do not carry out workforce planning in isolation; we work with employee representatives, the boards and personnel people from the health service to determine the future shape of the workforce and to identify the pressures that exist locally. We discuss with health boards workforce planning measures and what they need to deliver the service. The workforce planning processes that Executive officials carry out include getting information that the health boards hold. That has informed the conclusions that we have reached about what we need to do to ensure that everybody has access to dentistry in Scotland.

Shona Robison: I turn finally to vulnerable groups’ take-up of free dental checks. What plans do you have to address the physical access problems that exist in so many dental surgeries? Have you considered screening programmes to target the most vulnerable groups?

Mr Kerr: Sadly, there are huge inequalities in health, which relate to poverty and rurality. Some of the pilots on which we want to embark will ensure that we focus on the people affected by those factors. The statistics for dental decay in Glasgow show those inequalities. We are working on the grants that we apply to the dental service relating to premises. We will discuss later joint ventures, which apply to dentistry as much as to other community health settings and for which we will try to increase resources. My colleague Rhona Brankin recently attended the opening of a new centre. The issue is investment. There have been pretty substantial increases in investment; there have been increases of more than 70 per cent since 1999 in some of our capital investments. That comes back to the idea of having a package of measures.

We are focused on addressing issues of physical accessibility of dental services. We acknowledge that specialist dental services might be needed for those with special education needs or physical disabilities. We are focused on that part of our community to ensure that inequalities are ironed out and that a proper service is provided. The issue is about our having a spectrum of measures.

Mike Rumbles: For the benefit of the committee, I want to be absolutely clear about oral health assessments and comprehensive eye examinations. Are you saying that the Executive’s intention is to provide a comprehensive oral health assessment and follow-up dental checks and a comprehensive eye examination and sight tests? The bill is not about one test replacing another, but about a comprehensive package. Is that correct?

Mr Kerr: Our proposals are about preventive health in action; they are about preventive measures. You have postulated a position in which the oral health examination might be followed up by checks. Let us talk to the professionals about that and come back to the committee. I do not want to be prescriptive about the best way of proceeding. I am happy to listen to professionals about what is the most effective way of delivering what we want, which is all about preventive health. In the action plan that we...
published last week, we set targets on dental decay for different age groups.

Dr Turner: I know that you cannot say exactly what the oral health assessment will add up to. However, it might lead to more orthodontic crowns and bridge treatments. Worries have been expressed about that. Will there be a restrictive approach to treatments that result from enhanced oral checks? The NHS does not carry out all bridge treatments; some are private.

Mr Kerr: I will defer to Hamish Wilson on that point. As I understand it, what is provided currently will not be affected detrimentally as a result of the process. Anything that we do in health that takes the preventive route creates a bounce effect elsewhere in the service, for which we plan.

Dr Wilson: That is correct. An oral health assessment can perhaps more accurately determine the needs of the patient and, therefore, the treatment plan that will be required for that patient. There is no intention to reduce what is available under general dental services.

Dr Turner: So you are prepared for an expansion in treatment. Thank you.

15:00

Helen Eadie: One of the challenges that still besets you and your colleagues, minister, is the fact that, historically, much of the statistical information just has not been gathered. It seems to the committee that there is a lack of information at health board level about oral health. In that context, we wonder what plans you have to gather information to inform your decisions about implementing the proposals that will deliver general dental services.

Mr Kerr: I am not short of stats; I am just short of stats that make a difference. That is what I want to sort out. We are working with the information and statistics division and other professionals around the service to address the point about measurement that you make. We have set out in the dentistry paper targets for how many adults we expect to have some of their own teeth and how many fillings we expect our young people to have. Those imply that measures will be taken to ensure that, overall, we improve the oral health of the people of Scotland. We are not devoid of stats, but I share your view that we need stats that are more effective in proving delivery. If delivery is not made, how do the stats help us to ensure that delivery occurs?

The Convener: Before we move on to general ophthalmic services, will you clarify for the Official Report that both the basic dental check and the more comprehensive oral health assessment will be free?

Mr Kerr indicated agreement.

The Convener: Thank you.

Mr Kerr: Sorry, I should have said yes. For the Official Report, the minister nodded and then said yes.

The Convener: Let us move on to general ophthalmic services.

Kate Maclean: As the minister is probably aware, I chair the cross-party group on visual impairment, which is an area in which I have a particular interest. I have a couple of questions on the eye examination. There could be an eye test to determine whether someone needs spectacles and what prescription for spectacles they need. There could also be an eye examination to diagnose other health problems or eye problems, which, if carried out early enough, could prevent or reduce sight loss later in life. What type of eye examination is proposed under the scheme for free eye tests? Will any specific measures be introduced to help groups that are difficult to test, for example people who have learning disabilities or Alzheimer’s? Also, what measures can be introduced to ensure that people take up the tests? At the moment, 20 per cent of schoolchildren have some degree of undiagnosed sight loss, despite the fact that they are entitled to free eye tests and checks. What measures will you introduce to ensure that the groups that are least likely to take up the free tests to which they are entitled take them up in future?

Mr Kerr: Your latter point about active management of individuals’ health and not waiting for customers to come through the door is a broader point for the whole health service. We are doing much more on that through the pilot schemes that we are organising. The general medical services contract for GPs is much more assertive about looking for problems that can be resolved earlier in people’s lives and that should apply equally to the use of eye examinations.

The free examination is an eye examination. A sight test will be carried out if one is required, but the examination is about detecting the sort of problems that you identified. It is also about preventing problems that could arise, and I am sure that it will cover all such problems. The examinations are not free for the general population at the moment, but the fact that they will be free will be an incentive for people to take them up. It is part of the education process in which we are all involved.

I also believe that the community health partnerships, which were designed for the purpose of health improvement in a local setting, will help to deliver some of the change in uptake that you mentioned. Again, I think that a range of measures can be deployed through our schools, the CHPs
and so on that will ensure that problems do not go undetected in the way that you describe.

I am hopeful that the fact that the service is free will mean that uptake will increase.

**Kate Maclean:** I do not think that that will necessarily follow. Although I regard myself as being a good mother, I never took either of my two children for a sight test because they never had any symptoms that would have led me to do that. That is probably the case with many people. Going to the dentist every six months is one thing, but I think that it is less common for people to take their kids to have their eyes tested regularly, even though it is free. I am not sure how the fact that the service is free will encourage a group of people who do not tend to get screened for lots of conditions to get their eyes tested.

**Mr Kerr:** As I said in relation to a previous question, our experience is that uptake increases by 25 per cent, which means that a larger pool of people will be coming forward to take the tests. The argument that you make applies equally to tooth brushing and to all the other preventive health measures that we are involved in. It relates to the campaign of educating people about their rights and responsibilities and to the role of parents and our schools.

In relation to the review of eye care that is being undertaken, we will consider issues such as access and uptake to ensure that we increase the number of people who get their eyes tested. As the Minister for Health and Community Care, I can say that it makes sense to identify conditions at an early stage not only in the interests of people's quality of life and so on but financially as well. The professions will assist us in that process and I am happy to come back to the committee to talk about any innovations that we think are appropriate.

**Kate Maclean:** Would the Executive consider setting up a sight-screening programme that would test children in primary 1 and again when they go into secondary school? Around 20 per cent of that vulnerable group have undiagnosed sight problems and such a programme would ensure that those were picked up at an early stage.

**Mr Kerr:** I would take advice from those in the professional field on whether a national screening programme would be worthwhile. Not all national screening programmes provide value for the individual patient. I do not approach the issue from a financial perspective, but the question clearly relates to whether we want to devote our resources to that task. I would not rule out having such a programme, but I would have to consider its effect on the prevention that we want our measures to achieve.

**Kate Maclean:** I know that the Executive is conducting an eye care review. What impact will it have on this provision or vice versa? Are the two linked at all?

Following on from Shona Robison's question about dental checks, do you have a firmer idea yet of the cost of the free eye checks?

**Mr Kerr:** We are conducting two pieces of work in relation to the points that you ask about. The eye care review will examine children's services and the issues that you have raised before coming up with proposals, and a report is being prepared on screening. I am happy to share the proposals and the report with the committee.

I cannot say, off the top of my head, how much the free eye checks will cost. We have not yet talked to the profession.

**Kate Maclean:** I just wondered whether you had a firmer idea of how much the policy would cost. I guess that you would give the same answer as you gave to the question about dental checks.

**Mr Kerr:** We have an estimate, within a banding, of the costs that we expect to incur and, later, we will enter into negotiations with the profession about the scope and cost of the examination.

**Mrs Milne:** Most of the witnesses were happy with the new listing arrangements for ophthalmic practitioners and dentists. However, I gather that it is proposed that the disclosure provisions will apply only to new entrants to the lists. Why will they not apply to existing listed practitioners?

**Mr Kerr:** I can reassure you that they will also apply to existing practitioners.

**Dr Wilson:** That is, they can apply if we so wish.

**Mr Kerr:** Oh, that is a different answer. I ask Hamish Wilson to continue.

**Dr Wilson:** The bill allows us to apply the disclosure requirements both to existing and to new practitioners.

**Mrs Milne:** So the bill allows the Executive to do that, but it will not necessarily ensure that that happens. It seems appropriate and sensible to require existing practitioners on the list who have not already done so to go through the disclosure procedure as well.

**Mr Kerr:** That is what the legislation allows.

**Mrs Milne:** We have all heard about the length of time that can be involved in the disclosure procedure. What steps will be taken to ensure that extending the list of those who are required to go through the disclosure procedure will not exacerbate an already difficult situation?

**Mr Kerr:** Given our work on the subject, we hope that the new measures that will be put in place will make the process quicker rather than
slower. There is no reason to suggest that that will not be the case. The provisions will allow quicker reactions from health boards and quicker determination of individual cases. Again, I ask Hamish Wilson to confirm that.

Dr Wilson: We need to discuss the details with Disclosure Scotland to ensure that there are no delays in the system. Therefore, the potential volume of checks if we were suddenly to include all existing practitioners as well as all new practitioners is relevant. We need a sensible and practical approach to allow us to do the most effective thing quickly.

The Convener: We will now move on to consider part 3 of the bill, which deals with pharmaceutical care services. Nanette Milne and Jean Turner want to raise an issue about part 3.

Mrs Milne: A number of us have received representations from people who deal with those who need stoma appliances. In my reading of the bill, I found it hard to see where this slots in, but people are clearly concerned that the service that is currently available to patients who require such appliances might be impaired if the appliances need to come directly from community pharmacists. I think that the stoma appliances that are currently provided by ileostomists and so on are almost bespoke devices.

Mr Kerr: I do not think that the bill particularly affects that situation. We considered the procurement route for stoma appliances, which is captured by the section that deals with appliance suppliers. The policy intention with regard to the fitting of stoma appliances and other such products remains the same. Although the provision of such appliances will become a service in its own right, that should not change the patient’s understanding of the treatment that they receive. However, unless Hamish Wilson can help me out, I will need to re-examine the evidence that the committee has received about the impact that the bill will have on such patients.

Dr Wilson: Given the correspondence that we have seen—I think, literally for the first time today—I think that there might have been a misunderstanding on the part of some patient groups. As the minister said, the intention is that the supply of such appliances will become a specific service in its own right that health boards will secure either from existing appliance suppliers or from a small number of community pharmacies that currently provide the service. Such appliances are not part of pharmaceutical care services but are a separate service that requires its own standards and quality assurance, which it has not had in the past. The intention is not only to protect the existing service but to improve it in future.

Mrs Milne: There was concern that if health boards were given the responsibility for such things, they might not have the funding to cope.

Dr Wilson: That is not the intention.

Mr Kerr: The arrangements that are available for patients to engage with people in securing the appliances and having them fitted will remain the same. As Hamish Wilson indicated, we think that patient groups might have misunderstood our intention, given the correspondence that has been received. I will deal with that later, but I can reassure patients that the net effect of the provisions will be to ensure service improvement rather than diminution. The appliances will remain the same and the fitting procedures will remain the same, but the service will become a specialist service within the NHS.

Mrs Milne: That is helpful.

The Convener: Is Jean Turner’s question on a separate issue?

Dr Turner: No, it is connected with that issue. Some patients deal directly with manufacturers and have made-to-measure appliances. For them, the issue is very personal. Confidence comes into it, and there is a worry that they might not be able to continue to deal directly with the manufacturer, which some people definitely feel is the only way in which they can get the service that they want; they feel that they would not be able to get it through a pharmacy. If they were hindered by having to use another company, that would not suit them.

15:15

Mr Kerr: There are set quality criteria for health services. As long as the existing supplier matches those quality criteria, whether that supplier operates directly or through another provider, there will be no change. The bill deals with the organisation of the service in its own right; we want to increase quality and provide a better service.

Dr Turner: So no one need worry.

Mr Kerr: Absolutely. If we have received correspondence from groups that are worried about a diminution in the number of suppliers or about not being able to use their regular supplier—I have not seen any such correspondence—we will be able to reassure them about that.

The Convener: Thank you. We need to move on to part 4 of the bill, which deals with discipline. The minister is still accompanied by the same officials. Janis Hughes will lead off.

Janis Hughes (Glasgow Rutherglen) (Lab): Although it is fair to say that there was broad agreement on part 4 among the people from
whom we took evidence, a few issues were raised that we would like the minister to clarify. One witness suggested that the bill should include a definition of professional and personal misconduct. What do you think about that suggestion?

**Mr Kerr:** It would be quite restrictive to include such a definition in the bill; I would prefer the definitions to be dealt with through guidance.

**Janis Hughes:** Concerns were raised about the regulatory bodies having disciplinary procedures that are different from those of the NHS tribunal and about duplication of work by those bodies. What efforts have been made to harmonise disciplinary procedures and to save time and effort by joint working?

**Mr Kerr:** That is a valid point. I am assured that consultations on that are on-going. In an effort to ensure that there is no duplication, we are discussing the matter with the relevant bodies.

**Janis Hughes:** When will we know the outcome of that consultation?

**Dr Wilson:** As a result of the Shipman inquiry, all the national regulatory bodies are under review. Although we can continue our discussions, it could be difficult to conclude them until we are sure about the precise future role of the regulatory bodies. I am sorry, but I cannot give you a timescale for that.

**Janis Hughes:** Are you likely to be able to conclude your discussions prior to the conclusion of our consideration of the bill?

**Dr Wilson:** I am afraid that that is not within our direct control, as matters to do with the regulatory bodies are reserved.

**Janis Hughes:** The bill proposes that if a family health service professional is suspended for investigation, they will still be paid. In other words, they will continue to receive full pay pending the result of the investigation. In sectors such as optometry and dentistry, practitioners would find suspension very difficult, as they are self-employed and do not get paid unless they work, although they would continue to have staff and premises costs. What are your views on that?

**Mr Kerr:** We are discussing that with the professional bodies involved and we have not come to a conclusion. I imagine that we will be able to come back to the committee on that more quickly than we indicated before, because those matters are within our control. That issue has not yet been resolved.

**Janis Hughes:** That would be helpful, because there is a concern about the apparent disparity, which would affect staff.

**Mr Kerr:** Suspension should have a neutral effect. The fact that someone has been suspended suggests that the matter has not been investigated and that they have not been found guilty of malpractice or anything else. We are discussing the matter with the relevant bodies.

**Janis Hughes:** So you will come back to us on that.

Has the Executive considered including trainee professionals and students under the discipline umbrella, given their close contact with patients?

**Dr Wilson:** Students are in a different position from trainees because students are not registered and are not on a list. The discipline procedures relate to the listing. Whoever is listed to perform services becomes subject to the disciplinary process. Students are not listed but some trainees will be. There is a distinction to be made.

**Janis Hughes:** Another omission that has been highlighted is to do with NHS 24. The minister has told us that employees of NHS 24 will not be covered by an NHS tribunal. Are parallel procedures being worked on?

**Mr Kerr:** There are existing procedures. As we develop one side of the business, we will have to ensure that there is a matching effect in NHS 24.

**Dr Wilson:** In this context, NHS 24 is a health board like any other, and the employees of a health board are subject to their own internal disciplinary procedures.

**The Convener:** We now move to part 5 of the bill, which is on hepatitis C. I will allow a moment for new officials to come to the table.

**Shona Robison:** The Executive’s justification for the exclusion from the compensation scheme of those who died before 29 August 2003 is that that was the date on which health ministers across the UK announced the UK scheme. Do you believe that that is a good enough reason for determining eligibility?

**Mr Kerr:** Yes, I do. In such difficult circumstances, one has to draw a line somewhere. We are compensating people for changes to their lifestyle because of what happened to them. We are thinking about supporting people who are still with us. We drew the line at that date so that the announcements of the four relevant UK ministers coincided.

I fully understand some of the views on this issue—they have been expressed to me forcefully. However, we must bear in mind the effects of different methodologies on the NHS. We must also bear in mind what all this is about—trying to assist those who are suffering as a result of contracting hep C through past engagement with the NHS. Sadly, it is not about those who, unfortunately, have passed away; it is about supporting those who are still with us.
Shona Robison: I am sure that you would accept that many relatives will also be suffering financially, especially if they have lost the main breadwinner of the family. Are you prepared to keep the issue under review? Evidence from Skipton Fund Ltd seems to indicate an underspend. At the moment, it has spent £9.81 million out of the £15 million that was allocated. Skipton Fund has indicated that it has not received as many applications as were expected, so it expects an underspend. If that turns out to be the case, will you reconsider extending the eligibility to allow relatives whose loved ones died before 29 August 2003 to come within the scheme?

Mr Kerr: I am always happy to discuss these matters, especially with the Haemophilia Society, which has been in to see me and with which I have corresponded. However, I say again that I have to consider the protection of the health service as a whole. The costs of taking the radical step that you propose would affect the health service, so I am not inclined to take it.

I do not think that it is a question of how much money is left over from the amount we set aside and whether we should change the principle as a result. The principle remains sound in relation to what we want to achieve. The situation is unfortunate and distressing for those involved, but I believe that the principles of the decision made by the four UK health ministers stand. Whether or not there is money left in the budget is a different matter. The money might be used later, because there are a number of outstanding claims that we expect to come in. I am always willing to listen to those who are directly involved and to discuss the issues with them, but at the moment I do not see a change of view on the issue.

Shona Robison: Will you commit to keeping that £15 million set aside for people with hepatitis C one way or another, or, if there is an underspend, do you envisage the money going elsewhere?

Mr Kerr: We will have a long tail on the fund—much beyond my tenure as Minister for Health and Community Care, I am sure—to ensure that, when people come forward, their cases can be dealt with. A diagnosis might be made many years in the future, and the rights of those individuals must be protected. I am not saying that the fund will go on for ever, but I do not envisage any change to the approach for now.

Shona Robison: The appeals process is not yet in place. In your correspondence, you say that you hope to get it in place soon. Will you be more specific?

Mr Kerr: Sadly not, because others from the rest of the UK are involved. I raised the issue with John Reid, the UK Secretary of State for Health, just yesterday. It is a pressing matter and I fully understand why the Haemophilia Society in Scotland is concerned about it, but I continue to try to push as hard as I can to get a result. We have a four-nation agreement and we need to stick to it when considering arrangements for the appeals process, so I will alert the committee as soon as I am aware of significant moves in that direction.

Shona Robison: The Haemophilia Society in Scotland has raised the point that those who can claim should be defined according to whether they were infected by NHS Scotland rather than according to their place of residence at the time of making their claim, as the bill currently proposes. Your letter seems to imply that, as long as the person is resident at the time of the claim, it does not matter if they move after that. Is that the case?

Mr Kerr: Yes.

Shona Robison: If they happened to have moved two weeks before the scheme was announced, say to America, so that their family could look after them, would they be ineligible? Would they be debarred from making a claim? That does not really seem fair.

Mr Kerr: I would need to seek legal advice on that point, because the fund is based on residence in the UK. I am not sure whether anybody else could claim. I apologise for not having that information, but I can provide the committee with information on overseas residents claiming two weeks after contracting hepatitis C. Is that your point?

Shona Robison: No. The point is that someone could have been eligible for money from the scheme, but they might happen to have moved out of the country shortly before the scheme was announced. Under your residency rules, that would debar them. It does not seem fair that, because they happen to have left the country—perhaps because they were not well and their family had offered to look after them—they will be debarred. We cannot be talking about a large number of people who are in that situation.

Mr Kerr: I do not make legal decisions in committees, because that would be a dangerous thing to do, but that is a valuable and fair point and I am happy to consider it and come back to you.

The Convener: Perhaps we could get that information from you in writing.

Dr Turner: What justification is there for the Skipton Fund rule that states that, if eligible persons die after 5 July 2004, payments will be made to their estate only if the eligible person claimed while they were alive? Thompsons the lawyers have indicated that at a stressful time in someone’s illness, things can fall apart in many ways, and that might well be the case. People
might have been busy dealing with their illness and their relatives might have been coping with such matters, so that people who perhaps should have claimed did not do so before they died, although they would have been eligible. That is what I look from the information that we got.

Mr Kerr: Recently, I met the Haemophilia Society in Scotland and its legal advisers, and they never raised that issue with me, but I am happy to consider your point. We are involved in a UK deal, so I have to think about the implications of what I say for the rest of the UK. The point is valid, and I am happy to get back to the committee with clarification.

15:30

Dr Turner: If people are paid from the Skipton Fund, will they be able to take up other procedures? Is it a separate issue?

Mr Kerr: What do you mean by “take up other procedures”?

Dr Turner: Will they be able to go down a legal route that is separate from their claim?

The Convener: You said recently that you would consider an amendment to rectify an anomaly in respect of Skipton Fund payments being taken into account in other proceedings.

Mr Kerr: Yes.

The Convener: Is that still likely to form an Executive amendment?

Mr Kerr: Yes. We have had questions about the Skipton Fund that are not directly relevant to the bill, but the issue is relevant. We wish to ensure that people who benefit from Skipton are not affected elsewhere in the system. We will do that.

The Convener: We move on to authorisation of medical treatment in cases of incapacity. Jean Turner has a question.

Dr Turner: I am anxious about the increase in the duration of a certificate of incapacity to three years. I know how busy general practitioners are. It could be that everyone who is involved in a case is busy and that the annual, or more frequent, checks could be ignored; three years can go by quickly. Everybody might think that the checks have been done but—golly—the three years might pass with nobody having examined the patient.

Mr Kerr: I share that concern, but I do not think that that will happen. As we expand the range of people who are able to authorise medical treatment, we will provide superior treatment for patients and we will reduce and change the workload of people who are under pressure. We are responding to feedback on that point.

Three years of cover can be given as long as it is the absolute exception, for example in cases in which there is—to put it bluntly—little prospect of improvement because, for example, of degenerative illness or because the diagnosis is that a condition will not improve. That will not change the clinical engagement with the individual concerned, or the treatment and support that they will get from the health service. The bill will increase the term of certificates under current legislation, but I will seek to ensure that that does not affect the care that is given to patients.

Dr Turner: So there will be some way of monitoring patients in between assessments.

Mr Kerr: That would go on anyway—it is in the nature of the service. Of course, the people who will be able to fill out the forms will be given training to enhance their skills and understanding, therefore I hope that we will improve the condition of patients, not just for one year, but for the three years.

Helen Eadie: You have a list of professionals to whom you propose to extend powers of assessment. How did you compile that list?

Mr Kerr: It was arrived at by considering who has an impact on the well-being of particular people and the services that are provided to them. That was the key driving force in producing the list of professions.

Helen Eadie: Why are some professions, such as clinical psychologists, not included?

Mr Kerr: First, the list is not exhaustive. If good arguments are made by professional bodies, the committee or others for the inclusion of particular people, we can make the change. Secondly, it is about interventions and the effect that the clinician can have on the patient. A judgment was made about who would be on or off the list. As far as the treatment of individuals is concerned, we felt that dentistry, ophthalmology and—crikey, I have just forgotten the last one. [Interruption.] Nurse specialists, dentists and ophthalmologists have the biggest direct impact on patients. We are more than happy to consider any valid arguments for other inclusions; however, we focused on the interventions that professionals apply to patients.

Helen Eadie: Has there been progress in ensuring that GPs and medical practitioners receive proper training under the Adults with Incapacity (Scotland) Act 2000?

Mr Kerr: The medical profession has received training from, I think, NHS Education for Scotland. Joe Logan will come in on this question, but I believe that NES is extending the scope of its modular support and training.

Joe Logan (Scottish Executive Health Department): At the moment, we are consulting
NES on a specific proposal, on which we intend thereafter to consult various professional groups. We think that, under that proposal, GPs will be supplied with further training.

**The Convener:** Evidence that we received last week suggests that there are still issues to address about application of existing procedures and that, so far, training has not been particularly effective in quite a few areas. Do you accept that?

**Mr Kerr:** We want to revisit some of those issues.

**Joe Logan:** Take-up of the initial training has been patchy. Having said that, I point out that training has been offered on the code of practice, and that a video and leaflets about the Adults with Incapacity (Scotland) Act 2000 were produced. Furthermore, one of our professional advisers in the Executive held a series of roadshows across Scotland in an attempt to reach as many people who would be affected by the act as possible. However, we accept that take-up has been a bit patchier than we hoped. We hope to do something about that with the proposed follow-up training, which, with NES’s involvement, will be more detailed.

**Janis Hughes:** You said that the medical profession will receive the training, but will every other profession that is involved in treating patients with incapacity also receive it?

**Joe Logan:** It will go across all the professions.

**Janis Hughes:** It will be available to professionals who seek to issue certificates of incapacity.

**Mr Kerr:** It is all to do with professionals’ ability to sign off such certificates.

**Janis Hughes:** Okay.

**Mr Kerr:** You cannot sign off the certificates unless you have been through the training.

**Janis Hughes:** Does the current consultation include organisations that support patients with incapacity?

**Joe Logan:** The consultation on NHS Education for Scotland’s specific proposal has still to take place, but it will include representatives from the patient bodies.

**Janis Hughes:** The minister indicated that draft regulations will be available in June. Will you confirm that those are still on schedule? Obviously, the committee will want to see those regulations before stage 3, if the bill should reach that stage.

**Mr Kerr:** That is our target—we will deliver on it.

**The Convener:** We move on to questions on joint ventures.

**Helen Eadie:** Are the powers in the bill intended to cover only the introduction of projects under the English local improvement finance trust—LIFT—model? If so, why are they so broad?

**Mr Kerr:** With the joint ventures proposals, we want to enhance local authorities’ ability to work with health boards, and to allow the private sector to put additional investment into our health service. Their purpose is no broader than that.

We are dramatically increasing the amount of capital that is available to our health boards in Scotland, but we want to ensure that the additional resource is available to them not only to attract new investment, in addition to the substantial increases that they have already had, but to ensure that there is joint-venture planning with local authorities. There are some good examples of such work; the bill’s provisions on joint ventures are designed to allow such work to take place. It is about the LIFT model being used in Scotland to deliver joint ventures, be they public-public or public-private projects.

**Helen Eadie:** In your letter to the committee, you refer to the way in which risk will be shared between parties to a joint venture, but there is no comment on how services will be provided if a project collapses. Will you comment on that?

**Mr Kerr:** Are you talking about property joint ventures?

**Helen Eadie:** Yes.

**Mr Kerr:** As with any public-private partnership, the legal provisions around the project will ensure that the risk is transferred, if that is the design, to the private-sector provider in the partnership, who will ensure delivery. In that sense, such a scheme will work like any large PPP scheme; it will provide surety to the taxpayer and patients in respect of delivery. Such projects will be simply PPP schemes at local level that will work as amalgamations of smaller community-based projects, so the risk will remain with the provider.

**Helen Eadie:** What is the Executive’s position on the future of co-operative development agencies? I know that it was positive towards and supportive of them. Have you and your officials examined the projects in Plymouth that have gone down the mutual route? Do you see scope for that route in Scotland?

**Mr Kerr:** I am not sure about the projects in Plymouth; I will defer to my colleagues if they know more. On mutuals, the Executive has never taken a position against them; that is another model that people work up and which becomes available. We provide traditional capital substantially to renew and modernise our NHS
estate. It is the best-value approach that matters, whether in respect of the large increases that are available through traditional capital routes, the LIFT schemes that will exist if the legislation progresses, or mutuals. The delivery vehicle for investment is the choice of the boards. As long as they get the delivery vehicle to stack up and it goes through the public sector comparator, that will continue to be the case.

**Helen Eadie:** I ought to declare an interest as a sponsored member of the Scottish Co-operative Party.

**Mr Kerr:** Mike Baxter has more detail on the matter.

**Mike Baxter (Scottish Executive Health Department):** We have a governance arrangement that was established through the joint premises project board, which will consider the various models. The powers that we seek are generic. To be fair, the LIFT model is established; it is working and appears to be delivering. We can learn many lessons from that. The National Audit Office has also examined the LIFT model and is due to issue a report on it in April or May; we will also consider the lessons from that. We would be interested to hear details of the projects in Plymouth, although we have had contact with schemes in England on the planning and delivery processes that have been used there.

**The Convener:** The evidence that we took was that none of the schemes south of the border is far enough down the line for us to be able to use it as a clear model. However, you said that those schemes can be used as models. How can you be sure?

**Mike Baxter:** There are several aspects. First, the joint-venture concept, as it has been developed in the LIFT model, is about providing a vehicle to bring various parties round the table. It is based on a strategic planning framework. We can look at the experience to date and consider how that framework has developed by examining the broader service strategy and how it relates to premises development.

The second aspect is the commercial model itself and how its finances work. Deals have been signed and premises are being built; there is acceptance of the market and the commercial model has been tested.

**The Convener:** Is not it the case that there has not been much service delivery yet?

**Mike Baxter:** In terms of the operational phase of the schemes, I accept that that is the case.

**Dr Turner:** Evidence that we heard at a previous meeting suggests that LIFT schemes are usually smaller projects, such as small health centres or practices, rather than the bigger PPP-type hospitals. Concerns were expressed that some of them were getting involved with strictly commercial ventures, which were not necessarily related to the NHS; for example, shops that were not opticians.

15:45

**The Convener:** There is evidence that in some ventures south of the border, parts of premises have been used for ordinary commercial ventures such as newsagents, which surprised us.

**Mr Kerr:** I am impressed by such projects, which allow investment in areas where community regeneration has otherwise been at a standstill. If we aggregate public sector expenditure, bringing in health services—say, a dentist, a doctor and a physiotherapist—a post office, a police station, a newsagent’s and a hairdresser’s, that is good news for the community.

**The Convener:** Is that what is envisaged?

**Mr Kerr:** Yes—that is what joint ventures can and should deliver.

**Dr Turner:** That sounds good but, as time goes by, medical premises have sometimes to expand, so it might be difficult for practices, once they are tied into such commercial joint-venture arrangements, to have enough flexibility to pluck out what the NHS requires. We have some doubt about that.

**Mr Kerr:** The skill lies in contract negotiations and specification procedures, which allow scalability in projects. Mike Baxter has worked on that.

**Mike Baxter:** We do not envisage a one-size-fits-all approach. The needs of communities vary throughout the country, as will the opportunities for joint working between health and local government and the commercial opportunities at particular sites. We are keen that there be diversification in premises development. The commercial spin-offs of third-party revenues of joint-venture companies can bring financial benefits to the public sector. The public sector will be a stakeholder in any such companies; therefore, any profits will be shared proportionally between the public and private sectors. The ability to generate third-party revenue will have an impact on the level of rent that can be charged to the public sector tenant. There will not be commercial opportunities in every case, but the model is flexible enough to allow that.

**The Convener:** Last week’s evidence from the Convention of Scottish Local Authorities and the NHS Confederation in Scotland suggests that they do not feel that they have been properly consulted, as they wished. Are there plans for further discussions with those bodies about the proposals and their implementation? They clearly indicated
to us that they do not feel that they have been consulted much so far.

Mr Kerr: We have been long and weary in discussions since July 2002, I think. Far more structures have been set up, and there is co-chairing of those structures. Many papers have been produced and much official time has been put in. I was surprised by that evidence, but I seek to resolve any concerns that exist.

The net gain could be substantial. The Dalmellington centre might represent a different model of delivery, but the change that such a facility can make to a community, with the service delivery that it can offer, is simply fantastic. Lothian community treatment centre is another example of the sort of development that I want more of. If there is not enough faith or confidence among partners, however, that is a problem for me, which I will seek to remedy.

The Convener: It would be useful if you could do that, and if you could keep us informed in that regard.

Company law dictates that directors’ first responsibility is to shareholders; your letter addresses the issue of guarantees being offered so that joint ventures prioritise health services and facilities over commercial development. Those two things seem to present a bit of a contradiction. Commercial development might be more profitable. Are you confident that you can bring those two apparently contradictory positions together?

Mr Kerr: I am confident that we can do that as long as we correctly carry out the planning process for delivery of individual projects. We are all aware of what the balance of the package is with respect to commercial development opportunities—pure commerce—the provision of the NHS facility and the position of the local authority. As long as they are all aligned in the project, the partners will know what each will gain from it. That will be determined by the overall bundling of the project.

The risk will be transferred to the private sector partners and their funders, who must ensure that a project continues to be delivered if it goes wrong. Such situations have happened in the past with, for instance, East Lothian schools. Although an uncomfortable delay occurred when the company from Holland that was involved—its name escapes me—went bust, another provider was found and the project’s financial stability was underpinned by the bank that was involved in it. All the players round the table will agree on the commercial involvement in the project, and the public sector will sign off the project. If it goes wrong, protection exists in contractual arrangements to ensure that the public’s needs are met. I am therefore relatively comfortable with the arrangements.

The Convener: My question was more about whether the proposals are robust enough to overcome the issue of directors’ first responsibility being to shareholders.

Mr Kerr: I am happy to pass that to Mike Baxter—I am not sure that I understand the question.

Mike Baxter: There are a number of ways in which that issue is dealt with. As we said in the letter, the situation is not unique to joint ventures. Any corporate body needs to be able to deal with conflicts of interest. In the articles of association and shareholder agreements for the companies that have been established under the LIFT model in England, the objects of the company are closely aligned to public sector bodies, which provides a mechanism for minimising such conflicts of interest.

The Convener: So you are confident that the proposals are robust enough to overcome any difficulty in that respect.

Mike Baxter: Yes.

The Convener: As far as I understand the matter, under the joint-venture set-up about which we are talking, the assets would not revert to the health service at the end of the joint-venture period. However, in PFI projects, the assets revert to the health service at the end of the contract. As we have a choice between a situation in which, in the final analysis, the assets come to the health service and one in which they do not, why are we opting for a situation in which they will not?

Mr Kerr: The contract value and the price that the public sector pays reflect the fact that we do not get the asset at the end of contract.

The Convener: So it is cheaper.

Mr Kerr: Yes.

The Convener: Right. So it comes down to the calculation that it is cheaper to concede the asset. You have calculated that, in the long run, that will be better.

Mike Baxter: Under the joint-venture model, the property will not transfer back to the health service at the end of the period, so the residual value of the property and the risk will stay with the private sector firm. That is the prime risk transfer, which is a fundamental difference from traditional PFI models in which, as you rightly say, the asset transfers back. From a public sector point of view, joint ventures will also provide more flexibility in the way we manage our estate, because tenants or shareholders can disinvest from the premises.
The Convener: Does that relate to the issue that Jean Turner raised about the possibility that requirements will change over the years, which might mean that premises are no longer particularly appropriate for what they were originally built for?

Mr Kerr: Yes, but under the traditional PFI/PPP model, it is for the procurer—that is, the public sector—to decide whether it wants to take the asset back; it can decide not to take the asset back. It is not a must-do under PFI/PPP, but it is under LIFT. That reflects the smaller size of the properties that are involved in LIFT.

Shona Robison: On disinvestment, can both parties—the private sector and the public sector—disinvest? If so, and the public sector wanted to disinvest early, would there be a financial penalty for doing so and how would it be worked out?

Mike Baxter: Options for exit strategies from the firm will be contained in the shareholders agreement, which sets out the rights and obligations of shareholders, including lock-in periods; that is, how long they must stay involved with the firm. The condition for disinvestment is that the other shareholders agree to the selling on of the disinvesting shareholder’s shares. There are provisions in the contract arrangements and the shareholders agreement on the shareholders’ obligations to maintain or exit from the joint-venture company.

Mr Kerr: It is a standard form of contract.

The Convener: Do the details of the contracts, such as the shareholders agreements, have the capacity to vary from project to project? Will each one be a stand-alone contract?

Mr Kerr: Each contract will suit local circumstances. What the private sector and other public sector players bring to contracts will vary, as will the scope and length of contracts and the provision of facilities. However, underlying values will require us to assess each contract against the public sector comparator to ensure that the risk that is transferred is appropriate and the cost represents best value. At the moment, PPP contracts, whether in education or health, are various in their approach, but the underpinning values are still there in the relationship between the public procurer and the private supplier.

The Convener: We have almost exhausted our questions, but I want to sweep up one thing. We had a letter from the minister dated 18 March, which signified the Executive’s intentions for stage 2. Although it is only a short time since you wrote the letter, I wonder whether there is anything you want to add to it. Are there more issues about, or do you want to comment on, stage 2?

Mr Kerr: I am desperately trying to ensure that there are no significant amendments at stage 2.

The Convener: That would be useful.

Mr Kerr: We still have only three amendments. I hope that they are pretty straightforward. That is the way I want to keep it.

The Convener: I thank you for coming along. I also thank all your officials for attending.

I suspend the meeting until 4.05 pm.

15:56

Meeting suspended.
Dear Roseanna

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

I am writing to you following the Health Committee session on 22 March 2005 where I gave oral evidence on the Smoking, Health and Social Care (Scotland) Bill.

I indicated at that session that I would follow up on a number of points raised by Committee members. Annex A to this letter addresses the specific questions raised on smoking, dental & ophthalmic services, pharmacy, discipline, hepatitis C payments, authorisation of medical treatment and joint ventures. I have also indicated when information will follow if it is not readily available at present.

I have also enclosed the National Smoke-free Areas Implementation Group membership list at Annex B and a copy of Smoking Cessation Guidelines for Scotland: Update 2004. These are in response to questions 4 and 5.

I trust that you find this information helpful.

All the best

Andy

ANDY KERR

ANNEX A

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL
Additional Information for the Health Committee

Part 1: Prohibition of Smoking in Certain Enclosed Public Spaces

1. Has the Executive considered the impact of the smoking provisions on private clubs, with specific reference to the British Legion?

The use to which funding raised in clubs can be put depends on the relationship between clubs and the Legion, and the charity’s constitution. It is for the charity to seek advice from the Office of the Scottish Charity Regulator (OSCR) on the issue. However, in terms of reducing exposure to second-hand smoke to improve the health of both staff and members of clubs, it is quicker, easier and cheaper to go completely smoke-free, than install expensive ventilation equipment. Ventilation systems improve comfort by removing the smell and visibility of the smoke. They do not remove toxic carcinogens from the air.

2. Will guidance be issued on how enforcement of the ban should be carried out?

Executive officials have already met with CoSLA officials to discuss a number of issues relating to enforcement, including the need for guidance. A small group will be set up comprising CoSLA, Environmental Health and local authority interests which will take the issues forward, with input from the National Smoke-free Areas Implementation Group.
3. Will sanctions in this Bill or in other legislation extend to loss of licence for non-compliance in the case of certain businesses?

The Licensing Bill provides for licence review procedures if either a premises licence holder or a personal licence holder commits a ‘relevant offence’. The nature of those offences would be set out in regulations following the passage of the Bill and it is intended to include smoking offences. The Licensing Board would decide on the appropriate sanction. For a premises licence holder this can range from a written warning, a variation of the terms of the licence, a suspension of the licence up to, ultimately, revocation of the licence. For a personal licence holder the sanctions would be endorsement of the licence, suspension for up to 6 months or revocation.

In the latter case, the conviction of a personal licence holder, who may be the manager of the premises, wouldn't necessarily impact on the premises licence itself unless the Licensing Board considered that the premises was being run in a way which conflicted with the licensing objectives set out in the Bill. In those circumstances, the Board could also call the premises licence holder to account.

4. How will the funding to aid smoking cessation be distributed among health boards?

We are currently considering the most appropriate targeting of the new cessation funding which was recently announced in order to support our overall tobacco control objectives. We will provide details of this and the accountability arrangements which will apply to the Committee as soon as decisions have reached. Meantime, the Committee may be interested to see the “Smoking Cessation Guidelines for Scotland: Update 2004” which has been widely disseminated across Scotland to provide up to date evidence on effective smoking cessation interventions and practical guidance on the planning and delivery of smoking services. Implementation of the recommendations made will assist all health and related professionals to play an effective role and maximise the effectiveness of specialist smoking cessation. A copy of the Guidelines and accompanying desk top guide are enclosed for information. The publication is also available on www.healthscotland.com/tobacco

5. What publicity and public awareness raising campaigns will the Executive undertake prior to implementation of the ban next Spring?

Membership of the National Smoke-free Areas Implementation Group is attached (Annex B). The Executive is planning for an extensive public awareness campaign in the lead up to implementation of the smoke-free legislation and beyond, which will communicate to all Scotland, and those sectors most likely to be affected by the proposed law, the purpose, effect, liability, enforcement, and benefits of the legislation. We are currently in the process of choosing a contractor for this work. Two members of the Implementation Group are involved in this process and will also be working with the chosen agency, along with some other members of the Implementation Group, to advise on, and test, the proposals.

Part 2: General Dental Services, General Ophthalmic Services and Personal Dental Services

6. What will the new oral health assessment comprise and how much will it cost?

We have had discussions with the profession on the content of the oral health assessment and this is nearing finalisation. We have still to discuss the fee that will be involved and will attempt to conclude this by June 2005. We will keep the Committee updated on progress.

7. Will the Executive measure the uptake of the free checks?

Systems will be put in place to monitor the uptake of the free oral/ sight checks following implementation of the provisions.

8. How is the Executive tackling the poor uptake of sight tests?
This will form part of our discussions with the profession. We will also consult with consumer bodies on how to promote uptake in terms of information to the public. An initial report of the eyecare review will be submitted to Ministers shortly and could be made available to the Committee shortly thereafter.

Part 3: Pharmaceutical Care Services

9. In the written evidence submitted for this Bill some organisations have expressed confusion regarding the procedures for the supply of appliances under the new PCS arrangements, particularly for patients who deal directly with the supplier at the moment. Can the Executive clarify this?

In addition to responding fully to all correspondence on this issue, we shall write to Health Boards and the organisations that represent both appliance suppliers and their users to clarify the proposed new arrangements.

Part 4: Discipline

10. What is the process for pay arrangements for suspended professionals under the new discipline procedures?

We are currently discussing arrangements with each of the contractor professions and aim to complete negotiations by the summer. It will then be necessary to lay amendment regulations for each of the contractor professions; the amendments should come into force by October.

Part 5: Miscellaneous

Infection with hepatitis C

11. When will an appeals process be established for the scheme?

Officials from the four UK administrations have met twice this year, 28 February and 17 March to progress establishing the Agency Agreement and Appeals Process. Officials from the Executive noted the issue raised by the Scottish representatives of the Haemophilia Society during their evidence session to the Health Committee and these were highlighted in the discussions. The Department of Health for England is leading on setting up the Appeals Process and I have alerted John Reid to the need to establish this as a matter of urgency. I am personally monitoring progress towards a swift solution.

12. Can the Executive clarify why the scheme requires a claimant to reside in Scotland when the application for payment from the Skipton Fund is made? For example, what happens in the case of an individual who moved away from Scotland prior to the introduction of the scheme?

For the purposes of the Bill, it is irrelevant where in the UK the treatment was received. In order to be eligible to claim under a scheme made under the Bill, the person requires to be resident in Scotland at the time of making a claim. Consequently, if a person infected in Scotland moves elsewhere within the UK (and had not at that time made a claim to Scottish Ministers) they would not be eligible to make a claim under the provisions in the Bill.

If they are resident in England, Wales or Northern Ireland they would, however, be eligible to make a claim in England, Wales or Northern Ireland as appropriate. The provisions, in essence, enable more efficient administration and merely determine which of the four administrations will meet the costs of the claim. This will make no difference to the claimant – the form and process will be the same.

Officials are in discussion with officials from the other UK administrations on the matter of individuals now living abroad and I will respond to the Committee with the outcome of these discussions once they are complete.
13. Can the Executive clarify the position of the eligibility of those who died after August 2003 but before the Skipton Fund was established and who therefore could not have submitted a claim. Are their relatives entitled to claim?

We have great sympathy for relatives and dependants of those deceased infected persons who had not submitted a claim prior to death and are not entitled to payment but we have to consider the effects of the financial outlay on this scheme on the ability to provide treatment for other patients. For this reason, the UK-wide scheme focuses on those who are currently suffering.

The Skipton Fund, unlike both the Macfarlane and Eileen Trusts, is not a charitable trust. It has been designed to make lump sum ex-gratia payments on compassionate grounds and does not make follow up or day to day payments. However, the lump sums are comparable to those made by the Macfarlane and Eileen Trusts. Whilst the others do include dependants under their eligibility criteria, the Skipton Fund is distinct and was never designed to compensate for bereavement or loss of earnings.

14. Will the Executive amend the Bill to ensure claimants from the Skipton fund are not disadvantaged in respect of claims made elsewhere?

Section 24(3)(b) of the Bill is concerned with the right of a claimant to initiate or pursue court proceedings notwithstanding that a payment is received from Skipton. Ministers have power to specify conditions for eligibility and the Executive has made it clear that a person is eligible to receive a payment from Skipton notwithstanding that the person may have received a payment from other schemes.

An amendment is proposed for Stage 2 to make this clear.

Authorisation of Medical Treatment

15. Will professionals issuing incapacity certificates receive training?

I wish to assure the Committee that only those professionals who have undergone relevant training will be allowed to issue a section 47 certificate. We have asked NHS Education for Scotland (NES) to develop a suitable training package. These changes will be reflected in an updated Code of Practice which we hope to issue in the Autumn. I am also giving consideration to bringing forward an amendment at stage 2 of the Bill, where this would add greater clarity.

Joint Ventures

16. What discussions have taken place between the Executive and CoSLA and the NHS Federation on the issue of Joint Ventures?

The Executive is committed to an inclusive process for developing joint ventures as provided for in the Bill. The Joint Premises Project Board (JPPB) which was established in December 2004 has involved CoSLA directly from the start. I will be monitoring its work closely and will be receiving recommendations from it in due course. I look forward to discussing such issues directly with CoSLA on an ongoing basis. In support of the JPPB a wider body of interests has been brought together to inform its deliberations and work plan. This Joint Premises Stakeholder Forum meets for the first time on 16th May. The NHS Confederation has been invited to join this Forum.
ANNEX C

ANNEX B

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

The National Smoke Free Areas Implementation Group Membership

Chair
Andy Kerr, Minister for Health and Community Care

Members

• Paul Ballard, NHS Tayside
• Patrick Brown, Scottish Beer and Pub Association
• Gordon Greenhill, Society of Chief Officers in Environmental Health
• Prof. Gerard Hastings, University of Stirling
• Will Holt, Consolidated Communications
• Councillor Eric Jackson, COSLA
• John Loudon, British Hospitality Association
• Rory MacKail, Federation of Small Businesses
• Lindsay MacHardy, NHS Health Scotland
• Ken McGowan, Scottish & Newcastle Plc
• Alan Rankin, Scottish Tourism Forum
• Marjory Rodger, Confederation of Passenger Transport
• Jacquie Roberts, Care Commission
• Eddie Tobin, Bar Entertainment & Dance Association Ltd
• Alan Tomkins, Glasgow Restaurateurs Association
• Melanie Ward, National Union of Students
• Paul Waterson, Scottish Licensed Trade Association
ANNEX D: OTHER WRITTEN EVIDENCE

PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES - ORGANISATIONS

SUBMISSION BY THE AGAINST AN OUTRIGHT BAN (AOB) GROUP – PETITION 819

The AOB Group was formed in the Autumn of 2004 to communicate the views of the majority of pub owners in Scotland as to how to maximise the potential health and financial benefits from tobacco restrictions.

The membership of the AOB Group includes the Scottish Licensed Trade Association, the Scottish Beer and Pub Association, the Scottish Wholesalers Association and several multiple pub groups which are based in central Scotland. Altogether, we represent more than 3,500 licensed trade retailers in Scotland as well as the bulk of the brewing industry in Scotland.

Whilst we support tobacco restrictions, we are strongly in favour of choice and we fully endorse the views expressed at Westminster by Dr John Reid in November 2004.

“We believe that, in a free society, men and women ultimately have the right within the law to choose their own lifestyle.”

Our membership has been heavily involved in working with the Scottish Executive to reduce tobacco consumption in licensed premises. We were the principal contributors to the Scottish Voluntary Charter Group which promoted the introduction of smoke free areas and better quality ventilation from year 2000 onwards. We came to recognise that voluntary action does not provide a level playing field as individual licensees are naturally reluctant to take steps to restrict smoking if such steps place them at a competitive disadvantage. So, in May 2004, we asked the (then) Deputy Health Minister to introduce through legislation five measures which would have been compulsory for all licensed premises ranging from pubs, hotels, restaurants, sports clubs, social clubs and entertainment venues. The measures were:

- Smoking should be banned at the bar counter in all licensed premises.
- Smoking should not be permitted in any area where and when hot food is being served.
- All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be ratcheted upwards to 40% in year 2 and 50% in year 3.
- Every licensed premise should have a smoking policy sign at the entrance.
- Smoking should not be permitted in any area of licensed premises from which the public are excluded (ie back of house).

At the end of year 3 a review of progress would be made and appropriate further steps taken in the light of public opinion prevailing at that time.

The model proposed by us is very similar to the Norwegian model which has increased restrictions over a period of several years.

We do not underestimate the difficulties in introducing these measures but we believe that they will help Scotland to make a huge stride forward in improving choice for non-smokers and protecting their health as well as the health of employees in the industry. A firm message will be conveyed to the Scottish public in general and smokers in particular and, over a period of time, we anticipate a significant increase in the presence of non-smokers in licensed premises.
Our position remains unchanged from that of May 2004. We are even more convinced, having reviewed all the consultation documents and reports, that our own proposals would bring greater health and financial benefits to Scotland.

The reasons why we say that are as follows:

1. There is no public support for the provisions of the Bill. The Executive’s own research has demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in licensed premises. This is not to say that the public do not want increased restrictions on smoking – but they do not want, and are not ready for, an all out ban.

   The mruk opinion poll concluded that although a majority of those surveyed supported a ban on smoking in enclosed public places, two-thirds of those also believed that exemptions should be considered for the licensed trade. Only 18% of those surveyed supported a total smoking ban.

   The Scottish Executive evidence report gives a summary of the outcome of focus group studies and on page 21 states that “there was a deeply ingrained assumption that the pub is one of the few places where smoking should be freely allowed.”

   Further, in the evidence report on the outcome of youth consultation, the Scottish Executive states clearly that 66% of young Scottish people believe there should be some places where smoking is allowed (page 28). On page 29 the report goes on to say that “whilst smoking could be banned in most public places, some young people felt that some places should be exempt. Pubs and clubs were mentioned as the key areas that should be exempt. Young people suggested that there could be some “smoking bars” or there could be designated areas within pubs for smokers.”

   In the survey conducted by the UK Department of Health in 2003, 80% of participants wanted tobacco restrictions but, of these, 80% wanted exemptions for the licensed trade.

   In the most recent poll, conducted by Populus, more than 75% of Scots were found to believe that smokers should have the right to smoke in public provided they do not inconvenience non-smokers.

   In our opinion, the Scottish Government has wholly underestimated the importance of public support as part of major cultural change of this type.

2. One of the consequences of the lack of public support for this legislation is, potentially, a sharp increase in the number of smokers choosing to switch their disposable income from pub going to take home consumption. This has been the experience in Ireland, as is highlighted in the cebr report referred to in point number 5 underneath.

3. There has been no Scottish Executive research into the potential health consequences of smokers ceasing to visit licensed premises and switching their disposable spend into take home drinking.

The Evidence Report states that the best estimate of Scottish deaths from health problems resulting from ETS is 865 per annum. However, almost all of the research conducted in to ETS has taken place in the home.

Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations. It is quite possible that the outright ban approach will result in greater health problems as a result of increased smoking at home.

Under our own proposals, people will have the right to choose either a smoking or a non-smoking pub. Under the Executive proposals, people will have no such right of choice. Currently, more than 60% of pubgoers are smokers. If this legislation results in a significant switch from pubgoing to take home drinking/smoking, the risk of ETS exposure in domestic environments will increase. Non-smoking partners, relatives and children of smokers will have no escape from the impact of
ETS – or at least they have less chance of escape from the impact than those who visit licensed premises.

The most recent addition of the British Medical Journal carried a report of research which has concluded that children exposed to ETS in domestic environments are more than three times more likely to experience lung cancer and related diseases in later life than children who are not exposed to ETS in domestic environments.

This underlines the requirement for further research on the potential “shift” of ETS problems.

4. The Scottish Executive has failed to carry out any research on whether or not smoking cessation is greater following an outright ban on tobacco usage in public places than it is following phased restrictions on tobacco usage in public places.

There is no evidence from Ireland on this very important issue. However, Norway has recently released some statistics which show that the number of Norwegians between the age of 16 and 74 who smoke daily, which had dropped from 29% to 26% in 2003 without a smoking ban, has dropped by only 0.3% in 2004 following the ban. The number of daily smokers among young Norwegians aged 16 to 24 has actually increased since the smoking ban came into force, rising to 23.7% from 22.8% in 2003.

5. The Scottish Executive has not fully researched the benefits of effective ventilation systems.

In the 1998 UK White Paper Smoking Kills para 7.23 states “ventilation systems can improve the comfort and welfare of public and employees. The best systems can, provided they are properly operated and maintained, protect non-smokers from exposure to carcinogens.”

The Executive has ignored the conclusions of the University of Glamorgan report which found that the contaminants in the atmosphere of a smoking-permitted, well ventilated pub in Glasgow (the Doublet) were fewer than in the atmosphere of a no-smoking non-ventilated pub in Glasgow (the Phoenix).

The University of Glamorgan report has been criticised in a peer group review but the authors of the report remain convinced that their conclusions are correct. We believe that there has been insufficient follow up by the Scottish Executive to ascertain whether or not the University of Glamorgan report is correct in its findings. If it is, a better health option for the Scottish Executive would be to insist on all smoking-permitted pubs to have ventilation installed to a minimum standard.

6. The Scottish Executive has based its decision to proceed with a blanket smoking ban on a range of research which we believe to be fundamentally flawed. Much of it is irrelevant and it is incomplete. The principal piece of research was the “international review” undertaken by the University of Aberdeen. However, the international review considered the “specific effects on the hospitality sector” of a smoking ban using a number of studies - eleven of which related to restaurants and four to hotels. Significantly, only one related to the experience in bars (in California) and the report indicated that “this was the only study available to model results for Scotland”.

The AOB Group has commissioned the Moffat Centre for Travel and Tourism Business Development, Glasgow Caledonian University, to undertake a project to source, review and evaluate existing research which has been undertaken in analogous destinations and countries which have legislated for either an outright or a phased ban on smoking in workplaces. This included the aforementioned international review undertaken by the University of Aberdeen.
The Moffat Centre conclusions include:

The weakness of the international review is its lack of relevant evidence to:

(a) support the argument that an outright ban in all workplaces will reduce the number of smokers when increases in smoking may be displaced elsewhere eg in the home.

and

(b) make a claim that a no smoking policy will not harm the hospitality business, particularly bars.

Nearly all the governments in the countries and states reviewed for this work, with the exception of Ireland, have given significant notice of their intention to introduce a total ban on smoking in hospitality establishments. This is only fair given the apparent difference in perception of the public towards smoking in different categories of hospitality premises. The Scottish Executive could take a lead from the experiences of other nations’ legislature.

It has been acknowledged as a weakness in the Executive’s commissioned research that the studies reviewed do not include analysis of a total ban situation. This is compounded by the lack of transferability of the cases used in their argument.

A Government backed investigation into the effects of the ban in Ireland could be undertaken, using a cross sectoral group that encompasses health experts, industry practitioners and Government policy makers. This would surely provide a consensus on the effects of and timescale for introducing a total ban, if that was the conclusion of the group.

7. The AOB Group has been alarmed by the lack of any in depth study of the financial impact of the smoking ban. We commissioned the Centre for Economics and Business Research (London) to independently review the economic impact on both the licensed trade and the beer industry in Scotland.

The cebr report is attached as appendix 2. Its findings include:

The value of annual turnover in the licensed trade will decline by £105m.

Annual profits in licensed premises may decline by £86m.

Employment in the licensed trade can be expected to decline by 2,300 jobs initially.

About 142 average sized licensed premises may close as a result of decreased trade.

The Chancellor of the Exchequer may lose out on a total of £59m in annual tax revenues from the Scottish licensed trade.

8. The AOB Group proposal is similar to the UK Government’s proposal in that it provides choice for both smokers and for non-smokers. To create a divide in smoking policy between Scotland and England will put our nation at a significant competitive disadvantage. Currently 80% of visitors to Scotland come from England. There is a strong possibility that tourists will favour English destinations – where the visitor is free to choose between smoking and non-smoking venues – as opposed to Scottish destinations where there is no choice. The Moffat Centre research makes it clear that “boundary hopping” is common in the USA where different States have different regulations.

9. What we have found most surprising throughout the consultation process is the apparent assumption that a blanket ban is the best possible option to improve public health and benefit the economy. The debate seems to have been dominated by “black versus white” – either an outright ban or the status quo. There have been no discussions between the Scottish Executive and the AOB Group concerning the practicalities of the proposals which we have put forward. For us, this has been a source of considerable frustration. There appears to have been no serious
consideration given to the introduction of tobacco restrictions along the lines of those successfully implemented in countries such as Australia and Norway where a phased approach has proved to be acceptable to all stakeholders.

10. Little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment. The fear of unemployment affects the mental and physical welfare of all those who work in any industry which is subjected to such sudden cultural change as that being proposed.

11. Moreover, no assessment has been made by the Scottish Executive of the potential disruption of communities and social disorder through the provision of this legislation. Scotland has many licensed premises which form part of tenemental buildings and it is not possible for licensees in these landlocked situations to provide external smoking facilities for their customers, due to neighbourhood nuisance and noise issues. The likelihood is therefore that many Scottish streets will be disrupted by groups of smokers indulging their addiction on pavements outside the front of pubs and clubs. This will in turn bring new problems for the authorities to deal with and it will not be easy to introduce a law which forbids people to stand and smoke in unenclosed areas (unless tobacco is banned altogether). Once they leave the freehold of the premises, customers of licensed establishments cease to be the responsibility of the licensees.

Further, it is universally agreed that smoking is more prevalent in the less affluent areas of Scotland’s cities and towns. Smoking bans are likely to hit hard in the more deprived communities, driving people to stay at home rather than make their regular visits to their favourite hostleries. As UK Secretary of State for Health Dr John Reid has said on various occasions, - one of the few pleasures of the working man is to have a drink and a cigarette with his friends – if this right is denied him, community life will change radically, ripping the heart out of many localities.

Conclusions

The licensed trade has always been, and will always remain, supportive of the ultimate objective of a healthier Scotland. However, we strongly believe that the Scottish Executive has not afforded the time and consideration necessary to identify the best move for public health. As we have stated, there is a significant body of evidence to suggest that an alternative strategy, with the same aim, may further increase the health benefits achievable from restricting the use of tobacco in licensed premises.

Surely what is effectively the most radical move in public health policy this Executive has proposed deserves greater attention to detail?

We urge the Health Committee to request more time to conduct research into the financial and health benefits of alternative approaches. In addition, we would urge the Government to consider new and innovative ways to tackle smoking. This debate seems to have been dominated by an “all or nothing” approach. At no point in the process would it seem that anyone has really sat down and looked for the optimum solution.

Should the Executive decide to give the decision a bit more thought we would be delighted to help in any way whatsoever and we would be pleased to give oral evidence to the Health Committee, should you so wish.

SUBMISSION BY ASTHMA UK SCOTLAND

Second-hand tobacco smoke has a massive impact on people with asthma. Not only can it make asthma worse, but research has found it can actually cause asthma. • Even at low levels of exposure, second-hand smoke is associated with asthma symptoms.1 • Second-hand smoke is a major asthma trigger, reduces lung function and causes more frequent attacks.2 • Research published at the end of 2003 concluded that secondhand smoke also causes asthma in adults. For people exposed to asthma at work the risk of developing adult onset asthma is doubled, for people exposed to asthma in the home the risk is increased five fold.3 Research from Asthma UK
Scotland has found that:

- 4 out of 5 people with asthma say other people’s smoke makes their asthma worse.
- 55% of parents of children with asthma avoided restaurants and places with smoky atmospheres.

Second-hand smoke is the second most common asthma trigger in the workplace.

- 1 in 5 people with asthma feel excluded from parts of their workplace where people smoke.
- 60% of people with asthma say that government is not doing enough to protect them.

Those with more severe asthma symptoms are most severely affected:

- 44% reported missing out when friends or family go to restaurants or pubs where smoking is allowed.
- When we asked people with severe asthma “If you could get the government to do just one thing to improve your asthma, what would it be?” 21% said “Ban smoking in public places.”

(National Asthma Campaign’s National Asthma Panel fieldwork December 2003).

Asthma UK Scotland understands that prohibiting smoking in public places will cause concern for smokers and other industries such as restaurant owners. However, we believe that the overwhelming health arguments outweigh these personal liberty arguments put forward by smokers, particularly when compared with the personal liberty of people with asthma, who have a right to go to a restaurant without fear of having an asthma attack. Concerns have been raised that by introducing smoke free public places more people may smoke at home. This fear has not been borne out in countries that have already introduced smoke-free public places. Rather, people who smoke have taken this opportunity to stop smoking. Asthma UK Scotland expect that by introducing smoke-free enclosed public places will not lead to a rise in smoking in the home. Smoke-free areas have been compared to swimming in the chlorine free half of a swimming pool. It simply does not exist. Smoke-free areas are still contaminated by cigarette smoke and the carcinogens and toxins that it contains. Ventilation systems have also been suggested as a possible way forward. Again, scientific research has shown that ventilation systems are simply not effective in removing toxins and carcinogens from the air. We welcome the recognition given to this by the Health Committee and the Executive and hope that this resolve remains throughout the passage of this Bill.

Conclusion

Preventing smoking in public places is the only way that we can protect people from the adverse effects of second-hand smoke. Other measures that try to find common ground between interest groups, such as ventilation or smoke-free areas are a compromise, and a compromise that is dangerous to health. While in politics we often try to find a common path, or a compromise that brings different groups together, on this issue such a policy could lead to solutions that are detrimental to health and therefore cannot be pursued. Asthma UK Scotland understands that there will be calls for exemptions to be introduced in the Bill. Ideally we would like to see all enclosed public places smoke-free. This is the only way to protect the people who have to work in an environment that is seriously dangerous to their health. It is worth re-stating that people exposed to second-hand smoke for six or more hours per week are 50% more likely to develop asthma symptoms. We know that places that could be considered a home will not fall under this Bill, however we would ask the committee to consider this question and recommend protection for those who have to work in this dangerous environment. Asthma UK Scotland therefore supports this Bill that will introduce smoke-free enclosed public places as a positive way forward in improving the health of people in Scotland, and in particular those people with asthma.

A Personal Perspective

Elaine has asthma and explains how smoking in pubs and restaurants affects her life: “About 14 years ago and after a very healthy and busy social life where I played squash for my university and ran up the hills of Snowdonia I developed late onset asthma. How life changed! The most vicious trigger was cigarette smoke and so overnight I became a prisoner in my own home. I could not go with my friends and family to pubs, parties or restaurants. They all found this hard but not half as hard as I did. Imagine declining all meals out, going to pubs with friends, school/parent socials and parties. Sometimes I would sit at home alone and send my husband out to enjoy himself because I didn’t see why he should be a victim too. I pathetically looked forward to the annual Christian Aid Ceilidh in the local Church hall because smoking was not allowed. I sometimes became very angry.
at the ignorant rhetoric in the papers about the rights of smokers. They have no right whatsoever to pollute the air I or any other person breathes. Restricted areas are not effective as the smoke is still hanging in the air, evidenced by how people smell when they come out! Eventually I found a non-smoking restaurant in Edinburgh called Parrots and took all my friends and family there. More recently others have sprung up, probably about three and of course Starbucks are all non-smoking so at least we can go for a coffee now. The first non smoking pub/restaurant in Edinburgh has emerged and this is great news.” Elaine goes on and asks: “Please can we have a ban on smoking in public places? At the moment many people with asthma have had their choice and freedom of movement removed. With a ban, people who smoke can still choose where to go however their choice to pollute the air we breathe will be removed. That is justice.”

SUBMISSION BY BARNARDO’S SCOTLAND

Barnardo’s Scotland - children’s charity with over 60 community-based projects across Scotland. We provided a response to the consultation paper so our comments are brief. We would be happy to give oral evidence to expand on this written evidence.

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

Because of the public health dimension - smoking is the leading cause of premature illness and death in developed countries

Smoking behaviour is established in adolescence and young smokers may become addicted before reaching adulthood. Legislation that restricts opportunities to smoke along with educational and public health messages and effective cessation interventions should help force the pace of change - a wide range of tobacco control measures are essential

If not, why not? N/A Are there any other comments you would like to make?

The legislation will ban smoking in public places. This tobacco-control measure will complement the work of some of our projects that work with young people on lifestyle issues and healthy living. The fact that tobacco is a possible ‘gateway’ route into taking cannabis is another important consideration.

Some of our projects also work with expectant mothers and parents on the impact of second-hand smoke on developing embryos, babies and children. This is important work since exposure to second-hand smoke causes illness and premature loss of life, at all ages from the prenatal to late adult life.

Our projects need to work sensitively in this area since for many children, young people and parents, smoking is a normal part of their life and they believe it helps them deal with the many problems and difficulties they face.
SUBMISSION BY BELLHAVEN GROUP

The Belhaven Group is Scotland's leading regional brewery operating a range of activities which include beer brewing, drinks distribution, licensed retailing and tenanted estate management. We own and operate 270 pubs in Scotland and we supply beer and other drink products to approximately 2,000 licensees throughout the country. We employ approximately 1,600 people and we are Scotland's only publicly quoted (on the London Stock Exchange) company which derives its livelihood almost exclusively from the Scottish licensed trade.

We are a member of both the Scottish Beer & Pub Association and the Against an Outright Ban Group. We fully endorse the submission from the AOB Group which is attached herewith for easy reference.

I would emphasise the strong feeling within our company that the five point plan proposed in the AOB submission will deliver greater health and financial benefits for Scotland than the provisions contained in the Holyrood Bill.

Please take time to conduct the research which this hugely important subject deserves. To date, the research on which the Scottish Parliament decision has been predicated is, we believe, fundamentally flawed, incomplete and, in parts, quite irrelevant.

Thank you for having afforded us the chance to communicate our views to you. We will be happy to give oral evidence, should you so wish.

Yours faithfully

STUART ROSS
CHIEF EXECUTIVE

SUBMISSION BY BLANTYRE BOWLING CLUB

We are very concerned about the No Smoking ban that the Scottish Executive is going to impose on the Licensed Trade, and others, during 2006. We feel that a total ban on smoking is not in our best interest and that a partial ban would be better.

If a partial ban was brought in, we would set aside 50% (or more if necessary) of our clubhouse for non smokers and increase the ventilation to a set standard, as imposed by the authorities.

Our club depends on the revenue from the bar to keep our fees lower, improve the fabric of the club and maintain and buy machinery for the upkeep of the green.

I have spoken to members from other clubs in the district and the majority of them, like us, would prefer to have smoking and non smoking areas within the clubs. We sincerely hope that you will take into consideration our concern and public feeling before you make a decision on this important matter.

Yours on behalf of the Committee

SUBMISSION BY BMA SCOTLAND

Part 1: Prohibition of smoking in certain wholly enclosed places

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The
BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

Introduction

The BMA welcomes the opportunity to comment on Part 1 of the Smoking, Health and Social Care (Scotland) Bill which aims to prohibit smoking in enclosed public places. In previous evidence to the Health Committee on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, the BMA supported the general principles of the restrictions proposed in the Bill.

Written evidence to the Committee stated: “Ideally the BMA would like to see the introduction of primary legislation to make all enclosed public places smoke free.”

The BMA therefore fully supports the principles outlined in Part 1 of the Smoking Health and Social Care (Scotland) Bill which seeks to provide comprehensive legislation to create smoke free enclosed public places.

Smoke free public places and the public health

The BMA welcomes the Committee’s recognition that passive smoking harms health. International evidence has proven that legislation to create smoke free enclosed public places, as part of a wider strategy, works at reducing exposure of non-smokers to deadly tobacco smoke. Evidence has also found partial and voluntary restrictions to be ineffective in protecting the public.

Each year in Scotland 13,000 deaths are caused by tobacco related diseases such as cancer and heart disease. Secondhand smoke also kills hundreds of Scots each year, causes cancer, heart disease and asthma, aggravates asthma in adults and is known to cause middle ear and respiratory infections in children. Exposure to secondhand smoke is also a cause of cot death.

The BMA’s publication, Towards Smoke-Free Public Places, states that no safe level of exposure to second-hand smoke has been identified. The BMA welcomes the commitment to introduce this legislation as a public health measure to protect the public from the harmful health effects of exposure to secondhand smoke.

Section 4 (7) of the Bill enables ministers to add or remove, through regulations, premises that would be included within the legislation. The BMA understands that exemptions to legislation will be included in regulations to be published at Stage 2 of the Bill process. However, the BMA would emphasise that comprehensive legislation is needed, and that any exemptions should be extremely limited, as has been the case in Ireland. The central reason for this legislation is to protect health and the BMA believes that everyone should have the right to the protection from the significant health risks of secondhand smoke. If the regulations were to provide for large scale exemptions, such as those proposed and supported by the tobacco industry and licensed trade, it would be significantly less effective as a public health measure.

Alternative approach

Alternative approaches, such as voluntary agreements and partial bans, have proved to be ineffective in protecting the public from the harmful effects of secondhand smoke. A review of the hospitality industry revealed that despite repeated government support for voluntary measures, less than half of all businesses in Scotland surveyed even knew about the Voluntary Charter. This experience has been shared worldwide. In Australia, compliance with the Voluntary Code of Practice was also poor and played an insignificant part in the adoption of non-smoking policies.

There are 4,000 toxins and more than 50 cancer-causing substances in tobacco smoke and many of these are odourless, invisible gasses, which are not removed by ventilation systems. Ventilation has been proposed as a solution to the problem of passive smoking. However, the evidence shows that ventilation and air-cleaning systems do not provide effective protection against the health hazards of second-hand smoke.

Ventilation systems commonly involve the partial dilution and recirculation of filtered air. They are inadequate in offering protection from the harmful effects of secondhand smoke. Air cleaning
systems usually involve the filtration of air, which is then re-circulated. Because filtration systems can only filter out particles, they do not remove the gas phase of secondhand tobacco smoke. An assessment of filtered tobacco smoke concluded that it is as potent in inducing cancer as unfiltered smoke.1

Because only the particulate matter in smoke is visible, ventilation filtration systems can give the non-smoker the impression that they are safe from the exposure to tobacco smoke. Many people underestimate the extent to which they are exposed to tobacco smoke. Businesses installing expensive ventilation systems in the belief that they are protecting staff and the public from the ill effects of secondhand smoke are mistaken, even those of the highest quality do not provide adequate protection 4.

Financial Implications

One of the key arguments against smoke free enclosed public places is that businesses in the hospitality sector would suffer financial hardship. There is no independent evidence from anywhere in the world that supports the claim that the hospitality trade has been adversely affected by the introduction of smoke free policies.

Figures circulated by the Scottish Licensed Trade Association are remarkably similar to those predicted by Irish licensed trade representatives who warned that turnover would drop by 20 to 25 per cent and 30,000 jobs would be lost as a consequence of the legislation which came into force at the end of March 2004. These predictions have not been realised. A report from the Irish Central Statistics Office revealed that in November 2004 bar sales were down just 2.8% per cent compared with the previous year. The decrease in the year before was 7.1%. Scare stories about declining hospitality industry sales should be viewed in the context of the long term trend in Irish bar sales.

Furthermore, a report commissioned by the CMO in England revealed that concern about falling profits is unfounded. In other parts of the world where legislation to create smoke-free public places and workplaces has been introduced, profits in the hospitality and leisure industries have risen 7.

However, there is one industry which stands to suffer significant losses as a result of this legislation. A recent review of the introduction of smoke free workplaces estimated that if all UK workplaces became smoke free, consumption would fall, costing the tobacco industry £310 million annually in loss of sales 1. Internal tobacco industry documents have shown how the tobacco industry worldwide has vigorously opposed smoke free legislation, including funding “smokers’ rights” groups and lobby groups representing the hospitality trade.

Public Opinion

The majority of the public support smoke free enclosed public places. The recent survey commissioned by the Scottish Executive which shows that 70% of those surveyed do not support a ban in bars and restaurants is cited by the hospitality industry as proof that this move would go against the public’s wishes. It fails to highlight the fact that over 50% of the sample were smokers. This sample is not representative as only 30% of the Scottish population smokes. The evidence from other countries that have gone smoke free shows that public support increases after legislation is announced, and continues to increase as the measures are introduced.

Conclusion

International experience clearly illustrates that comprehensive tobacco control programmes, supported with national legislation, work. If smoke free public places were introduced, it is estimated that smoking rates could drop by 4% and tobacco consumption would fall by 30%. Indeed, after legislation for smoke free public places was introduced in Australia, children’s exposure to passive smoke in the home fell, both because when fewer adults smoke, fewer children are exposed, but also because more families introduced smoke free homes.
Smoke free enclosed public places would save hundreds of lives each year and reduce the impact of chronic disease on individuals and the health service. It would be the best possible measure that the Scottish Parliament could take to improve the health of the nation.

**SUBMISSION BY BRITISH LUNG FOUNDATION SCOTLAND**

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the Bill? Yes

If yes, why?

The British Lung Foundation (BLF) is pleased with the sections in the Bill that will ban smoking in wholly enclosed public places in Scotland.

The health risks associated with secondhand smoke have long been acknowledged and the BLF is delighted that Scotland is leading the way for the rest of the UK on this issue.

We believe the Bill will be instrumental in reducing the estimated 1,000 deaths per year in Scotland attributed to secondhand smoke. In addition to this, there are more than 800,000 people living with a lung disease in Scotland whose conditions are severely aggravated by exposure to secondhand smoke. These people will finally be able to socialise and work in smoke-free environments which do not damage their health.

We also agree with the assertion that a complete ban will provide the most comprehensive protection and will also be simpler to implement than other compromise measures that have, for instance, been announced for England in the Choosing Health? White Paper.

If not, why not?

N/a

Are there any other comments you would like to make?

It is noted that the Bill makes provision for certain exemptions to be prescribed through regulations. The BLF would urge the Executive to minimise these exemptions as much as possible to ensure that the health of all workers in Scotland is protected by this Bill.

We feel that enforcement by local authority environmental health officers is appropriate and believe that making it an offence ‘to permit others to smoke in and on no-smoking premises’ will facilitate compliance by ensuring owners and managers enforce the ban.

The BLF thinks it is vital that the implementation of this Bill is underpinned by support for smokers who wish to quit. We feel that this is the most important element of any comprehensive package to reduce the burden of smoking related disease. Many smokers find giving up incredibly difficult – in 2000, the Royal College of Physicians published a report on nicotine addiction which concluded that “cigarettes are highly efficient nicotine delivery devices and are as addictive as drugs such as heroin or cocaine.” The BLF believes it is essential for NHS Scotland to lead the way in providing effective support to quitters in the most appropriate settings and at the most convenient times.

If you require additional information, please do not hesitate to contact us. We are happy to provide further evidence at a later date if this would be useful to the Committee.

Andrew Powrie-Smith
Head of BLF Scotland
SUBMISSION BY BROOMHOUSE CENTRE

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? no
If yes, why?
If not, why not?

No. I am the co-ordinator of a small group providing day care to elderly people with dementia in a small public building. I see allowing smoking after meals as a part of the provision of care for elderly people with dementia as many of them have smoked all their lives.

I am concerned that when smoking is banned in public places, people will not wish to attend our day centre, putting further strain on already lengthy waiting lists at social work day centres in the area (where I understand there will be no ban).

Day care can help combat social isolation and such problems as becoming de-skilled and unmotivated in people with dementia and isolation and stress in carers, and the successful care of people in the community depends on readily available services.

I would therefore like to see provision in the bill to allow a public place in use for the provision of care to be treated as private space where appropriate.

SUBMISSION BY CAMRA

Thank you for the opportunity to express our views on the above Bill.

1.0 The Prohibition of Smoking in Public Places

1.1 CAMRA supports action to manage the issue of smoking in licensed premises, but does not support a complete ban on smoking in all licensed premise by next spring.

1.2 CAMRA believes that a complete ban on smoking in all licensed premises by next spring is the wrong approach for the following two reasons:

- Lack of public support. We highlight the finding of an opinion poll commissioned by the Scottish Executive, which reveals 57% of the public consider pubs should be exempt from a ban on smoking in public places.
- Adverse economic impact on licensed premises. As a higher proportion of licensed trade customers are smokers than the population as a whole we believe that licensed premises will be particularly hard hit as a result of a ban. Research by BDO Hayward (2004) reveals that 46% of licensed trade customers smoke compared to only 26% in the population at large.

1.3 The implementation of a complete smoking ban in all licensed premises next spring will have an adverse effect on licensed premises, as smokers choose to drink at home rather than in licensed premises. The resultant loss in trade will mean:

- Significant job losses as licensed premises reduce staffing levels to cope with a downturn in trade.
- Reduced investment in maintenance of licensed premises.
- An increase in pub closures particularly in rural areas.
It is argued that banning smoking will mean non-smokers will be more likely to visit licensed premises. However an increase in licensed premises visits by non-smokers is unlikely to happen overnight, but is likely to build slowly over time.

2.0 Proposed Exemptions for Licensed Premises

2.1 CAMRA urges the committee to consider the following exemptions, which we believe will mitigate the adverse economic impact of a ban on licensed premises:

- Licensed premises should be exempt from a smoking ban until spring 2008 to allow a three-year period for licensed premises to prepare for a smoking ban.
- Where a licensed premise has two or more separate rooms then smoking should be allowed to continue in the smaller of those rooms, provided measures are introduced to minimise harm to staff.

2.2 CAMRA believes that a delay in implementation of a smoking ban until spring 2008 will mitigate the impact of ban on smoking in licensed premises by allowing time to:

- Attract non-smokers to licensed premises by introducing new no smoking areas.
- Develop other areas of the business, such as food, to help compensate for any loss in trade.

3.1 CAMRA believes that where a licensed premises has two or more separate rooms then smoking should be allowed to continue in the smaller of these rooms for the following reasons:

- Non-smokers will not be subjected to other peoples smoke as they can choose to sit in the larger non smoking room.
- Measures can be introduced to allow employees to opt out of working in the smoking area of any licensed premise.

Thank you for considering our views. Please contact us if you require any clarification or further information.

Yours sincerely

Jonathan Mail
Public Affairs Manager

SUBMISSION BY CANCER RESEARCH UK SCOTLAND

Cancer Research UK Scotland thanks the Committee for the opportunity to present evidence for the above Bill, which we regard as one of the most important pieces of legislation for the improvement of Scotland’s health. We are pleased to see the evidence for the health hazards posed by second-hand smoke acknowledged by the Scottish Executive in the Policy Memorandum for this Bill.

Cancer Research UK Scotland is both a participating member of Scotland CAN! (Cleaner Air Now), the coalition of organisations that lobby for smoke-free enclosed public places in Scotland, and a member of the Steering Group of the parent coalition SCOT (Scottish Coalition on Tobacco). Having consulted on and contributed to the coalition’s submission of evidence Cancer Research UK Scotland endorses the arguments submitted by that body to the Health Committee.

We particularly endorse the evidence showing that the hospitality groups and tobacco industry present flawed arguments in their proposals for alternative legislation. Cancer Research UK has been tracking the activities of the tobacco industry on smoking regulation issues for many years and is familiar with their lack of peer-reviewed reports and the tactics used to mislead the public on the dangers of second-hand smoke.
Should you require oral evidence, our research experts in Scotland or further afield remain at your disposal. Our position as part-funders of the current International Tobacco Control study on smoking legislation may be of particular value.

Please contact me in the first instance on 0131 311 4802 or e mail me on Lesley.Conway@cancer.org.uk

Yours sincerely

Lesley Conway
Public Affairs Officer for Scotland

SUBMISSION BY CARLTON CLUBS

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the Bill?

No

Carlton Clubs believes that the proposed ban on smoking as it currently stands would have a huge detrimental impact on our fourteen clubs in Scotland. A total ban on smoking in public places in the timescale proposed could seriously impact on the future viability of our business, with the potential loss of 400 Scottish jobs. Just as importantly, the closure of local bingo clubs would also remove from Scotland’s local communities a safe, social, fun and friendly leisure facility.

Carlton Clubs has been investing heavily in appropriate ventilation systems within the clubs over a number of years with a view to providing freedom of choice to our smoking and non-smoking customers. In 2005, for example, we have committed over half a million pounds to a state of the art ventilation system in a new build club, this investment decision was taken in summer 2004 before the bill was announced. A total ban will render this significant investment totally unnecessary.

It is our belief that an enhancement of building regulations to provide better ventilation and air quality systems within smoking premises would provide the best solution to both smokers and non-smokers. This change in the law, combined with the Executive’s continuing successful campaign of public health education about smoking, would be enthusiastically welcomed by our members and the wider public - who believe an imposed blanket ban on smoking in public places will seriously and unfavourably affect their current social activities.

Are there any other comments you would like to make?

Carlton Clubs is an indigenous Scottish company with a remarkable 69-year corporate history. Today, with its headquarters still in its home town of Inverness, the UK’s largest independent bingo operator has evolved and grown to a £20 million turnover organisation with fourteen clubs across Scotland and four in England employing 500 staff in total.

The company adheres to strong ethical principles of social responsibility towards its customers, suppliers, staff and the local community. Indeed in December 2003 Carlton Clubs became the first bingo company in the UK to be awarded a GamCare certificate of Social Responsibility. Carlton Clubs regularly seeks the views of its members particularly where changes will have a direct impact on their leisure activity. Over four days in December last year, Carlton Clubs sought members’ opinions on the Executive’s proposed ban on smoking in public places. Research conducted within our clubs indicates that 67% of our customers are smokers leaving 33% of non-smokers, demonstrating by their frequency of visits, that they are comfortable playing bingo in this environment.
Feedback from our membership, smokers and non-smokers alike was strong. Over 7,100 members, or more than two thirds of the people who were in the clubs over those four days, signing a petition expressing their view against the proposed ban of smoking in all public places. This petition has been sent to the Health Minister and shared with MSPs local to our bingo clubs.

Our members feel that any imposed ban will affect them adversely and that they will not be able to continue to enjoy playing bingo if they are not able to exercise their right to smoke and therefore may stop this social activity. In reality this could result in hundreds of our members spilling onto the streets between our main session games to smoke. This merely shifts the problems associated with smoking, not to mention creating other problems in terms of managing large groups of people converging on the pavements and roads in our local towns.

I feel that our petition reflects much the same findings of the MRUK opinion poll, commissioned by the Scottish Executive in September 2004, which found that of the two thirds of the sample who would support such a law, 57% of those thought pubs should be exempt.

Carlton Clubs do not advocate smoking to our members, but we do recognise their expressed preferences and individual rights as customers and to this end offer smoking and non-smoking areas plus ventilation in our clubs.

Bingo is the second largest participative leisure activity, for the over eighteen population, in the UK. It offers a safe and social environment for those who take part, the majority of which are women.

Carlton Clubs is therefore urging you to reconsider the blanket ban and amend the Smoking, Health and Social Care (Scotland) Bill to reflect the views of our members and the Scottish public.

Carlton Clubs would welcome the opportunity to discuss any aspect of our submission with the Committee should further clarification be required.

9 February 2005

SUBMISSION BY CHARTERED SOCIETY OF PHYSIOTHERAPY SCOTLAND

1 The Chartered Society of Physiotherapy Scotland

1.1 The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing physiotherapists, physiotherapy students and assistants. More than 98% of all physiotherapists in Scotland are members of CSP Scotland and physiotherapy is the fourth largest health care profession in the UK, and the largest of the allied health professions.

1.2. CSP Scotland has around 4,000 members in Scotland. Approximately sixty percent of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and with other employers, such as sports clubs or large businesses. Three Scottish universities offer degrees in physiotherapy. These are among the most over-subscribed university courses in the country. Approximately 150 newly qualified physiotherapists graduate in Scotland each year.

1.3 Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being. Using problem solving and clinical reasoning, physiotherapists work to restore functional movement or reduce impairment utilising movement, exercise and the application of electro-physical modalities.

2 The Smoking, Health and Social Care (Scotland) Bill

- Part 1 – Prohibition of smoking in certain wholly enclosed places
2.1 In respect of Part I (Prohibition of Smoking) - health promotion remains a crucial aspect of the work of chartered physiotherapists. In addition, chartered physiotherapists have a primary interest in the cessation of smoking and reduction in exposure to cigarette smoke, as so many come in to direct contact with the harmful effects of smoking on patients. This is particularly true for chartered physiotherapists working in oncology and in respiratory care in Scotland. Physiotherapy also plays an important role in cardiac rehabilitation and amputee rehabilitation, conditions that often result from smoking.

Prohibition of Smoking
The Smoking, Health and Social Care (Scotland) Bill
Part 1 – Prohibition of smoking in certain wholly enclosed places
3.1 The Chartered Society of Physiotherapy has policy supporting a total ban on smoking in enclosed spaces, in support of public health promotion. A more detailed submission to the Scottish Executive consultation concluded;

CSP Scotland welcomes the Health Committees own report conclusions in reference to the Prohibition of Smoking in Regulated Areas (Scotland) Bill. CSP Scotland welcomes the view that a ban on smoking would be positive for the public health of Scotland, and supports the majority view of the Committee that the private member’s bill did not go far enough. With the majority of committee members, CSP Scotland would support a full rather than partial ban on smoking in enclosed public places.

4. CSP Scotland has drawn on three major elements in support of its policy on the prohibition of smoking.
4.1 Public Health
that an outright ban on smoking in public places is both a progressive step for the health of the nation and a necessary step to protect non-smokers from the harmful effects of tobacco smoke. The Scottish Executive is right to consult widely, and must face this issue as a question of promoting public health and protecting non-smokers from the harmful effects of tobacco smoke.

4.2 The Physiotherapy
The Physiotherapy profession is heavily involved in the treatment of patients suffering diseases caused by tobacco inhalation, and has a primary interest in supporting moves to ban smoking in public places. While the main & obvious effects of smoking are in respiratory conditions and oncology, another main set of conditions is cardiovascular. Physiotherapy plays an important role in cardiac rehabilitation and amputee rehabilitation also.

4.3 Chronic Obstructive Pulmonary Disease (COPD)
This condition deserves particular mention by the Society with reference to the harmful effects of tobacco smoke inhalation. Chronic Obstructive Pulmonary Disease (COPD) is a disease caused by smoking that is well known to chartered physiotherapists but receives less publicity than other conditions.

4.3.1 A survey by the Chartered Society of Physiotherapy among physiotherapists specialising in respiratory care revealed that a staggering 83 per cent have cited smoking as the cause of COPD (chronic obstructive pulmonary disease) in patients. COPD is a frightening disease, characterised by airflow obstruction - a disorder that persistently obstructs breathing. The airflow obstruction is usually progressive, is not fully reversible and does not change markedly over several months. This condition receives far less publicity attention than other smoking-related disorders such as lung cancer.

4.3.2 Chartered physiotherapists in respiratory care report that a significant proportion of their workload (see 5.4 below) is devoted to this patient group. Physiotherapists are involved in the care of COPD from acute hospital admissions through to maintaining patients in the community, employing evidence based initiatives such as early supported discharge, non invasive ventilation and pulmonary rehabilitation. This patient group often has complex management problems and physiotherapists often assist in helping to manage chest clearance, coping strategies, breathlessness and anxiety management in conjunction with other multidisciplinary team members.
4.3.3 A survey of members of the CSP clinical interest group, the **Association of Chartered Physiotherapists in Respiratory Care (ACPRC)**, also revealed that physiotherapists spend over 50 per cent of their workload treating patients with the disease.

4.3.4 The number of acute cases presented to hospital represent only a fraction of the cases in the population, and people suffering from mild to moderate symptoms of COPD often go unidentified. Chartered Physiotherapists report that people who have been smoking for as little as five years could start to suffer symptoms of COPD.

4.3.5 Physiotherapists working in this area tend to see patients at the severe end of the spectrum. Some patients may also have secondary diseases such as heart failure, vascular disease or circulatory problems, and lung cancer. Not all COPD patients present with same symptoms. Some patients may also suffer from anxiety, which could lead to depression because they are physically limited due to breathlessness and have a poor quality of life.

4.3.6 In Glasgow there are currently initiatives on going to identify these patients earlier to try to optimise their medical care to prevent deterioration and subsequent hospital admissions; smoking cessation advice is an integral part of this drive.

4.3.7 Early detection of the condition is key so that physiotherapists can employ a proactive approach - it is estimated only 25 per cent of cases are currently being diagnosed.

4.3.8 Physiotherapists can treat COPD through management strategies that can prevent the condition progressing to the severe category. They can also promote disease mastery, develop coping strategies for breathlessness, reduce work of breathing and teach patients to clear secretions and manage anxiety through relaxation techniques.

4.3.9 Pulmonary Rehabilitation has an excellent evidence base for the benefits gained, and improvement in quality of life is a major benefit. Smoking cessation can only benefit the health of physiotherapy patients and the health of the nation.

5 Conclusion to Part 1
In its submission to the Scottish Executive consultation on smoking in public places, Chartered Society of Physiotherapy Scotland asserted the following:

“**Chartered Physiotherapists have a primary interest in reducing the harmful effects of tobacco smoke. Health promotion remains central to the practice of physiotherapy, and the profession is engaged in the treatment of tobacco-related diseases. Certain conditions rely heavily on the health benefits of physiotherapy.**

**CSP Scotland fully supports the campaign to ban smoking in public places. The Scottish Executive must take the steps necessary to protect the staff and customers of licensed premises, and protect members of the public in public places, from the harmful effects of inhaling tobacco smoke. Such steps would contribute to the health of Scottish society, assist the aim of reducing smoking among the Scottish population.”**

The full submission can be viewed at [http://admin.csp.org.uk/admin2/uploads/1a42792-fff954676e- -7c8e/smokingbansubmission30904.doc](http://admin.csp.org.uk/admin2/uploads/1a42792-fff954676e- -7c8e/smokingbansubmission30904.doc)

7.1 Chartered Society of Physiotherapy Scotland takes an active interest in the above legislative measures. Health promotion and safe effective practice are essential to the physiotherapy profession, and CSP Scotland is committed to patient centred services and continual measures to improve patient care.

7.2 CSP Scotland is also interested to learn more detail on the nature of training to be offered to health professionals to assess the capacity of patients.

Kendryck Lloyd-Jones
Children in Scotland is Scotland's national agency for organisations and professionals working with and for children and their families. It exists to identify and promote the interests of children and their families and to ensure that relevant policies, services and other provisions are of the highest possible quality and are able to meet the needs of a diverse society. Children in Scotland represents over 350 members, including all the major voluntary, statutory and private children's agencies, professional associations and local authorities as well as many smaller community groups and children's services. The work of Children in Scotland encompasses extensive information, policy, research and practice development programmes. The agency works closely with MSPs, the Scottish Executive, local authorities and practitioners. It also services a number of groups such as: the Cross Party Parliamentary Group on Children and Young People; the National Children's Voluntary Forum; the National Early Years Forum and the Special Needs Advisory Group. Children in Scotland also hosts Enquire, which is a national information program for parents of children with additional support needs.

Children in Scotland welcomes the introduction of the Smoking, Health and Social Care (Scotland) Bill and the opportunity to provide evidence to the Health Committee. This evidence is informed by discussions with Children in Scotland's Policy Committee and by consultation with children and young people through the Participation Network.

Children in Scotland strongly supports the objectives in Part 1 of the Smoking, Health and Social Care (Scotland) Bill.

Prohibiting smoking in enclosed public places is a significant measure in protecting the fundamental rights of children and young people. Introducing this bill would contribute towards the UK’s compliance with Article 24 of the United Nations Convention on the Rights of the Child (UNCRC):

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

Research suggests that young children in households where both parents smoke have a 72% increased risk of respiratory illness. More than 17,000 children under the age of five are admitted to hospital every year as a result of the effects of passive smoking.

Part one of the bill would also help to ensure the rights of young people to be protected from health risks in the work place:

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development. UN Convention on the Rights of the Child, Article 32

In addition to contributing to the safeguarding of children and young people's rights in relation to health and employment, the introduction of Part 1 of the bill would represent a vital first step in promoting a cultural shift towards lower rates of smoking, particularly amongst young people.
For further discussion or amplification of any of the points raised in this evidence please contact Shelley Gray (Policy Officer)

SUBMISSION BY CPL ENTERTAINMENT GROUP LTD

I would like to take this opportunity to make a formal written submission to the Health Committee concerning the Health and Social Care (Scotland) Bill. I own a number of bars, restaurants and night clubs in Glasgow employing over 600 people and servicing over 1 million customers every year, and am a member of the SLTA.

Whilst I am fully supportive of the government initiatives to protect the public from passive smoking, supporting smokers in their attempts to quit and am delighted that the government is making proactive steps to safeguard the nations health, I have been alarmed by the way in which the legislation has been progressed and am worried that the Executive has not taken enough time to review all the necessary information in making its decisions.

I would like to concentrate on what I consider to be the main issues.

1) The Executive is about to impose the most radical piece of health legislation the devolved parliament has seen - based on incomplete research; against overwhelming public opinion; with no idea of how to police the legislation; and no real guarantee that it will improve the nation's health. It is with absolute incredulity that I witness the speed at which the Executive has forced the Health and Social Care Bill through the Scottish Parliament. As I have said, I am totally in favour of increasing smoking restrictions but surely the Executive should take some more time to truly consider whether an outright ban is the most effective way to tackle the smoking issue. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

2) I believe that one of the most formidable arguments against the forthcoming legislation is that the public is opposed to it. The Executives own MRUK opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in public places - 77% of Scots who were consulted did not want a total ban in pubs yet we are to have it. This is not to say that they would not support increased restrictions on smoking policy -but they do not want, and are not ready, for an all-out ban.

In my opinion the government has wholly underestimated the importance of public support as part of the legal system. One of the vital assumptions made when imposing new laws is that the majority of the individuals will comply. If there is evidence to suggest that the law will be rejected you create extreme policing difficulties and threaten to make a mockery of the legislation. We are to be criminalized if we do smoke and possibly lose our livelihoods if we allow it.

I could understand the government making a decision against public opinion if it was absolutely sure that it was in the nation's best interest, but the Scottish Executive has rushed its research and failed to fully consider the possibility that the gradual introduction of smoking legislation which would give the general public time to adjust, may make a more definitive move for public health.

3) As an interested party, naturally we have read through the economic research and health reviews used to guide the Executive's decision. We were astounded to note the following points.

Firstly, as far as the economic impact of the ban on smoking is concerned, the International review conducted by the University of Aberdeen acknowledged that studies undertaken did not actually include an analysis of a total ban situation. Therefore, the conclusion drawn from smoking policy in foreign countries were non-transferable.

Secondly, the Executive did not take the time properly to assess the Irish situation, which is the closest benchmark we have, and even if it did it would have to assume that any negative impact would be felt more greatly in Scotland which has a much less stable licensed trade industry. We as
a profession were ignored when we pointed out that since 20th March 2004 there has been a drop in sales of around 23 million pints (as reported by the Irish Brewers Association) and that 42 pubs/clubs are already for sale in Dublin alone with 3,000 jobs on the line and a further estimate of between 10,000-15,000 jobs to be lost.

4) I was extremely disappointed by the Scottish Executive’s management of the consultation process. This is the most important stage in the introduction of new legislation, where individuals and organisations can offer valuable advice and opinions on government proposals. There are certain guidelines that should be followed during any consultation to ensure a degree of scientific integrity. Consultation documents should present all the facts, should be simple, wholly, unbiased, without presumption or implication. They should allow any individual to make an informed and objective judgement.

The document presented as part of the Executive’s consultation was a far cry from these guidelines. Both the First Minister and the Deputy First Minister pre-empted the consultation process by indicating firmly and clearly their preference for a total ban. The preface of the questionnaire was extremely heavily weighted towards the health issue and makes no attempt to introduce all necessary factors that need to be taken into account, the economy, jobs, compliance and policing. The questions were misleading, at no point making reference to public houses, which are at the heart of the matter. We would urge you to make reference to the consultation papers when considering these points.

5) The Scottish Executive seems to have underestimated the economic impact of an outright ban on smoking in public places on two levels.

Firstly, it has underestimated the actual financial toll a ban will take on the Scottish economy. New independent research from the Centre for Economics and Business Research (London) reports, amongst other things, that the value of annual turnover in the licensed trade will decline by £105m, that employment in the licensed trade can be expected to decline by at least 2,300 jobs, that 142 average sized licensed premises may close as a result of decreased trade and that the Chancellor of the Exchequer may lose out of £59m in annual tax revenues from Scotland.

Secondly, it seems to have underestimated the importance of the economic impact in the debate on smoking policy. Many hold the view that the economic situation is largely irrelevant when one is consider the health of the nation. However, little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment.

6) Creating a divide in smoking policy between Scotland and England will put the nation at a significant competitive disadvantage. There is a strong possibility that tourists will choose English destinations -where one is free to choose between smoking and non-smoking venues, over Scottish destinations -where one is not. Tourism is Scotland’s largest business sector; it employees more people than any other industry nationwide. Not to mention the fact that eighty percent of Scotland’s visitors are in fact English.

One might also consider the implications this divide in policy may have in policing guidelines. Those on the border will feel legally tom, especially if they, are loosing customers to neighbouring villages in the North of England. We’ would be out of step with Westminster which is ridiculous given that it is the same political party that governs.

7) Given the prevalence of already established non-smoking public areas (museums, libraries, modes of transport, cinemas, shops, offices), it would seem that the forthcoming legislation on smoking in public places is almost exclusively directed at the licensed trade. I am therefore slightly angered that the Executive has not tried to work more closely with the publicans, restaurateurs and hoteliers on Part 1 of the Health and Social Care (Scotland) Bill.

The Scottish Licensed Trade Association has in fact been working with the government for many years in developing smoking policing. As an organisation, it was one of the founding members of Voluntary Charter on Smoking. However, in the latest debate its opinions and guidelines seem to
have been marginalized. Perhaps this is because the trade has wrongly been portrayed as opposed to plans to increase restrictions on smoking in public places.

I for one would, and will, welcome tighter smoking laws; however I do not feel that an outright ban is the correct approach and I do not believe the executive has taken the time to fully consider other options which may make a more definitive move for public health.

8) What we have found most surprising in this debate is the apparent assumption that a blanket ban is the best possible option to safeguard public health and benefit the economy. This debate seems to have been dominated by a ban/no ban approach. At no point in the process would it seem that anyone has really sat down and looked for the best solution.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will safeguard the nation's health and avoid the shift in smoking in the home, protect the hospitality and licensed trade industries and will prove enforceable. There has been no Scottish Executive research into the potential consequences of smokers ceasing to visit licensed premises and switching their disposable spends into take home drinking. Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence.

9) Legislation should only be accepted and introduced when there exists an appropriate and viable strategy with which to enforce and police it. With regards to enforcement, the Executive has created itself a difficult task. It has chosen to "impose an outright ban on smoking in public places regardless of the fact a) the public do not support it and b) it is in opposition with our neighbouring States. Do we really expect to be able to form a contingent of "smoking police" that will stretch from Stranraer to Stornaway? Just like Ireland we will end up with one law for the country and another for the city, making a mockery of smoking legislation.

In addition, with smokers forced out into the street to indulge their habit, there is a real risk of increases in social disorder and violence, which at present no organisation is claiming responsibility for. Once they leave the premises, customers of licensed establishments cease to be the responsibility of the licensees. This brings significant issues for local authorities, which the Executive has yet to address.

10) Most of the SLTA members own pubs in small rural villages of approximately 500 people. It is likely that these public houses and communities around them will feel the impact of a smoking ban more acutely than most - and yet the Executive doesn't seem to have afforded them a great deal of thought.

The pubs in question really form the heart of the community, which is often made up of the retired and elderly. They depend on their regular clientele to keep the business afloat - and in turn their customers depend on the local venue for quality of life. To impose a ban in this area just seems ludicrous, you can't expect the elderly smoking population to nip outside in the middle of winter, people are far more likely to choose, or to be forced to stay at home.

11) The government failed to take into consideration that ventilation systems can cut out ETS gases and particles by 85-95% thus greatly reducing exposure to staff and customers. Positive air systems can also stop smoke drifting into areas where it is not wanted or desired thus preventing the need for partitioned smoking areas.

We hope that you will take these points on board and consider taking a little more time to analyse the facts and urge the Committee to afford the issue some greater consideration and thought. I believe we live in a democracy where politician's worked with the people not against them - where the duly elected majority embraced industry rather than destroy it and where freedom of choice was guaranteed.

Donald MacLeod
Managing Director
Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

Diabetes UK Scotland supports any initiative calling for a ban on smoking in closed public places, including the workplace, across Scotland. Smoking is harmful to the estimated 213,000 people with diabetes in Scotland and they should not be subject to the effects of passive smoking.

We support national and local decisions made to ban smoking in closed public places, such as the provision made in the Smoking, Health and Social Care (Scotland) Bill.

Everyone risks damaging their health through smoking but for people with diabetes the risk is even higher. People with diabetes are already at increased risk of heart disease, stroke and circulatory problems. Smoking doubles the risk of these problems again and doubles the chances of developing erectile dysfunction and kidney problems. Cardiovascular disease (CVD) is the main cause of death in people with Type 2 diabetes and is two- to fourfold more frequent than in those who do not have diabetes.

People with diabetes who smoke should be encouraged to stop smoking.

FOREST (Freedom Organisation for the Right to Enjoy Smoking Tobacco) is a media and political lobbying group that defends the interests of smokers and voices the opinions of many smokers and tolerant non-smokers.

FOREST does NOT agree with the main objective of the Bill on the general principles that, by removing all freedom of choice and failing to permit reasonable alternatives, it is wholly disproportionate and not justified either by science relating to environmental tobacco smoke (ETS) or public demand.

FOREST’s specific objections to the Bill as introduced are as follows:

1. Definition of a public place
   1.1. The definition as it stands in Part 1 of the Bill provides no certainty on what constitutes ‘no smoking premises’ since it permits Ministers to modify the definition at any time in the future by adding or removing kinds of premises at a later date. It is therefore entirely unclear what scope of premises the legislation is intended to cover.

   1.2. For example, no distinction is made between genuinely ‘public’ premises where the public has automatic right of access (such as railway stations, public transport, hospitals) and those that are destinations of discretionary choice for their patrons and/or private establishments capable of determining their own smoking policies, taking into account the interests of their customers and employees.

   1.3. It is completely unacceptable that businesses and places of work should have to take onerous steps to conform to a vague description of an ‘enclosed public place’ without any accompanying detailed clarification or any guarantee that the definition will not be changed on the whim of Ministers at some time in the future.
2. Private membership clubs
2.1. A notable casualty of the proposed Scottish legislation will be private members’ clubs, which include ex-servicemen and community social clubs. The general public does not, by definition, have access to private membership clubs. These clubs, which are open only to paid-up members, should therefore be exempt from the Bill and permitted to offer smoking facilities to their members if the majority of them so wish. If obliged to become no-smoking, private clubs - many of which are the focal point of community socialising, particularly in rural areas - will lose their smoking members and risk suffering irreparable social and economic harm.

3. Disregard for reasonable alternatives
3.1. Many people (including some smokers) do not want to eat, drink or work in a smoky atmosphere and FOREST supports initiatives that encourage proprietors to (a) introduce substantially more no smoking areas, (b) ban smoking at the bar and (c) improve ventilation.

3.2. The hospitality sector in Scotland has already made significant progress in extending the availability of no-smoking areas and premises. A survey into the voluntary charter on smoking in public places in Scotland (September 2003) showed that the number of businesses that had introduced smoking policies for the public had risen by 26% since 1999. The review, carried out for the Scottish Executive by the market research consultancy MVA, looked at 974 pubs, clubs, hotels and other leisure facilities and revealed that the Scottish hospitality industry had met three out of four of the targets set for it in 2000: 39% allowed smoking throughout, 43% restricted smoking and 18% were completely smoke free.

3.3. FOREST notes that the Scottish Licensed Trade Association is committed to continuing this programme of improvements and has recommended a five point plan of action:

(i) Smoking should be banned at the bar in all licensed premises
(ii) Smoking should not be permitted in any area where and when hot food is being served
(iii) All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be increased to 40% in year 2 and 50% in year 3
(iv) Every licensed premise should have a smoking policy sign at the entrance
(v) Smoking should not be permitted in any area of licensed premises from which the public are excluded (ie back of house)

3.4. Good ventilation, properly maintained, removes the need to ban smoking in indoor public places. Modern ventilation and air cleaning technology is effective in removing smoke particles and keeping gases well within the Health and Safety Executive guidelines. An independent study by the University of Glamorgan, carried out at the Doublet bar in the west end of Glasgow in April 2004, has shown that such systems can ‘clean’ the air of tobacco smoke and give pubs air quality equivalent to a non-smoking public place. The study has been replicated at other outlets elsewhere in the UK.

3.5. In England, the Secretary of State for Health John Reid has proposed a regime that will allow smoking in pubs that do not serve food prepared on the premises (approximately 10-20% of all pubs). Others have called for strict air quality standards that will require pubs and bars to install state-of-the-art ventilation systems as one of the criteria for being granted a ‘smoking licence’ by the local authority.

3.6. The Scottish Executive has totally disregarded these alternative policies which recognise that a combination of more no smoking pubs, more no smoking areas, and premises with good ventilation provides a reasonable alternative to an outright smoking ban.

4. Removal of all choice
4.1. The proposal within the Smoking, Health and Social Care (Scotland) Bill to ban smoking in public places, including pubs, bars and private members clubs, is an unnecessary infringement of individual freedom. It removes entirely the element of choice; it goes far beyond the reasonable scope of what government should and should not regulate; and it assumes that there are no alternatives to an outright ban on smoking in public places, which – as argued above – is manifestly not true.
4.2 FOREST believes that proprietors, publicans and restaurateurs should have the freedom to choose the smoking policy that best suits their business and the preferences of their customers and staff. Reasonable alternatives have been put forward that will increase substantially the availability and choice for non-smokers – both customers and staff – while retaining some choice for those who do smoke.

5. Total ban does not have support of Scottish public

5.1 The Scottish Executive claims that its proposal of an outright ban has the support of the majority of the general public. The Executive’s own consultation documents as well as independent opinion polls show that this is not true.

5.2 A random telephone poll of 10,000 people (including 1,000 in Scotland) conducted by Populus in April 2004 found that only one in five people (22%) in Scotland thought smoking should be banned completely in pubs, clubs and bars. Almost two thirds (63%) said decisions on smoking policies in pubs, clubs and bars should be left to the owners and managers of individual premises, rather than central government (14%) or local councils (21%). Of those not in favour of a ban (77%), the vast majority (95%) said they preferred a choice of separate non-smoking and smoking areas. Other reasons for not supporting a ban were that it infringes people’s rights and would harm the business prospects of pubs, clubs and bars.

5.3 A further Populus poll conducted among a representative sample in Scotland in January 2005 found that a majority (59%) supported the new legislation when offered a ‘yes/no’ answer. However, when offered a variety of choices instead of a simple blanket ban, 66% of Scots said that pubs, bars and clubs should be able to accommodate smokers. Two-thirds of those surveyed believe it should be up to the owners of licensed premises – and not politicians – to determine their own smoking policy. The same proportion believes that the government should not use legislation to dictate the public’s lifestyle choices.

5.4 Support for exemptions is a consistent finding of the Executive’s own consultation feedback. In its Omnibus survey, 66% thought there should be exemptions from the ban on smoking in public places, with 57% spontaneously naming pubs and 21% naming clubs. Other Executive consultation methods were deeply flawed but, even so, 66% of those responding to the youth consultation believed that smoking should continue to be permitted in some places. In focus groups, many people were “not in favour a total ban for a number of reasons” and of the organisations responding to the public consultation, only a minority were favour of an outright ban.

6. Criminalisation of landlords and smokers

6.1 Part 1 (Sections 1 and 4) will make it an offence for a landlord or licensee to allow smoking within their licensed premises. As smoking, in itself, is not an illegal activity, this is an unacceptable intrusion into private property rights. The ‘pub’ is not a public place. It is neither owned by the public nor does any member of the public have an automatic right of access. Entry and service granted to any member of the public is at the landlord or licensee’s discretion entirely. The ‘pub’ is private property and the owner has the right to determine which legal activities take place there. It is the landlord or the licensee who has the right to ban or allow smoking, not the government.

7. Risks of ‘passive smoking’ overstated

7.1 The justification for the bill is based on the alleged health risks from environmental tobacco smoke (ETS). These ‘risks’ are based on inconclusive, disputed and, at times, discredited scientific research which has nonetheless been presented to the Scottish Parliament and the Scottish people as incontrovertible fact.

7.2 The more extreme estimates place the increased risk of a non-smoker - exposed to ETS consistently - acquiring lung cancer as 1.3 in 10,000. The chance of a non-smoker who is not consistently exposed to ETS acquiring lung cancer is estimated to be 1 in 10,000. If there is an increased risk it is so small that it is not statistically significant.

7.3 The Scottish Executive has also claimed that 1,000 people die every year in Scotland from illnesses related directly to passive smoking. This figure, based on a report by Professor David Hole of Glasgow University, is pure guesswork based upon extrapolating from various published studies about relative risk and attempting to relate them to Scotland. Nonetheless the Executive
has presented this figure to the Scottish Parliament and the Scottish people as if it were an established fact.

7.4. Professor Hole acknowledged himself that there were different motivations at work when he said on BBC Radio Scotland: “The point of the ban really is twofold. One is to protect the health of individuals who are working in an environment where they are consistently exposed to other people’s cigarette smoke, so that’s one issue; and secondly, I think there is a more general issue about what Scots people feel they can do about tackling the bigger problem of cigarette smoking, both active and passive.”

7.5. The scientific evidence is too flimsy to prove assertions that environmental tobacco smoke causes diseases and should not be used to justify the Scottish Executive’s draconian legislation. Dr James Le Fanu, writing in the Daily Telegraph on 18 January 2005, summed up the uncomfortable relationship between present scientific knowledge and proposed legislation:

“There may well be reasons for welcoming smoking restrictions in pubs and restaurants, but the specific claim that this will prevent the allegedly injurious health effects of passive smoking is clearly spurious. Or, as one of the protagonists puts it: ‘It is rotten science, but in a worthy cause. It will help us get rid of cigarettes and become a smoke-free society, and that’s all that really matters.’

“The rotten science in question is the proposition that the miniscule exposure to tobacco fumes can cause a significantly increased risk of lung cancer in innocent bystanders. If doctors can persuade government to act on the basis of such absurdities, they can persuade them of anything.”

8. Negative effect of a ban on smoking in public places
8.1. Evidence from Ireland suggests that many pubs and bars have seen takings fall by 15-25% since the introduction of the smoking ban. In Elgin, Scotland, a pub was recently forced to close after a smoking ban proved to be a commercial failure. Many pubs in England have been forced to reverse smoking bans following a severe loss of income.

8.2. From the village style communities of the major cities to the more remote towns, villages and islands of Scotland, the loss of the community pub would be sorely felt by residents and visitors alike. The community pub, social club or bingo hall plays a fundamental role bringing the citizens of a community together, enriching the lives of residents of all ages and cultures. For many, time spent in the pub, social club or bingo hall, is the perfect opportunity to congregate with friends, old and new, to set up a football tournament, participate in the local fishing club, perhaps organise a round of golf amongst friends or plan an away day for the regulars.

8.3. Rural communities rarely have access to theatres, cinemas etc. The only social gathering places, apart from the local church, are hotels and pubs. A total ban on smoking in all leisure venues could destroy a vital part of Scotland’s community life. No more congregating with friends in a leisurely manner as the pubs, social clubs and bingo halls of the community may not survive the loss of the many patrons who like to smoke in a social environment.

8.4. With no leisure venues available for smokers to enjoy their (legal) tobacco products at the same time as enjoying the company of their friends, many will undoubtedly spend more time at home. Not only will children be exposed to more concentrated levels of ETS (with no ventilation systems to remove the gases and particles) but they will be at risk from the much more serious hazards – such as fire, domestic abuse and household accidents – that inevitably arise when people spend more time drinking at home.

8.5. A complete ban on smoking indoors will not appease the more extreme anti-smoking campaigners. In America they refer to “the next logical step”. In California smoking is now banned in many open air parks, on beaches and coastal footpaths. There is now talk of banning smoking in cars. The consequence of such anti-smoking intolerance is clear for all to see: recently an American company sacked seven workers for smoking in their own home. A ban on smoking in all indoor public places represents a significant step towards the type of discrimination that no tolerant, civilized society should be willing to countenance.
9. Conclusions and recommendations

9.1. FOREST urges the Scottish Executive to amend its proposals and adopt the following policies in lieu of a total ban on smoking in public places:

9.2. Offices: non-smoking to be the norm in offices, shops etc. However, employers who wish to accommodate smokers by providing a well-ventilated smoking room indoors should be allowed to do so.

9.3. Pubs, clubs and bars: Scottish Executive to reach a voluntary agreement with the hospitality industry that will allow smoking in pubs, clubs and bars but will also set tough new targets (eg ban on smoking at the bar, substantially more no-smoking areas, better ventilation etc).

9.4. Restaurants: over a three-year period existing restaurants to be given the option of going no-smoking (with the exception of a separate bar area) or installing modern ventilation systems that can remove most of the gases and particles from environmental tobacco smoke; in addition, all new restaurants to be no-smoking unless they can provide a separate (and well-ventilated) smoking area divided from the no-smoking area by a fixed wall.

9.5. Cafes: to be allowed to accommodate smokers if certain conditions (eg agreed standards of ventilation) are met. In practice this will mean that many cafes will go no-smoking but there will still be an element of choice for café owners and the consumer.

9.6. Hospitals: to be allowed designated smoking rooms at the discretion of the management. Likewise community and other civic centres.

9.7. Private clubs: to be exempt from further restrictions on smoking; policies on smoking to be chosen at the discretion of the members.

FOREST

SUBMISSION BY HEALTH ECONOMIC RESEARCH UNIT

Introduction

In April 2004 Health Scotland commissioned Anne Ludbrook (Health Economic Research Unit) and colleagues from the University of Aberdeen to conduct a study of the health and economic impact of the regulation of smoking in public places. The researchers were advised by a reference group that included experts in the field of epidemiology, respiratory medicine, health economics and tobacco control. The draft report was sent for peer review to four referees with international reputations in the fields of tobacco epidemiology, health economics and tobacco control. Reviewers commented on the high quality and robustness of the research and agreed with the overall conclusions. Indeed a consistent view was expressed that the overall estimates of the health and economic benefits were, if anything, rather conservative.

In their evidence the SLTA were critical of the research. The remainder of this submission is the response of the principal researcher Anne Ludbrook and the research commissioner from Health Scotland, Sally Haw to the issues raised by the SLTA.

Comments

These next comments relate to the first two points in the evidence submitted by the SLTA.

(a) Completeness, relevance and timescale of the ‘Financial Impact Study’.

The SLTA claim that the research was incomplete but fail to identify any studies that the evidence review missed.

All of the evidence reviewed related to the health and economic impacts of the regulation of smoking in public places and was entirely relevant. It is true that there was little evidence relating
to impact on bars and this is made clear in the report. We excluded evidence from New York relating to the one year follow up of the comprehensive ban on smoking because it was not published in a peer reviewed source. However, it should be noted that this report showed a positive impact on bars and restaurants but did not show results for the sectors separately. As with all aspects of the research, the authors have been careful not to overstate the case for regulation.

Based on their own research report, the SLTA state that the International Review did not identify evidence that a ban would reduce the number of smokers because the smoking may be displaced elsewhere. However, the review cites specific evidence that both smoking prevalence (number of smokers) and cigarette consumption by continuing smokers are reduced by restrictions and bans and that bans have greater effect than lesser restrictions (such as segregation). Again, this evidence was interpreted cautiously in terms of modelling the results for Scotland.

There is a difference between conducting research efficiently to a short timescale and rushing the research. No evidence is put forward to identify any aspects of the report that were not conducted properly.

(b) CEBR estimates of likely financial impact.

We have not as yet had the opportunity to attempt to replicate the CEBR analysis. However, our examination of the data indicates a number of concerns. The CEBR researchers do not justify the starting date of 1996 and there is no obvious reason to include 8 years data prior to the ban. This start date introduces problems of re-indexing the published data (not discussed by the CEBR researchers). It also takes in a period of growth in the value of the bar sector, relative to the whole retail sector, in the early part of the period, whereas the performance of the bar sector relative to the retail sector has been in decline in the more recent period. This pattern of increase and decline introduces structural problems in the analysis.

Furthermore, the CEBR model does not take into account the impacts of other relevant changes on the bar sector. In particular, restrictions on children being in bars after 9 pm were introduced from September 2003. It is reasonable to hypothesise that these restrictions would have most impact on holiday and tourist business (as this would be the main time at which families might wish to be out together in licensed premises). In this case, there might be an effect in the summer months of 2004, which would confound the analysis of the smoking ban.

The CEBR researchers indicate that the accuracy and reliability of their results are supported by observation of monthly trends. However, extrapolating the seasonally adjusted trend from 2000 (which we believe is a more reasonable starting point) and comparing this with observed monthly data gives a reduction in ratio of the sales value index for bars to the sales value index for all retail business (excluding the motor trade) of 4.4% (rather than 7.3%) and for the ratio of the volume indices of 2.4% (rather than 10.7%). This is without taking into account any possible effect of the restriction on children after 9pm.

Points (c) – (f) are not related to the evidence review.

Comments relating to the Moffat Research Centre Report

Chapter 9 – Review of Aberdeen University Study.

1. The first paragraph states that the Aberdeen study defines its geographic scope by selecting and reviewing studies from other countries. This is incorrect. We reviewed all the studies that met the quality criteria and these happened to be from other countries. We have not excluded evidence from the UK, as this opening paragraph might imply, and the Moffat report does not offer any evidence that has been missed.

2. The Aberdeen study reviewed all of the evidence from all of the sectors. Only one study related to smoking restrictions affecting bars but this reflects the available evidence. We excluded the one-year report from New York City, which has introduced a comprehensive smoking ban, because the report was not a peer reviewed publication. The reported experience in New York of
the Smoke Free Air Act was an increase in tax receipts from bars and restaurants but this was not broken down between the two sectors.

3. The Moffat report attempts to argue that because areas where restrictions have increased incrementally have reported no significant effect on business, an outright ban in bars where smoking restrictions have previously been very limited will necessarily have a more adverse effect. This is a logical fallacy and is not supported by any evidence. Most studies have found no significant effect when restrictions are first introduced. Also, the study cited relates to restaurant restrictions, and the author(s) of the Moffat report maintain a position that evidence relating to restaurants and hotels is not relevant to bars.

4. The comments under 9.3 relating to the study by Glantz and Smith 1997 are erroneous. Although this study was undertaken before a State wide ban on smoking in bars took effect in California, the data in this study were taken from 5 cities and 2 counties which had already enacted bans on smoking in bars.

5. The author(s) of the Moffat report then totally misinterpret the use of the term ‘subjective’ in the Aberdeen University report, despite a clear distinction having been made. Subjective is used to describe the type of information contained in certain reports and papers; i.e. opinion survey results. This is in comparison to objective data, such as sales tax receipts. At no time does the Aberdeen University report refer to self-interest or bias. An overview of the subjective research findings is provided in the Aberdeen University report.

6. The author(s) of the Moffat report assert that there are two weaknesses in the Aberdeen University report relating to a lack of evidence on:
   o reduction in smoking following a ban rather than a displacement of smoking from the workplace; and
   o the impact of a no smoking policy on the hospitality sector, particularly bars.

In relation to the first point, the author(s) have either not read, or not understood, the section of the Aberdeen University report relating to changes in smoking behaviour. This provides a clear overview of evidence of a reduction in smoking prevalence (number of smokers) and a reduction in total number of cigarettes smoked by continuing smokers. The only reservations expressed in the Aberdeen University report related to estimating the precise size of the effect, not its direction, and a cautious interpretation was employed in modelling the results for Scotland.

Regarding the second point, the main argument resorted to by the Moffat report is an attack on the background of the authors of two studies cited in the Aberdeen University report (one of which is referred to by the wrong date and was not included in the evidence review). The study that was used in the review, Glantz and Smith 1997, was published in a leading medical journal and subject to rigorous scientific review. These are appropriate considerations in a serious review of evidence; personal attacks on the authors are not. The Moffat report author(s) neglect to comment on the authors of nine other studies cited in the review, all reporting similar findings, one of which was published in a hospitality sector journal (Cornell Hotel and Restaurant Administration Quarterly). As no ‘economists familiar with the hospitality and tourism industry’ appear to have published any analysis of objective data in peer reviewed publications, it is unclear what additional evidence such individuals could bring to the study.

The remainder of this section of the Moffat report largely consists of repeating the caveats included in the Aberdeen University report. We had considered all the potential weaknesses of both the health and economic impact evidence and drew very careful conclusions taking these into account. The author(s) then indicate that the level of analysis of economic impacts has to be similar to that given to the health argument. However, it is almost impossible to replicate the kind of study designs available in medical research. We recommended that research should be undertaken at the level of individual businesses using objective data, such as tax information, although this could be difficult to achieve for reasons of confidentiality relating to such data.
Chapter 10  The counter argument

This chapter provides no new evidence and repeats the argument that there is no reliable evidence for reduction in active smoking despite the evidence put forward in the Aberdeen University report.

Anne Ludbrook
University of Aberdeen

Sally Haw
NHS Health Scotland

SUBMISSION BY THE HOWARD LEAGUE FOR PENAL REFORM IN SCOTLAND

The Executive Committee of the Howard League Scotland has only recently had an opportunity to consider the terms of Part I the Executive bill: Smoking, Health and Social Care as introduced in to the Parliament. Though the deadline for comment has passed it has a number of comments that it hopes may still to be considered and taken in to account in the Parliament’s consideration of the Bill.

The Howard League Scotland does not wish to offer a view on the health objectives of this proposed measure though it is certainly not opposed to them and regards the reduction of harm caused by secondary smoking as laudable. The HLS does however have sincere doubts about the criminalisation of the behaviour caught by the Bill. It believes that in general the Scottish Executive and the Government are too ready to make use of the criminal law without fully exploring whether other forms of influence and control might be used to achieve the policy objectives. It further believes that in the preparation of this Bill the Executive has paid too little attention to how it might achieve its objectives without resorting to criminalisation of behaviour which may be anti-social but could not be regarded as criminal in the true sense.

It must be supposed that the situation harmful to health which the Executive seeks to avoid is the exposure of the public or employees to smoke filled enclosed places and that it is not the Executive’s present purpose to reduce the amount of [primary] smoking by adults in situations where such smoking cannot harm those who do not smoke. If that is so then the League does not consider that legislation which criminalises smoking per se in defined circumstances is an appropriate manner in which to achieve its policy aims.

It is apparent from the terms of the bill that having geographically defined the enclosed places or parts of places, the legislation would criminalise smoking in these places even at times when they were not open to the public or not in use by employees. For example a lone individual who smoked while cleaning in a public house that was closed would commit an offence. This inclusion could not further the policy objective and it is suggested that the bill should be amended so as to allow the prohibition on smoking to apply only at times when the public or multiple employees had access.

It is noted that the scope for prescribing premises would appear to allow Scottish Ministers to exclude from the application of the provisions a club formed for the purpose (or one of its purposes) of permitting its members to smoke perhaps while eating or drinking. However we understand from public statements that the Scottish Ministers would not choose to exercise their discretion in this way. The League here too feels that the legislation should not be capable of being applied to persons, who choose to smoke, doing so in the company of others who smoke and who have explicitly agreed to share the premises for this purpose. As a general rule the League feels unable to support legislation which seeks to prohibit consenting adults from undertaking higher risk activities provided the risks do not extend to anyone who has not so consented.

Where it is clear that the application of a smoking prohibition to premises in defined circumstances can assist the health objective the use of criminal sanctions may still be inappropriate and unnecessary. The League feels that criminalising smoking in such circumstances is a disproportionate response and that the Executive should instead devise schemes that allow those responsible for these places to discourage and where necessary prevent individuals from smoking.
Management rules, powers to expel and bar individuals and so forth should be explored in preference to criminal sanctions.

Finally, the League notes that the powers of search together with the prohibition should be confined to times when the public or employees have access to the premises and that powers of search going beyond this would be unnecessarily invasive.

Robin MacEwen

SUBMISSION BY LYNNET LEISURE GROUP

I would like to take this opportunity to make a formal written submission to the Health Committee concerning the Health and Social Care (Scotland) Bill. I am the Group Operations Manager for a Glasgow based – family run leisure group. Primarily our interests are focused in the Strathclyde area, but also own 4 bars in and around London. In addition to our retail estate we own and operate to wholesale companies serving the length and breadth of Scotland and Northern England. We are members of the SLTA, BEDA and of the AOB Group.

As a member of the SLTA I have been working with the government for a number of years now in developing smoking policy and as such I am delighted that the government is making proactive steps to safeguard the nation’s health. However, I have been alarmed by the way in which the legislation has been progressed and I am worried that the Executive has not taken enough time to review all the necessary information in making its decisions. I am greatly concerned as to whether the nation’s health is the true objective here, especially when compared to the Westminster Governments proposals for legislative change, or indeed whether the Holyrood government’s actions are serving individuals agendas rather than the nation as a whole.

As a member of the AOB Group, I fully support and endorse their submission to yourselves but also feel that an individual submission on behalf of our directors, staff and customers should be voiced. I would like you to consider the following points:

1. Haste with which the legislation is being progressed
2. Lack of public support
3. Poor preliminary research
4. Flawed consultation process
5. Underestimation of the economic impact
6. Inability to appreciate the need for concordance with UK legislation
7. Lack of communication with the licensed trade which is the public sector at the heart of this legislation
8. Inability of the Executive to consider that an outright ban may not actually be the best approach to safeguarding this nation’s health.
9. Poor appreciation of the policing issues of imposing the legislation
10. Underestimation of the effect this will have on one-pub villages/small communities

We hope that you will take these points on board and consider taking a little more time to analyse the facts and urge the Committee to afford the issue some greater consideration and thought. We urge the Committee to request more time to conduct appropriate research into the financial and health benefits of alternative approaches. We really would recommend that the government opens its mind to more effective ways in which to maximize the health benefits achievable from restricting the use of tobacco in licensed premises.

Craig Amner
Lynnet Leisure Group
SUBMISSION BY MACMILLAN CANCER RELIEF

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

Legislation on smoking is required because voluntary regulation has not worked and a major cultural shift is required towards ensuring non-smoking becomes the norm in Scotland, which only legislation will achieve. The evidence for the harmful effects of second-hand smoking is overwhelming. In November 2004 the Scientific Committee on Tobacco and Health summarised research that had been published since their previous report in 1998, in response to a small number of groups, mainly funded by the tobacco industry, that still denied the health risks associated with second-hand smoke (SHS). The conclusion was that the health hazards were even greater than previously expected overall, with increased relative risk of lung cancer remaining at 24%, the risk of ischaemic heart disease now being in the order of 25% and a strong link between the evidence of exposure to SHS and adverse health effects in children, including serious respiratory illness, asthmatic attacks and Sudden Infant Death Syndrome. There is also an association between SHS and respiratory symptoms, and reduced lung function in adults. The Committee’s conclusion was that SHS is “a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to, and SHS represents a substantial public health hazard”.

The requirements of the proposed content of the Bill of making an offence of permitting others to smoke in No Smoking premises, making it an offence to smoke, the requirement to display warning notices and the clarity of definition are all sound points. There needs to be an incentive to ensure that both those responsible for premises and those using the premises abide by the regulations and clarity is needed to show that any particular area is covered by the regulations.

There are other reasons for agreeing with the objectives of this part of the Bill:

a. There is increasing evidence from tobacco industry documents in particular that second-hand smoke is even more harmful, volume for volume than directly inhaled cigarette smoke and evidence of attempts by the tobacco industry to undermine second-hand smoking restrictions by recruiting scientists to criticise the science in second-hand smoke. The only people who continue to challenge whether second-hand smoke causes ill-health are hospitality groups and the tobacco industry.

b. The suggestion that ventilation is an alternative, or that small areas at a bar counter should be No Smoking are totally inadequate. Banning smoking in one part of an area is akin to allowing the shallow end of a swimming pool to be used as a public toilet. The addition of ventilation makes a room look less smoky and feel more comfortable, but tobacco contains 4,000 toxins and more than 50 cancer-causing substances, many of which are odourless, invisible gases which cannot be moved by current ventilation systems. There is a wealth of scientific papers from around the world demonstrating that efforts will at best provide partial protection from second-hand smoke and, as there is no safe level of exposure to second-hand smoke, this is an entirely illogical way of proceeding.

Are there any other comments you would like to make? Yes

a. For Macmillan Cancer Relief this legislation is partly about the benefits that will be reaped from banning smoking in public places for smokers, non-smokers, staff who have no choice but to be in the area etc. However, it is part of a broader cultural change within society in Scotland that will ensure non-smoking is the norm and the rights and health of the majority of the population that do not smoke are protected. In the Republic of Ireland we know that total sales of cigarettes are estimated to be down over 17½% on 2003, and more than 7,000 extra
smokers have quit than otherwise could have been expected. This mirrors the impact of a ban on smoking in public places in the States and Australia, where this was also associated with a greater awareness of the risks of second-hand smoke and changes in behaviour. In households with children the proportion of homes that had smoking restrictions more than doubled in less than 10 years, and the increase was most dramatic in households where one or more adults smoked. Smoke-free legislation will clearly support the current 70% of smokers who want to quit, and de-normalise smoking in society so that future generations do not become addicted to smoking, or suffer the consequences of other people’s second-hand smoke.

b Possible exemptions outlined in the draft Bill: Macmillan Cancer Relief believes that if any exemptions are to be considered they should be justified only on humanitarian grounds and on the existing evidence base with safeguards built in to protect employees who could potentially be put at risk by any such humanitarian action. Specifically there should not be exemption for hotel and bed-and-breakfast rooms or private clubs. This would only serve to undermine what otherwise would be a very effective piece of legislation. It is much easier for the public to understand and for regulatory provision if the same rule applies equally to all premises to which the public has access.

c Macmillan Cancer Relief has noted with interest the attempts by the tobacco and hospitality industries to predict economic meltdown. We have kept abreast of all the published information and, to our knowledge, no objective peer-reviewed study ever conducted has found any significant negative economic impact associated with smoke-free legislation. This seems logical, given that 70% of people do not smoke, and one could confidently expect any ban to increase the number of non-smokers in the population.

A comprehensive smoke-free law is the only way in which to protect the people of Scotland from the health hazards associated with second-hand smoke. Smoke-free legislation will clearly support current smokers attempting to quit and de-normalise smoking in society so that future generations do not become addicted to smoking.

I Gibson
Macmillan Cancer Relief

SUBMISSION BY MACLAY GROUP PLC

I write as Managing Director of Maclay Group plc, a family owned group which owns and operates 21 pubs, bars and inns in Scotland. Maclay employs in excess of 350 people and has annual turnover in excess of £10m.

We are members of the Scottish Beer and Pub Association and supports of the AOB group (Against Outright Ban).

We firmly believe that a ban on smoking in public places is a positive move for Scotland but that this has to be managed carefully to ensure smooth and effective implementation.

The timescale of Spring 2006 and the immediate implementation of a full ban at that time does not, we believe, provide for such time as is necessary to achieve the objectives of the legislation.

We support a phased implementation over a longer time frame such as that supported by the industry in its voluntary charter (which Maclay actively supports).

The reasons for us holding these beliefs are given below:-

1. The consultation process leading to the drafting of the Bill was flawed.
   • The questionnaire was poorly drafted and ambiguous.
   • There was a delay in the issue of sufficient numbers of forms to licensed trade bodies.
   • When eventually issued, the forms were marked to identify the source of the forms.
   • Ministers pre-empted the conclusions of the Consultation process by publicly voicing their views on its outcome.
More consultation is required.

2. Research into the economic impact of the proposed ban have been limited to the limited analysis of a single study on pubs done by Aberdeen University on the Californian experience. The quality and relevance of the source material to Scotland is dubious and this inadequacy was compounded by the quality of the analysis thereafter.

More research is required.

3. The proposed ban will create a business disadvantage. Maclay is a small company endeavouring to grow a sustainable business in Scotland and at the same time provide quality amenities for locals and visitors alike. Such growth requires capital and it is evident to us that investors are reluctant to invest in the Scottish leisure sector because of the increased uncertainty facing the industry here when compared to the English situation.

In order to grow the sector and support Scottish business it is vital that the uncertainty is removed and that a workable framework is phased in over an appropriate period.

4. The costs of implementing and policing the ban by our own staff will result in higher costs to consumers.

It is vital that support is provided to operators in order that we can comply with any new requirements of signage, training etc etc.

5. Based on the Irish experience it is likely that many pubs will experience a fall in profitability, leading to job losses and closures.

It is vital that the non-domestic rating system is reviewed and revised to ensure that rates due are quickly adjusted to reflect the lower levels of trade.

6. It is unclear who will enforce the smoking ban, particularly as the new licensing legislation (and its proposed licence enforcement officers) has yet to be enacted. It is also unclear if a liquor licence could be lost through a customer defying the ban.

It is vital that the uncertainty surrounding such key operational matters is removed quickly.

7. The legislation will create a risk of Civil Disobedience and Social Disorder. There are some reasons for genuine concern about the risk of disobedience of this legislation by the Scottish smoker:

• Scottish smokers feeling prejudiced because of the English (Westminster) decision to allow choice and to let the public make their own lifestyle decisions. The Scottish Parliament’s approach throughout the process has smacked of high handedness and a desire to move positively towards a nanny state environment.

• Scottish smokers feeling irritated by the misrepresentation and exaggeration of the health benefits by Scottish Parliamentarians. For example, the First Minister makes reference to 1,000 Scots dying each year through the impact of ETS without informing Parliament that this figure is primarily related to ETS experienced in domestic environments. (November 10th speech to Parliament.)

• Scottish smokers feeling anger that the Scottish Executive has ignored clear evidence about public opinion on the subject.

• Scotland has many licensed premises which form part of tenemental buildings and it is not possible for licensees in these landlocked situations to provide external smoking facilities for their clients, due to neighbourhood nuisance and noise issues. The likelihood is therefore that many
Scottish streets will be disrupted by groups of smokers indulging their addiction on pavements outside the front of pubs and clubs. This will in turn bring new problems for the authorities to deal with and it does not seem easy to introduce a law which forbids people to stand and smoke in external public areas. Once they leave the premises, customers of licensed establishments cease to be the responsibility of licensees.

- It is universally agreed that smoking is more prevalent in the less affluent areas of Scotland’s cities and towns. Smoking bans are likely to hit hard in the more deprived communities, driving people to stay at home rather than make their regular visits to their favourite hostleries. As UK Secretary of State for Health Dr John Reid has said on many occasions, one of the few pleasures of the working man is to have a drink and a cigarette with his friends. If this right is denied him, community life will change radically, ripping the heart out of many localities.

I would urge you to ensure that the proposed legislation is phased in a more appropriate timescale in order that the points I raise can be satisfactorily addressed.

Yours sincerely

Stephen G Mallon
Managing Director
MACLAY GROUP PLC

SUBMISSION BY NHS GRAMPIAN

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

Yes

If yes, why?

It is consistent with the response of NHS Grampian to the public consultation on smoking in public places.

The provisions within the Bill are appropriate in order to protect people from breathing environmental tobacco smoke.

This legislation will have a hugely beneficial impact to the health of people in Scotland.

SUBMISSION BY NHS LANARKSHIRE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

1. It will help reduce the approximately 1200 deaths a year among Lanarkshire residents caused by smoking, and its associated morbidity and human misery.

2. It will gradually enable NHS resources to be used for patients with other health problems.
3 It lends enormous weight to the ongoing efforts of the NHS, individuals, voluntary sector, companies, etc. to reduce smoking among the population.

4 It will greatly reduce the impact of the mixed message given by the lack of legislation which is used by smokers to justify their continuing to smoke.

5 It is more restrictive than the original Prohibition of Smoking in Regulated Areas (Scotland) Bill proposed by Stewart Maxwell.

6 It covers all enclosed places of work thereby forbidding individual employees to smoke in their own offices.

7 It removes the problem of staff abusing their position of seniority in the work place in order that they can continue to smoke.

8 It places responsibility on individuals as well as on organizations for compliance, and there are financial penalties for failure to comply.

If not, why not?

It does not address some important issues.

1 ‘Smoke’ is defined in terms of tobacco. This could result in people smoking cannabis in enclosed premises.

2 Current local requirements in some premises for people not to smoke, e.g. health care premises, educational establishments, shopping centres, mean that:
   i) the area around their entrances is made exceedingly unpleasant by the tobacco smoke and/or smell from smokers outside the entrance which all those entering the building have to walk through;
   ii) patients (some with their intravenous infusion equipment), visitors and staff smoke outside hospital entrances and other health care facilities which results in mixed messages to the public, and the smoke and smell permeating the entrance hall and nearby corridors which are enclosed spaces.

Potential means of improving this situation are:

a) there should be no smoking on any NHS property, thereby including its land and car parks, and as an organization devoted to health would demonstrate the NHS’s commitment to this;

b) there should be no smoking within 50 yards of doorways, windows and ventilation systems of buildings to which the public have access or are places of work, including educational and care service establishments.

3 Section 4(4) addresses employees and public access but is unclear about the facilities used by non employee bosses who may exclude the public from part of their premises in order to ensure the boss(es) can continue to smoke.

Are there any other comments you would like to make?

1 There is a typographical error in Section 4(6)(b) second line: ‘or such’ is repeated.

2 The specification of no-smoking premises is so all encompassing that, rather than have all of them put up signs saying they are no-smoking premises, would it be better to legislate that
smoking is forbidden in all enclosed places unless otherwise indicated, and require the few exempt locations to put up signs saying smoking is permitted there?

This response is made by the Chief Executive and the Director of Public Health for NHS Lanarkshire which is responsible for improving the health of approximately one tenth of the population of Scotland.

David Pigott, OBE  Dr Dorothy C Moir, CBE
Chief Executive   Director of Public Health

SUBMISSION BY NHS TAYSIDE

NHS Tayside fully supports the section within the Smoking, Health and Social Care (Scotland) Bill which relates to Prohibition of Smoking in certain wholly enclosed public places. In its own Smoking Policy, NHS Tayside has prohibited smoking in all of its enclosed areas – however, for humanitarian reasons, it has given discretion to managers to provide specific designated smoking rooms for three categories of patients – i.e. psychiatric in-patients, patients for whom there is no likelihood of discharge and terminally ill patients. This is done in a way which poses little or no risk to the health of staff. It should be stressed that at Ninewells Hospital and Perth Royal Infirmary, NHS management has decided not to offer any internal designated smoking room to terminally ill patients and thus these hospitals are totally smoke-free.

Paul Ballard
Consultant in Health Promotion
NHS Tayside

SUBMISSION BY PHILIP MORRIS INTERNATIONAL LTD

Philip Morris International welcomes this opportunity to provide comments to the Health Committee on the Smoking, Health and Social Care (Scotland) Bill.

Public health authorities have concluded that secondhand smoke causes diseases, including lung cancer and heart disease, in non-smokers. In addition, public health authorities have concluded that environmental tobacco smoke can exacerbate adult asthma and cause eye, throat and nasal irritation.

We believe the public should be guided by the conclusions of public health officials regarding the effects of secondhand smoke in deciding whether to be in places where secondhand smoke is present; or if they are smokers, when and where to smoke around others.

Philip Morris International believes that the conclusions of public health authorities are sufficient to warrant measures that regulate smoking in public places. We believe smoking bans are appropriate in many places including educational establishments, health care facilities, and places providing services to children. In general, people should be able to avoid being around secondhand smoke in places where they must go, such as public buildings, many areas in the workplace and public transportation.

At the same time, government regulations should recognise that some business owners and their customers wish to permit smoking in certain locations. Regulation should provide business owners with the choice to permit or prohibit smoking, and to decide how best to address the preferences of non-smokers and smokers, such as through separation, separate rooms and/or high quality ventilation.
We do not believe a total prohibition on smoking in all premises is necessary or justified. We believe the issue can be addressed more pragmatically by requiring a combination of separation between smoking and non-smoking areas coupled with ventilation and warning signs which state the public health community’s conclusion that secondhand smoke causes diseases in non-smokers.

Addressing the issue in a more flexible way would allow people to choose to visit a restaurant, which permits smoking or one which does not allow any smoking at all.

Philip Morris International wants to work cooperatively and constructively with the Scottish Parliament and other governments throughout the world to achieve effective tobacco regulation and to address issues that are of legitimate concern to both governments and consumers. We look forward to additional opportunities to discuss tobacco related issues with the Committee.

SUBMISSION BY PUNCH TAVERNS PLC

I should like to take this opportunity to make a formal written submission to the Health Committee concerning the Smoking, Health and Social Care (Scotland) Bill.

Punch Taverns plc owns some 450 public houses within Scotland, all of which are owner operated as leases or tenancies. As such, these pubs represent 450 small businesses.

I am delighted that the Government is making proactive steps to safeguard the nation’s health. I am, however, alarmed by the way in which the legislation has been rushed and am worried that the Executive has not taken enough time to review all the necessary information in making its decisions.

As far as I am concerned the most salient arguments in this debate are as follows:-

1. The haste with which the legislation is being progressed
2. Lack of public support
3. Poor preliminary research
4. Flawed consultation process
5. Underestimation of the economic impact
6. Inability to appreciate the need for concordance with UK legislation
7. Lack of communication with the licensed trade which is the public sector at the heart of this legislation
8. Inability of the Executive to consider that an outright ban may not actually be the best approach to safeguarding this nation’s health.
9. Poor appreciation of the policing issues of imposing the legislation
10. Underestimation of the effect this will have on one-pub villages/small communities
11. Lack of appreciation of the industries own approach to self regulation

The Executive is about to impose the most radical piece of health legislation the devolved parliament has seen - based on incomplete economic research and against overwhelming public opinion.

It was with absolute amazement that I witnessed the speed at which the Executive is forcing the Health and Social Care Bill through the Scottish Parliament. As I have said, I am totally in favour of increasing smoking restrictions but surely the Executive should take some more time to truly consider whether an outright ban is the most effective way to tackle the smoking issue. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

I believe that one of the most formidable arguments against the forthcoming legislation is that the public is opposed to it. The Executive’s own MRUK opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in public places. This is not to
say that they would not support increased restrictions on smoking policy - but they do not want, and are not ready, for an all-out ban. You are taking away their freedom of choice.

I could understand the Government making a decision against public opinion if it was absolutely sure that it was in the nation’s best interest, but the Scottish Executive has rushed its research and failed to fully consider the possibility that the gradual introduction of smoking legislation, which would give the general public time to adjust, may make a more definitive move for public health.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will safeguard the nation’s health, avoid the shift in smoking to the home, protect the hospitality and licensed trade industries and which will prove enforceable.

I would also point out that a number of our pubs are in small rural villages of approximately 500 people. It is likely that these public houses and the communities around them will feel the impact of a smoking ban more acutely than most – and yet the Executive doesn’t seem to have afforded them a great deal of thought.

The pubs in question really form the heart of the local community, which is often made up of the retired and elderly. They depend on their regular clientele to keep the business afloat – and in turn their customers depend on the local venue for quality of life. To impose a ban in this area just seems ludicrous, you can’t expect the elderly smoking population to nip outside in the middle of winter, people are far more likely to choose, or to be forced, to stay at home.

I would ask that the Government opens its mind to more effective ways in which to maximize the health benefits achievable from restricting the use of tobacco in licensed premises. As an industry, nationally, we have put in place a plan which gets us to a position of:-

- Non smoking at the bar, 45% of trading area non smoking in wet led pubs and 50% in food led pubs by December 2005;
- Non smoking at the bar and 80% of trading area in all pubs non smoking by December 2009

This will be actively monitored and fed back to all parties with a vested interest. I feel this to be a far more pragmatic and achievable approach which will deliver the aim of creating a social climate where smoking is no longer the norm whilst protecting a group of small businesses which provide employment, tax revenue and support for local communities. I also feel that it will have far wider public support.

I would welcome any opportunity to discuss this with you further and hope that my comments will be received in the constructive manner that they are intended

Yours sincerely,

Giles Thorley
Chief Executive

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?
Health professionals are united in their belief that reducing smoking levels is the most important public health issue facing decision-makers at present. The RCN has always adopted a proactive approach to public health issues, supporting credible measures aimed at improving health and wellbeing.

The issue of smoking in public places was debated at the RCN’s annual congress in 2004 and the overwhelming majority of delegates (86%) voted in favour of a ban in enclosed public places. Following that vote a call for smoking to be banned in public places throughout the UK was made a key public health objective in the RCN UK manifesto for the next UK general election. RCN Scotland also consulted with members prior to Congress at our annual conference with similar results.

The central issue for RCN members in expressing this view has been the impact that they believe a ban will have on the health of people in Scotland. This is both in terms of reducing the exposure to second-hand smoke and additionally the knock-on benefits of a reduction in the number of cigarettes being smoked by those who continue to smoke and in the overall number of smokers. Evidence from other countries where bans have been instituted is now becoming available and we are clear that the desired benefits in health terms are being delivered already by the action taken elsewhere.

With regard to the specific offences that the Bill would create we believe that the measures outlined are necessary to ensure that the ban is clear and effective and support the proposed penalties for offending as reasonable.

If not, why not?

Are there any other comments you would like to make?

RCN Scotland has already submitted evidence previously on both Stewart Maxwell’s Member’s Bill and the Scottish Executive’s public consultation and consequently have restricted our comments here as requested by the Committee.

However, we would like to add that we are particularly supportive of the comprehensive scope of the legislation as drafted and believe that Scotland is acting as a driver for action on this issue throughout the UK.

SUBMISSION BY THE ROY CASTLE LUNG CANCER FOUNDATION

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? yes

If yes, why?

Introduction

As the UK’s only charity dedicated to defeating lung cancer, the Roy Castle Lung Cancer Foundation firmly supports the restricting of smoking in public places, which it must be remembered are workplaces. Such a restriction in areas where people can smoke can only be positive – protecting the health of 74% of the population who have chosen not to smoke, encouraging those addicted to tobacco smoke to “give up” and most importantly protecting those exposed to a smoke filled environment in their place of work.

1. The Health Risks of environmental Tobacco Smoke

Tobacco smoke contains 4,000 toxic chemicals and at least 40 known carcinogens. Smoking is the single greatest preventable risk to health and is responsible for 13,000 deaths in Scotland annually.
Smoking is not only a threat to smokers, passive or secondhand smoking (involuntarily breathing in the smoke of others sometimes called exposure to environmental tobacco smoke) is established beyond doubt as a cause of serious disease in non-smokers - including cancer, cardiovascular disease and numerous respiratory conditions. Children, pregnant women and those with established disease processes such as asthma are particularly vulnerable.

Short-term exposure to passive smoking leads to effects ranging from headache, sore throat, dizziness and nausea, increased cough, wheeze and phlegm production, to irritation of the eyes and the nuisance of foul smelling clothes and hair – interestingly many who suffer this ‘inconvenience’ will not ask a smoker to stop for fear of causing offence! Research indicates that 5-minutes exposure to secondhand smoke significantly reduces the coronary blood supply in a fit and healthy adult.

3 million people in the UK are exposed to environmental tobacco smoke in the work place and latest estimates suggest that 12,000 U.K. non-smokers die annually as a result of exposure to secondhand smoke.

2. The Economic Impact of restrictions on smoking in public places

Employers have a legal responsibility to protect the health of their employees. Having a policy can reduce legal liability; create a safer working environment, improve workers’ health, reduce tensions between smokers and non-smokers and demonstrate your commitment to the well being of all your staff and customers.

- A report commissioned by Smoke Free Liverpool earlier this year estimated that the economic cost to employers of smoking amongst the Liverpool workforce is approximately £28.5 million per annum

- In New York since they went smoke-free tax revenues from the hospitality sector have increased by 12% and 10,000 new jobs have been created in this sector.

- The Ring ‘O’ Bells pub on the Wirral went smoke-free in 2003 and has not looked back, seeing a massive increase in their takings including a 50% increase in drink sales and 60% increase in food sales.

- The Lauriston Farm Brewers Fayre in Edinburgh has become a no smoking building after managers decided that a total ban could boost their takings. Staff at the pub, which is part of a chain, say takings have actually gone up after they banned smoking in their adjacent restaurant and they expect the pub ban to have the same effect.

The Rushbrook Arms in Bury St Edmunds went smoke free in June 2004 and has experienced a 33% in sales across the board.

- Failure to act to protect employees from exposure to secondhand tobacco smoke in the workplace could result in legal action against employers.

Smoking could be harming business because…

- An average smoker may take six – 10 minute smoke breaks each day, that’s an hour of work lost for each smoker employed. Five hours per smoker per week!

- Non-smokers may resent the number of additional breaks their smoking colleagues take and take additional breaks themselves

- Due to these tensions staff moral and productivity may suffer

- Smokers are more likely to be ill and take longer to recover placing additional strain on business

- Secondhand smoking may damage the health of non-smokers leading to sickness, loss of productivity and the threat of litigation

- Businesses who don’t provide separate accommodation for smokers and non-smokers maybe be failing to meet their health and safety obligations

- Smoking increases fire risk and so insurance premiums will be higher
• Nicotine stained furnishings curtains and decoration need more frequent cleaning, replacement and refurbishment
• Many non-smokers avoid places where smoking is allowed. More than 70% of people are non-smokers and generally they have more money to spend – because they don’t smoke

Therefore having a policy has significant benefits for business:
• Increased on-the-job productivity, just think of the cost of all those ‘smoke breaks’
• Improved working relationships and morale
• Reduced sickness and early retirements due to ill health
• Reduced annual health-care costs and health insurance for smokers
• Fulfilment of health and safety regulations and reduced risk of litigation
• Reduced risk of fire damage, explosions and other accidents related to smoking
• Reduced insurance premiums
• Reduced maintenance and cleaning costs
• Greater appeal to non-smoking customers – the majority of the population
• Increased income – remember all those non-smokers with money to spend

Attitudes toward smoking, even amongst smokers themselves, are changing:
• Smoking is a minority activity – more than 70% of the population are non-smokers
• 86% of all adults agree there should be restrictions on smoking at work
• 88% of all adults agree there should be restrictions on smoking in restaurants
• 53% of all adults agree there should be restrictions on smoking in pubs
• Smokers are increasingly considerate towards others in their smoking behaviour
• 57% of smokers say they would not smoke at all if they are in a room with children
• 45% of adult smokers say they would not smoke at all in the company of adult non-smokers

3. The Impact of a ban in reducing the prevalence of smoking

A recent BMJ study using data from other countries showed that if all UK workplaces were smoke-free, we could expect smoking rates to fall by 4% and overall tobacco consumption by 7.6%. Around 90% of lung cancers are caused by tobacco smoke; The Roy Castle Lung Cancer Foundation would be delighted to see any measures taken to help the public to quit smoking and eliminate this devastating disease.

4. The effectiveness of extractor Fans and other ventilation equipment to remove tobacco fumes form the atmosphere

This is a statement prepared by the Roy Castle Lung Cancer Foundation and endorsed by ASH and the Chartered Institute of Environmental Health and Asthma UK, July 2004 on the subject of ventilation which appears on the National Clean Air Award Website and in the Chartered Institute of Environmental Health Toolkit for Local Authorities

The Ventilation Argument

It is often claimed by the tobacco industry that ventilation will remove the effects of secondhand smoke from work and public places. However, it is interesting to note that the tobacco companies who endorse ventilation systems have issued disclaimers about such systems having any ability to address the health effects of secondhand smoking.

Tobacco companies have a vested interest in maintaining and promoting smoking in public places as it has been shown that effective smoke free policies in public places can reduce smoking prevalence by up to 4%.

Secondhand smoke

Everyday at least three million workers in the UK, unwillingly, become secondhand smokers. Secondhand smoke causes or exacerbates a wide range of adverse health effects, including cancer, a range of respiratory diseases, including asthma, and heart disease. Shockingly, it is
estimated that one employee in the hospitality industry dies every week from the effects of secondhand smoke.

There are no safe levels of exposure to secondhand smoke.

Is Ventilation Effective?

No. Tobacco smoke is a toxic mix of over 4,000 chemicals including over 50 cancer-causing agents.

Ventilation may remove the smell of tobacco smoke but it does not eliminate all the cancer-causing particles and gases from the air. Just because the air is not visibly smoky does not mean it is safe.

In the case of separate smoking areas with discrete ventilation systems, pollution levels may be slightly reduced but tobacco smoke drifts and therefore staff and customers will still have no choice but to breathe secondhand smoke.

For ventilation to have any significant effect, it would need to be ‘tornado strength’. The scientific evidence is strong and robust:

Ventilation systems cannot eliminate the risk of disease or death from secondhand tobacco smoke.

Ventilation is very costly

Ventilation systems cost tens of thousands of pounds but do nothing to guard against the real health dangers of secondhand smoke. Furthermore, the cost of maintaining and cleaning systems is such that reports have shown that many proprietors leave their ventilation systems switched off, as they find the running costs too high. Poorly maintained ventilation systems are even less likely to be an effective means of reducing the effects of secondhand smoke.

Recent research in venues in Sydney, Australia, shows that designated “no-smoking” areas in the hospitality industry provide at best partial protection and at worst no protection at all against the damaging effects of secondhand smoke

As all environmental health practitioners are aware, in any risk reduction hierarchy, ventilation, whether general background or local exhaust ventilation are techniques of last resort.

Who promotes ventilation?

The tobacco industry and its lobby organisations (particularly FOREST) advocate "ventilation solutions" as a "reasonable" alternative to the establishment of smoke free work and public places. They fully understand that smokefree environments reduce the consumption of cigarettes and they therefore have a vested interest in maintaining the smoking status quo. They seek to mislead the public by maintaining that ventilation systems effectively address the issue of secondhand smoke. And yet, Philip Morris the largest tobacco company in the world admits on it's website that ventilation systems have

“…not been shown to address the health effects of secondhand smoke.”

The Public Places Charter on Smoking

This scheme is designed to encourage venues to increase provision for non-smokers and improve overall air quality. The charter advocates ventilation as a means of providing clean air despite the overwhelming evidence to the contrary.

Moreover, the scheme is voluntary and four years after being introduced fewer than 1% of venues in the hospitality trade are totally smoke-free.
The solution?

The only way to eliminate the health risks from secondhand smoke is to implement completely smoke free work and public place policies. This action will protect all staff and customers from the harmful constituents of secondhand smoke. It also has the lowest cost implications for employers.

5. Human rights arguments in respect of smokers and non-smokers

This is not about a persons right to smoke, it is about where and possibly when they smoke. No one should be exposed to harmful substances just to earn a living and this is what is happening in any workplace where smoking is unrestricted. No one can argue that a workers right to clean air should be eroded to accommodate a smoker. In the workplace the rights of the worker to clean air trumps the smokers right to smoke.

6. Enforcement

In common with the legislation in Ireland it is our opinion that inspections should be undertaken by Environmental Health Officers and by Inspectors of the Health and Safety Executive. These two agencies should act in a co-ordinated capacity to help to ensure compliance with the legislation. Proactive enforcement checking for compliance should also be backed up with a quick response to any complaints about non-compliance. It is also essential that a number of proactive inspections are undertaken outside normal office hours.

Fines / breaches of the legislation

A significant fine should be imposed on any person found guilty of breaching the law, as this will act as a significant deterrent. The owner, manager or person in charge of a workplace is legally responsible for ensuring compliance with health and safety requirements and with the introduction of a law banning smoking in the workplace this would include the prohibition on smoking in the workplace.

If not, why not?

Are there any other comments you would like to make?

The Foundation is happy to give oral evidence to the committee.

SUBMISSION BY ROYAL COLLEGE OF GENERAL PRACTITIONERS (SCOTLAND)

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

RCGP Scotland submitted evidence to the Health Committee in response to Stewart Maxwell’s Prohibition of Smoking in Regulation Areas (Scotland) Bill. We refer you to this submission for details of our evidence in support of creating smoke-free public places.

Are there any other comments you would like to make?

We welcome the opportunity to reiterate our support for legislation to create smoke-free public places in Scotland, and congratulate the Scottish Executive for making a commitment to introduce legislation in this area.
The Bill as introduced offers a comprehensive ban on smoking in public places. We feel it is vital that legislation offers protection across the board to all employees and members of the public. Exemptions to the Bill must only be made in exceptional cases which are carefully considered and justified.

This legislation will succeed where voluntary action has failed, and will have a positive effect in reducing the effects of secondhand smoke in Scotland. It is a vital part of the campaign to change public attitudes towards smoking in public places, and a significant step towards our ultimate goal - a smoke free Scotland.

SUBMISSION BY THE ROYAL COLLEGE OF PHYSICIANS EDINBURGH

The Royal College of Physicians of Edinburgh is pleased to respond the Scottish Parliament’s Health Committee on its call for written evidence on the Smoking, Health and Social Care (Scotland) Bill.

The College applauds the vision and determination of the Scottish Executive in introducing this key public health measure for the benefit of Scots in general, and staff working within the hospitality and other service industries in particular. This is in sharp contrast to the position in England and this College, with Fellows and Members across the UK, whole-heartedly supports the Scottish plans to ban on smoking in enclosed public places.

The case for introducing this legislation has been made in the previous responses of the College and other organisations citing the evidence-based dangers of environmental tobacco (secondhand) smoke. The Scottish Parliament now has a clear responsibility to enact this legislation.

Implementation will require further thought and guidance to support managers, employees and service users in all sectors to deliver full compliance and agree controlled exemptions only. The College believes that it is in the interest of the health of Scots that exemptions are restricted to situations where the individual might reasonably regard the location as being their own long-term home. In these situations, the employees must be carefully protected from the detrimental effects of second-hand smoke.

Specific guidance would be helpful for NHS premises in Scotland and the College recommends:

1. All hospital grounds and NHS premises should be smoke-free.

2. Outdoor smoking shelters on NHS premises should be considered for a transitional period only and located away from the main entrance and exit doors.

3. In general hospitals, a single indoor smoking area, fully enclosed and effectively ventilated, should be provided for the genuine addicts among patients. Such an area should ideally be near to A&E Departments, for the avoidance of conflict/violence to staff. Such an area should be for patients only. Similar areas will also be required in short stay in-patient psychiatric facilities. In addition, all patients should have access to smoking cessation support while in hospital. However, the direction of travel must be towards a complete smoke-free environment within NHS premises in a defined short time.

4. Smoking for visitors and staff should be totally prohibited in hospitals and other NHS premises and property immediately, with any transitional shelters removed after 2 years.

5. Smoking in long-term care facilities is a significant challenge, and the main principles should include:
   - recognition of a person’s right to do as they wish in private
   - recognition of the need to protect staff from second-hand smoke

Inevitably, there is tension between these two key principles and solutions could include:
providing a communal and enclosed smoking room that is ventilated by an efficient extractor system and empty for 30 minutes before cleaning etc. undertaken

prohibiting smoking in any other communal area

allowing people to smoke in single rooms in long-stay facilities, with a 30 minute non-smoking period before regular staff attendances for care and other needs such as meals and cleaning

The College would be pleased to provide oral evidence if required at a later date.

All College responses are published on the College website www.rcpe.ac.uk.

Further copies of this response are available from Lesley Lockhart (tel: 0131 225 7324 ext 608 or email: l.lockhart@rcpe.ac.uk)

SUBMISSION BY SCOTLAND CAN!

This submission is on behalf of Scotland CAN! (Cleaner Air Now), a broad-based coalition of organisations that lobby for smoke-free enclosed public places in Scotland. The submission does not necessarily reflect the views of individual member organisations (see end of response form for full list). The SCOT (Scottish Coalition on Tobacco) Steering Group, which oversees the work of Scotland CAN!, consists of representatives from the following organisations: ASH Scotland, Asthma UK Scotland, Beatson Oncology Centre, Cancer Research UK, Health at Work, Macmillan Cancer Relief, NHS Greater Glasgow, NHS Health Scotland, Royal College of Nursing, Royal College of Physicians in Edinburgh, and the Royal Institute of Environmental Health in Scotland.

We understand that the Health Committee has access to, and will be taking account of, evidence submitted to the Scottish Executive as part of their public consultation on smoking in public places last year. On this basis, the current submission makes reference largely to research that has been accessed and/or published since 30th September 2004.

We ask to be called to give oral evidence to the Health committee.

Part of Bill: Part 1

Main Objective: Prohibiting Smoking in Enclosed Public Places

Do you agree with the main objective of this part of the bill? YES

Do you have any other comments? YES

The Health Risks associated with Second-Hand Smoke

There is a wealth of robust medical and scientific evidence that documents the health risks associated with second-hand smoke (SHS). SHS has been labelled “carcinogenic to humans” by the WHO’s International Agency for Research on Cancer (IARC).\(^ {141}\) It has also been labelled a “class A human carcinogen” by the US Environmental Protection Agency\(^ {142}\), along with asbestos,

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\(^{142}\) US Environmental Protection Agency. Respiratory health effects of passive smoking: Lung cancer and other disorders. Smoking and tobacco control monographs No. 4 (NIH Publication No 93-3605). Bethesda,
arsenic, benzene and radon gas. The IARC Monograph Working Group on Tobacco Smoke and Involuntary Smoking has recently published their long awaited 1,500-page review of all published evidence related to passive tobacco smoking and cancer. The scientific Group was convened by the World Health Organisation, and consists of 29 experts from 12 countries. They too have concluded that second-hand smoke is carcinogenic to humans.143

In 1998, The UK Government’s Scientific Committee on Tobacco and Health (SCOTH) issued a report which concluded that exposure to second-hand smoke causes lung cancer and heart disease in adult non-smokers, and a variety of conditions in children, including respiratory disease, cot death and middle ear disease.144 In November 2004, the Committee summarised additional research that had been published since 1998, to examine whether any further revisions to SCOTH’s conclusions were required. This was in response to the tobacco industry and their allies who still deny the health risks associated with SHS. In their additional report, SCOTH concludes that knowledge of the health hazards associated with exposure to SHS has consolidated over the past five years; that more recent evidence strengthens earlier estimates of the size of health risks. The evidence continues to point to a causal effect of exposure to SHS on risk of lung cancer – estimated increased relative risk remains at 24%. The evidence pointing to a causal effect of exposure to SHS on risk of ischaemic heart disease is now stronger, and now estimated to be in the order of 25%. Published evidence continues to point to a strong link between exposure to SHS and adverse health effects in children – SCOTH concludes that smoking in the presence of children is a cause of serious respiratory illness and asthma attacks. Sudden infant death syndrome is also associated with exposure to SHS, and this association is now judged to be one of cause and effect. The evidence published since 1998 also points to an association between SHS and respiratory symptoms and reduced lung function in adults. The Committee conclude that SHS is a controllable and preventable form of indoor air pollution that no infant, adult or child should be exposed to; and that SHS represents a substantial public health hazard.145

Since the close of the Scottish Executive’s consultation in September 2004, a number of additional research findings have been published that add further weight to concerns regarding the health risks associated with second-hand smoke. For example, in one of the most comprehensive Europe-wide studies into the health effects of second-hand smoke of its kind, researchers have recently found that children exposed to SHS on a daily basis, and for many hours, face over three times the risk of lung cancer than those who grow up in smoke-free environments.146 The study also demonstrated that former smokers (who had stopped for at least 10 years) exposed to SHS at home and/or at work have higher risks for developing respiratory diseases, specifically lung cancer, than those who have never smoked.147 SHS exposure in pregnant women has recently been shown to adversely affect pregnancy by increasing foetal mortality and preterm delivery at higher exposure levels, and slowing foetal growth across all levels of SHS exposure.148 Severity of the condition bronchiolitis is increased in babies and young children who are exposed to SHS.149 The
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Links between SHS and asthma are well documented. In addition a recent report has demonstrated that children with asthma whose parents smoke at home are at least twice as likely to have asthma symptoms all year compared to children of non-smokers.149 Recent research has also suggested that exposure to SHS may lead to abnormal tissue repair; delaying wound repair, preventing the formation of the healing tissue, and increasing the possibility of fibrosis and excess scarring.150

Recently discovered tobacco industry documents suggest that second-hand smoke may be even more harmful, volume for volume, than directly inhaled cigarette smoke.151 Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places. There are now a number of published reports that document tobacco industry projects to recruit scientists in developed countries around the world who would criticise the science on second-hand smoke, cast doubt on whether SHS harms people and “prolong the controversy” about the effects of health effects of SHS.152 153 154

As early as 1993, the Philip Morris Tobacco Company made preparations to mount a strenuous and well-funded effort to subvert the IARC monograph and associated IARC studies, as they feared that their findings would lead to increased smoke-free restrictions in Europe.155 Their attempts to discredit IARC’s work via industry-directed research, mass media and public communication campaigns, and prevent increased smoking restrictions, failed.

Without exception, the ‘evidence’ presented by hospitality groups and the tobacco industry suggesting no association between SHS and ill-health is flawed, weak, and lacking in scientific credibility. The WHO International Agency for Research on Cancer’s (IARC) classification of SHS as a human carcinogen1 is based on the full scope of evidence; observational studies, carcinogenic components of SHS, experimental models, and biomarker studies. The issue of whether exposure to SHS causes ill-health and death has been resolved scientifically. It is only hospitality groups and the tobacco industry that continue to “debate”.

Possible Exemptions

The possible exemptions under consideration may include police and prison cells, secure hospitals, hotel and bed-and-breakfast rooms, and hospices. Scotland CAN! strongly believes that if any exemptions are to be considered, they should be justified only on humanitarian grounds and on the existing evidence base, not on economic grounds.

Exemptions may lead to the marginalisation of some sectors of society and parts of the workforce, effectively implying that their health is less important. In making decisions regarding exemptions, it is crucial to remember that a dwelling place for some is a workplace for others. On this basis, Scotland CAN! believes that the only exemptions that should be considered are those in exceptional cases, such as hospices and long stay wards, in order to accommodate people who would be regarded as ‘dwelling’ in these places. In the Republic of Ireland, even though exempt institutions are not obliged to enforce the legislation, all employers still have the right to enforce the legislation, and are free to do so if they wish. Scotland CAN! suggests that the Scottish Parliament

154 http://tobaccodocuments.org/profiles/whitecoat.html
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considers a similar model. In the event that these exemptions were introduced on humanitarian grounds, employers and service providers should provide all reasonable means for employers and other service users to avoid exposure to SHS.

Exemptions for hotel and bed and breakfast rooms, and private clubs are not workable. If they were introduced, some establishments would undoubtedly exploit the exemption loophole, as has been demonstrated in shared experience of other countries that have already introduced legislation. This would only serve to undermine, and potentially contribute to the demise of what would otherwise be an effective piece of legislation in Scotland. As far as possible, consistency is required in protecting all workers from the harmful effects of second-hand smoke. It is much easier for the public to understand a ‘one rule applies to all’ smoke-free provision. A level playing field is considered fairer and easier. Even organisations with strong links to the tobacco industry, such as the Empire State Tavern Association, and the SLTA (who recently teamed up with the big tobacco companies like Imperial Tobacco to present health evidence opposing legislation) state that smoke-free legislation should be applied even-handedly, to bars, pubs and private clubs. Legislation which applies equally to all enclosed public places has the additional advantage of requiring minimal lead time, since no building alterations need to be made nor equipment installed. This is clearly the most effective and fairest way to reduce the health risks caused by tobacco and exposure to SHS.

There is an additional advantage related to legislation that requires minimal lead-time. As evidence from other countries has indicated, the option of extending or postponing introduction of new law provides the hospitality trade and tobacco industry with increased ammunition, giving them time to step up attempts to scupper the introduction of legislation. The tobacco industry has a vested interest in opposing legislation and, as previously experienced in New York and Ireland, they actively support groups attempting to derail smoke-free laws before they are introduced. Restaurant and bar owners continue to argue that custom will fall and the law will be difficult to enforce. Opponents continue to advocate for compromises such as ventilated rooms or designated smoking areas, which we already know to be wholly ineffective measures. An Aberdeen License Trade Official has reportedly recently called on pubs to consider introducing a voluntary smoking ban, in order to help stop Scotland-wide legislation being introduced in 2006. FOREST, the tobacco industry funded front group, has recently appointed a Scottish spokesman, in order to try and persuade MSPs to introduce a system that offers greater choice to smokers. Both the Scottish Licensed Trade Association, and the Tobacco Manufacturer's Association, have recently indicated they are examining the possibility of mounting legal challenges against the legislation. The threat of legal action is a delaying tactic, intended to overturn the introduction of smoke-free enclosed public places in Scotland.

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160 A valuable resource exposing the tobacco industry's tactics to attempt to undermine the introduction of smoke-free legislation in other countries is available online at: [http://www.tobaccoscam.ucsf.edu/index.cfm](http://www.tobaccoscam.ucsf.edu/index.cfm) (Accessed 10/02/05).
161 ‘Pubs urged to consider voluntary smoking ban.’ This is North Scotland news report (07/01/05). Available online at: [http://www.thenisnorthscotland.co.uk/displayNode.jsp?nodeId=149235&command=displayContent&sourceNodePK=11613474&moduleName=InternalSearch&keyword=smoke&formname=sidebarsearch](http://www.thenisnorthscotland.co.uk/displayNode.jsp?nodeId=149235&command=displayContent&sourceNodePK=11613474&moduleName=InternalSearch&keyword=smoke&formname=sidebarsearch) (Accessed 07/01/05)
163 ‘McConnell faces retreat on smoking ban.’ The Sunday Times – Scotland, December 12th 2004. Available online at: [http://www.timesonline.co.uk/article/0,,2090-1400506,00.html](http://www.timesonline.co.uk/article/0,,2090-1400506,00.html) (Accessed 05/01/05)
Economic Impacts

The tobacco industry and their allies remain active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries. The tobacco industry and hospitality trade groups systematically issue predictions of a serious decline in business in every country where legislation has been, or is currently being, introduced. In the Republic of Ireland, The Licensed Vintners Association (LVA) have published research concluding that the economic impact of smoke-free legislation is unfavourable for the licensed trade, resulting in a decline in the Irish bar trade.\(^{164}\) The LVA has also claimed that the introduction of smoke-free legislation in the Republic of Ireland has led directly to the loss of 2,000 jobs in Dublin.\(^{165}\) These research findings are based on subjective estimates and subjective interviews with publicans, and not on objective economic information. Interestingly, the publicans’ estimates of their sales figures are significantly different to the hard data available, such as the drink sale figures produced by the Central Statistics Office (CSO) as well as the drinks manufacturers themselves. According to the latest figures from the CSO, bar sales are reported to have picked up sharply, with sales figures rising by 2.3% between September and November 2004.\(^{166}\) This rise marks a turnaround after two months of declining volumes. Whilst bar sales continued to be down on 2003, falling by around 5.1%, this is dramatically less than the 29% fall in volumes claimed by the LVA, whose figures do not take account of seasonal changes to drinking purchases.\(^{167}\)

The decline in Irish bar trade began more than three years ago, before legislation was introduced. Sales reportedly hit their peak in May 2001, and since then, the volume of drink sold in Irish bars has fallen by approximately 15%.\(^{26}\) Many other factors have contributed to this climate, including changing demographics, the price of drink, increased price competition from supermarkets and off-licences, and changing working patterns and lifestyles.\(^{168}\) Yet the LVA report attributes all of the alleged downturn in the trade to smoke-free legislation. Furthermore, records of Mandate Trade Union, which represents almost two thousand bar workers, mainly based in Dublin, indicate that job losses in the greater Dublin area have been in the order of a couple of hundred, not the thousands claimed.\(^{169}\) Grim forecasts were also provided concerning widespread bankruptcies in the pub, bar and restaurant sectors after Norway introduced smoke-free workplace legislation last year. Legislation was in place for seven months in 2004, and, on the contrary, the number of bankruptcies in the hospitality industry declined.\(^{170}\)

Anecdotal reports, polls or interviews with business owners concerning economic impacts of smoke-free legislation should be treated with great scepticism. The Scottish Licensed Trade Association has recently estimated that “cost of compliance with the Bill will be in the region of £85m, suggesting that “costs may be well in excess of that, depending on the views of the local regulatory authorities on matters such as the provision of fire escapes and facilities for the disabled”.\(^{171}\) However, a recently published international review has modelled the likely impacts of moving from the current voluntary code to comprehensive legislation on smoking in public places in Scotland. Modelling procedures utilise existing evidence on the economic impacts that have been measured in other countries with comprehensive smoke-free legislation. The report concludes that conservative estimates of savings in the workplace exceed the ‘worst case scenarios’ for losses in the hospitality industry. The effect on the hotel, restaurant and bar sectors in Scotland is centrally estimated at +£110 million (range –£63 million to +£281 million). The study also suggests that the

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\(^{165}\) Ireland implements Europe’s toughest smoking ban’. Online at http://www.able2know.com/forums/about21568.html


\(^{169}\) ‘Fewer businesses bust after smoking ban’. Press article in the Aftenposten (01 February 2005). Available online at: http://www.aftenposten.no/english/local/article959680.ece (Accessed 01/02/05)

\(^{170}\) SLTA response to Stewart Maxwell Bill, page 3, para. 1
most sizeable economic impact is a net gain for society in resource terms, which are centrally estimated at £115 million five years post legislation.\textsuperscript{172}

Smoke-free legislation has been passed in every conceivable type of community, from small towns and rural areas to a number of states, and economists have studied the impacts on communities across the spectrum. No objective, peer reviewed study ever conducted has found a significant negative economic impact associated with smoke-free legislation.\textsuperscript{173} The reliable evidence, that measures hard numbers from independent sources, remains clear. Legislation on smoke-free enclosed public places will not harm the economy, and will improve Scotland’s appalling rates of cancer, heart and lung disease, both by cutting smoking rates and by reducing people’s exposure to unwanted smoke.

**Increased Health Benefits: Reduced Tobacco Consumption**

Recent research has documented that health improvements can occur within months of smoke-free policy implementation. Employees in workplaces with no smoking restrictions are thought on average to smoke three more cigarettes daily than those whose workplaces are completely smoke-free.\textsuperscript{174} In the Republic of Ireland, smoking rates have plummeted from 31% to 25% in just four years. In the six months after their legislation was introduced, an estimated 7000 Irish smokers had given up smoking.\textsuperscript{175} These figures have not been matched in the North, where smoking rates remain static.\textsuperscript{176} Some one billion fewer cigarettes were sold in the Republic of Ireland last year, a 15% decrease on 2003. The Department of Finance acknowledges it is too early to say whether all of this decrease can be attributed to smoke-free legislation, but state that it smoke-free workplaces and enclosed public places play a significant role.\textsuperscript{177} Similarly, although smoke-free legislation in Italy was only introduced on January 10\textsuperscript{th} 2005, Italian cigarette sales have already fallen by 23%.\textsuperscript{178}

Recently published figures show that Scotland now has the highest proportion of smokers in the UK. 31% of Scots are smokers compared to 27% in Wales and 25% in England.\textsuperscript{179} It should be recognised that there is a substantial benefit to be gained from smoke-free legislation in terms of the impact it will have on active smoking rates. A review of smoke-free workplaces in the USA, Australia and Canada estimates that smoke-free legislation reduces smoking prevalence by 4% and overall tobacco consumption by 30%.\textsuperscript{32} A modest reduction in active smoking rates would have major benefits in terms of reducing numbers of deaths among the Scottish population generally.

The hospitality and tobacco industry continue to voice concerns regarding a ‘dramatic escalation in a possible rise in smoking in the home’ as an immediate consequence of the introduction of smoke-free enclosed public places.\textsuperscript{180} However, evidence from countries such as the USA, Canada and Australia suggests that the introduction of legislation for smoke-free workplaces and enclosed public places may have the effect of enhancing protection from SHS in the home. In Australia, the introduction of legislation for smoke-free workplaces during the 1990’s was accompanied by a steep increase in the proportion of adults who avoided exposing children to tobacco smoke at


\textsuperscript{176} The British Medical Association (2004). “The Human Cost of Tobacco.”

\textsuperscript{177} ‘One billion fewer cigarettes sold last year’ News article printed in the Irish Examiner (06 January 2005). Available online at: http://www.tobacco.org/news/186413.html (Accessed 07/01/05)

\textsuperscript{178} ‘Ban stubs out Italy Tobacco sales.’ News article printed on the BBC News webpage (25 January 2005). Available online at: http://news.bbc.co.uk/1/h/eurnews/4195249.stm (Accessed 25/01/05)


\textsuperscript{180} Beers, R. ‘One way to increase smoking in the home’. Letter to the Herald, 25 January 2005.
home. Among households with children, the proportion with smoking restrictions more than doubled, from 25% in 1989 to 59% in 1997. The increase among households where parents smoked was even more dramatic: among homes where one adult smoked, the proportion with smoking restrictions rose from 17% to 53%; among those where all adults smoked, it increased from 2% to 32%.\(^{181}\)

Young children are thought to face highest levels of exposure to SHS in the home.\(^{182}\) A recent US survey demonstrated that most US parents still do not have a clear understanding of the adverse health effects of exposure to second-hand smoke on children, despite what has been established in published scientific research literature.\(^{42}\) Smoke-free gains are when smoke-free is part of a wider tobacco control strategy. For example, media campaigns are required to increase adults’ awareness of the dangers of secondhand smoke, and they should be used in conjunction with smoke-free legislation to ensure the greatest protection for young people from the adverse health effects of secondhand smoke exposure. Smoke-free legislation will clearly support current smokers attempting to quit, and denormalise smoking in society, so that future generations do not get addicted to smoking.

The Scottish Licensed Trade - Proposed Alternative to Legislation

The licensed trade umbrella group, Against an Outright Ban (AOB) represents the SLTA, the Scottish Beer and Pub Association, and other pub groups based in Scotland. In May 2004 they outlined proposals for implementation of a 5-point plan, across a 3-year period, as an alternative to the comprehensive legislation that the First Minister outlined in November 2004. The SLTA’s Chief Executive, Paul Waterson, believes that the 5-point plan would provide a “major contribution to improve health prospects in Scotland”.\(^{183}\) This alternative approach proposes that:

6. Smoking be banned at the bar counter in all licensed premises.
7. Smoking be banned in any area where and when hot food is served.
8. Smoking be banned in any area from which the public is excluded
9. Licensed premises must allocate
   a. 30% of total floor space to a non-smoking area in year one
   b. 40% in year two, and
   c. 50% in year three.
This would be followed by a further review
10. Licensed premises must display a smoking policy at the entrance in order that customers can see the facilities available before they enter.

As the current Scottish Voluntary Charter on Smoking in Public Places has demonstrated, designated smoking areas continue to expose people in the vicinity to SHS, and increase the exposure to smoke by concentrating smokers in the one place. Like the Voluntary Charter, the proposed 5-point plan put forward by the licensed trade is not based on evidence of how to protect health, either for staff in the workplace, or for the public who use these facilities.

Inherent in the licensed trade proposals is the assumption that ventilation in bars could protect the public from the harmful effects of SHS. Although good ventilation systems can help reduce the irritability of smoke, there is a wealth of published scientific evidence that demonstrates there is no ventilation system that fully removes harmful gases that are present in second-hand smoke.\(^{184}\)\(^{185}\)

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184 British Medical Association (2002). Towards smoke-free public places.
Only 15% of second-hand smoke is in the form of particles that are visible to the eye. Ventilation filters trap these particles, making a room look less smoky and feel more comfortable to be in. However, tobacco smoke contains 4,000 toxins and more than 50 cancer-causing substances. Many of these are odourless, invisible gases, which cannot be removed by ventilation systems. It has recently been suggested “You can do what you like with ventilation so long as you are prepared to spend the money”. Many businesses end up installing expensive ventilation systems in the mistaken belief that they are protecting staff and the public from the ill effects of SHS. However, any efforts to provide partial protection from SHS remain flawed, as there is no safe level of exposure to second-hand smoke.

Those individuals who continue to advocate ventilation as an appropriate solution to the health hazards of SHS have argued that indoor air pollution could be further reduced by introducing higher air exchange ventilation rates. However, higher ventilation rates do not lead to a measurable improvement of indoor air quality, as increased ventilation rates have no significant influence on the air concentration of tobacco components. It has already been demonstrated that in excess of 10,000 air changes per hour would be required to produce levels of risk acceptable to bar staff from SHS. This would be equivalent to a tornado-like gale, and this is clearly unachievable.

Recent controlled experiments have shown that the air pollution emitted by cigarettes is 10 times greater than diesel exhaust. These experiments have also demonstrated that comparative pollution levels for the tiniest particles – the most dangerous to health, are even greater. Yet improvements in air quality can also be observed within weeks of smoke-free policy implementation. Averaged levels of respirable suspended particles (RSPs – an accepted marker for SHS levels that are known to increase risk of respiratory disease, cancer, heart disease and stroke) have been shown to decrease by up to 84% in smoke-free venues within the first 4 months after legislation takes place. Similarly effects have also been demonstrated just two months post-introduction of smoke-free legislation.

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The Scottish Licensed Trade’s 5-point plan represents a backward step. Hospitality workers, children and other members of the public would not be adequately protected from the harmful health-effects of SHS. A recent Scottish study demonstrated that non-smokers exposed to SHS in the workplace may have their lung function reduced by up to 10%.\textsuperscript{199} It has also been estimated that SHS in the workplace poses 200 times the acceptable risk for lung cancer and 2000 times the acceptable risk for heart disease.\textsuperscript{200} Second-hand smoke kills up to 1,000 people every year in the UK, and some studies suggest that the figure is even higher than this. Scotland.\textsuperscript{201, 202} Ventilation does not protect employees and customers from the harmful effects of SHS.\textsuperscript{44-50} The Scottish Executive has made their decision regarding legislation on a wealth of robust scientific and medical evidence. The new laws will benefit everyone. A comprehensive smoke free law is the only way to protect the people of Scotland from the health hazards associated with SHS.

Scotland CAN! involves the following member organisations:

ASH Scotland
Asthma UK Scotland
Beatson Oncology Centre
British Lung Foundation
British Medical Association
Cancer BACUP
Cancer Research UK Scotland
Centre for Social Marketing
Chest, Heart and Stroke Scotland
Children in Scotland
Fast Forward
Health at Work
Macmillan Cancer Relief
Marie Curie Cancer Care
NHS Greater Glasgow
NHS Health Scotland
Path House Medical Practice
Roy Castle Lung Cancer Foundation
Royal College of Nursing
Royal College of Physicians in Edinburgh
Royal College of Physicians and Surgeons in Glasgow
Royal College of Surgeons in Edinburgh
Royal Environmental Health Institute Scotland
Scottish Trade Unions Congress
West Lothian Drug & Alcohol Service

SUBMISSION BY THE SCOTTISH BEER AND PUB ASSOCIATION (SBPA)

About the Scottish Beer and Pub Association (SBPA)

The Scottish Beer and Pub Association was originally formed in 1906. Our members are made up of brewing and large pub companies representing the licensed trade industry in Scotland. The

main aim of the Association is to contribute to the economic and social wellbeing of Scotland through employment, investment and training.

The Scottish Beer and Pub Association’s members include Scottish Brewers Ltd, Tennent Caledonian Breweries Ltd, Carlsberg U.K. (Scotland) Ltd, Belhaven Group plc, Caledonian Brewery Ltd, Diageo Ltd, Broughton Ales, Scottish and Newcastle Pub Enterprises, Mitchell and Butlers, Spirit Group, Punch Taverns plc & Maclay Group plc.

Our members account for 1,500 of the 5,100 licensed public houses in Scotland.

A total of 150,511 people are employed in the licensed trade in Scotland and in the manufacture of alcohol products, including beer. 10,573 people are employed in manufacturing alcoholic beverages in Scotland, including beer.

If further information is required please contact:

Patrick Browne
Chief Executive

Summary

SBPA is fully supportive of the objective of providing more smoke free areas in Scotland’s pubs and clubs. Moreover, we are committed to providing more comfort and choice for non-smokers within the hospitality environment and to provide a more healthy work environment for our staff.

However, we are opposed to the legislation relating to smoking in the Smoking, Health and Social Care (Scotland) Bill.

There are a number of reasons for this:

Firstly, in May 2004, the licensed trade in Scotland put forward a proposal to the Scottish Executive, outlining a five-point plan which we believe would have achieved the Executive’s objective of creating more smoke free areas in Scotland without the potential damage to the industry of an outright smoking ban. We believe the Scottish Parliament should legislative for additional anti-smoking measures as outlined in the industry’s five-point plan which we believe will maximise both the health and the financial benefits of tobacco restrictions.

Secondly, we oppose the legislation because we do not believe the proposals for a total smoking ban in all premises as outlined in the Bill are supported by Scottish public opinion. This is borne out by the results of a public opinion survey commissioned by the Scottish Executive on this issue and by the Scottish Executive’s own consultation which showed mixed support for the proposal.

Thirdly, we believe the economic and financial research on which the decision to proceed with a total smoking ban in Scotland is fundamentally flawed and we fear that the Bill if implemented would have a detrimental impact on the licensed sector in Scotland, our staff, and our customers. Indeed, studies commissioned by the Against and Outright Ban (AOB) Group, of which we are a member, bear this out.

For the reasons as above we would ask the Scottish Parliament to reject the clauses relating to smoking as outlined in the Smoking, Health and Social Care (Scotland) Bill.

The Industry’s Preferred Approach

Over the last few years, we realise that there has been tremendous pressure to take positive action by way of legislation for smoke free areas. It is clear to the industry, as well as everyone else, that the status quo is not an option. Whilst significant progress was made on this issue through the Voluntary Charter in providing more smoke free areas and much better ventilation for pub goers, we recognise that voluntary action does not provide a level playing field as individual licensees are naturally reluctant to take steps to restrict smoking if these steps place them at a competitive disadvantage.
In recognition of this in May 2004, the licensed trade asked the Scottish Executive, through the then Health Minister, to legislate for smoke free areas and introduce five measures which would have been compulsory for all licensed premises ranging from pubs, hotels, restaurants, sports clubs, and social clubs, to entertainment venues. The points were:

- Smoking should be banned at the bar counter in all licensed premises.
- Smoking should not be permitted in any area where and when hot food is being served.
- All licensed premises (whether or not they sell food) should be required to allocate a minimum of 30% of total floor space as a non-smoking area and this percentage would be ratcheted upwards to 40% in year 2 and 50% in year 3.
- Every licensed premise should have a smoking policy sign at the entrance.
- Smoking should not be permitted in any area of licensed premises from which the public are excluded (i.e., back of house).

At the end of year three a review of progress would be made and appropriate further steps taken. This was very similar to the Norwegian model which has moved to a total ban over a period of years.

The licensed trade did not underestimate the difficulties in introducing these measures but we believed that if these measures were introduced, Scotland would have made a huge stride forward in improving choice for non-smokers and protecting their health as well as the health of employees in the industry. A firm message would be conveyed to the Scottish public in general and smokers in particular, and, over a period of time, we would anticipate a significant increase in the presence of non-smokers in licensed premises.

We strongly oppose the introduction of a total smoking ban believing instead that a stepped approach as outlined above is preferable.

Scottish Public Opinion

Responses to the Consultation on Smoking in Public Places

The Scottish Executive undertook its “Consultation on Smoking in Public Places” before arriving at its decision to introduce a smoking ban.

The Scottish Executive’s own consultation, although showing that 80% of respondents favoured a ban on smoking in enclosed public spaces, also showed that a bare majority, just 56% of respondents, favoured a total ban on smoking without any exemptions for any sector which is the proposal contained in the Bill.

mruk Research Findings

mruk research were commissioned by the Scottish Executive to undertake a research exercise with a sample of the Scottish population, regarding smoking in public places and addressing aspects of the smoking in public places consultation exercise itself.

A key finding of the opinion survey was that: “Views were mixed with respect to the level of support for a law that would make enclosed public places smoke free, with just over half expressing support for such a law and around a third indicating that they were unsupportive.

“Overall, two thirds of those who would support such a law were also of the opinion that should such a law be introduced, exemptions should be considered, with pubs and clubs the most commonly suggested exemptions (57% and 21% respectively).”

This suggests that although a majority of those surveyed supported a ban on smoking in enclosed public places, two thirds of those also believed that exemptions should be considered, meaning that just one in five, or 18%, of those surveyed supported a total smoking ban.
It is evident from the findings of the Scottish Executive’s own consultation exercise that a bare majority of respondents want a total smoking ban in Scotland and that less than one in five respondents to a Scottish Executive commissioned survey support the proposed total smoking ban. These findings have been borne out by other surveys including research commissioned by the UK Department of Health in 2003.

Flawed Scottish Executive Research

The Scottish Executive based its decision to proceed with a total smoking ban on a range of research which we believe to be fundamentally flawed. This research included the “International Review of the Health and Economic Impact of the Regulation of Smoking in Public Places” undertaken by the University of Aberdeen.

There were a number of comments in the Summary version of the report which illustrated the weakness of this piece of research.

The Aberdeen Study considered the “specific effects on the hospitality sector” of a smoking ban and used a number of studies. 11 of these related to restaurants, four to hotels. Significantly only one related to the experience of bars in California. The report indicated that “this was the only study available to model results for Scotland.”

In relation to the “quality and relevance of the literature,” the Aberdeen Study indicates “There are a number of valid criticisms relating to the studies carried out in this area and these reflect the difficulties of conducting research into policy impacts. The problems include: the inadequacy of sales tax data to capture all the effects, the timing of the intervention in relation to the data periods; limitations to the smoking restrictions; compliance with the smoking restrictions; selection bias; and the transferability of the results to other settings. The failure to find any significant impact on revenues in the sectors analysed does not rule out the possibility of a small negative effect on business … However, it is also the case that there has been no analysis of impacts within sectors and no analysis based on measures such as sales volume or profits.”

The Study also makes no attempt to analyse the macroeconomic impact of any smoking ban on the Scottish economy, instead the report relies on the statement that “the net effect on the Scottish economy of any impact on the hospitality sector will be reduced as any change in spending is redistributed to or from other sectors of the economy. Expenditure that is diverted from or gained by the hospitality sector will be taken up in or lost from other sectors.” However, the study also stated that “it was outwith the scope of this study to provide a full macroeconomic model of the net economic effects.”

Given the lack of robustness within the research produced by the University of Aberdeen on which the Scottish Executive based its decision and on the incompleteness and non-transferability of the international studies analysed, we do not believe that the Executive has justified its assertion that a smoking ban will cause minimal impact to the hospitality sector, and specifically pubs in Scotland.

Economic Impact of a Smoking Ban

Tobacco is not a banned substance and research shows that 67% of Scottish pub goers are also smokers who are addicted to nicotine. The dictionary definition of addiction is “something, usually a narcotic drug, upon which people are dependent.” So it is hardly surprising that we fear the impact of a total smoking ban as it could greatly reduce turnover in all licensed establishments with the possible exception of those which specialise in the provision of food.

A reduction in turnover would result in a much higher reduction in operating profit in most licensed businesses, further exacerbating the impact of a downturn in trade.

Recent reports from Ireland suggest that volume sales of beer have fallen by 10% in the first five months of the smoking ban, with sales in Dublin down 14% (Figures from AC Nielsen.) Industry trade bodies in Ireland have estimated that so far some 2,000 jobs have been lost within the industry.
It is impossible for us to quantify the precise economic impact in Scotland of a total ban but we take the view that it would have a significant effect on both large and small businesses many of which would become unsustainable.

Research commissioned by the Against and Outright Ban (AOB) Group, of which we are a member, from the Centre for Economics and Business Research (CEBR), suggests that as a result of a smoking ban in Scotland:

- The value of annual turnover in the licensed trade will decline by £105m
- Annual profits in licensed premises may decline by £86m
- Employment in the licensed trade can be expected to decline by 2,300 jobs initially
- About 142 average sized licensed premises may close as a result of decreased trade

It should be stressed that these figures are based on the reduction in the volume and value of bar sales which has already been experienced in the Republic of Ireland and suggest that a total and immediate smoking ban introduced in Scotland would cost jobs and result in the closure of a significant number of licensed premises.

Conclusion

As we have already stated, SBPA is fully supportive of the objective of providing more smoke free areas in Scotland’s pubs and clubs. Moreover, we are committed to providing more comfort and choice for non-smokers within the hospitality environment and to provide a more healthy work environment for our staff.

However, we are opposed to the legislation relating to smoking in the Smoking, Health and Social Care (Scotland) Bill.

We would propose that the Scottish Executive and the Scottish Parliament delay the implementation of its proposals for total smoking ban in enclosed public spaces until the impact of the ban in the Republic of Ireland over a period of twelve months has been fully assessed.

As we have indicated if the impact of the smoking ban on the value and volume of beer sales already experienced in Ireland were replicated in Scotland we would possibly be faced with:

- The value of annual turnover in the licensed trade declining by £105m
- Annual profits in licensed premises declining by £86m
- Employment in the licensed trade can be expected to decline by 2,300 jobs initially
- About 142 average sized licensed premises closing as a result of decreased trade

We would ask the Scottish Executive and Parliament to:

- Adopt the industry five-point plan as put forward last May to the Scottish Executive. Similar solutions have worked well in Norway and Australia and our proposal would not be materially damaging to the Scottish economy.
- At the very minimum research should be undertaken on the economic impact of the workplace tobacco ban introduced in Ireland at the end of March 2004 and the outcome of that research should be carefully studied before any further action if taken on the smoking aspects of the Smoking, Health and Social Care (Scotland) Bill.

The licensed trade in Scotland and the membership of the Scottish Beer and Pub Association will of course continue to work in partnership with the Scottish Executive in furthering its objectives of promoting health and tackling smoking. We would however urge the Scottish Executive and the Scottish Parliament to think again before proceeding with the current proposals and to instead work with the industry to introduce the change we all want to see in a considered way.
SUBMISSION BY SCOTTISH WHOLESALE ASSOCIATION

I would like to take this opportunity to make a formal written submission to the Health Committee concerning the Health and Social Care (Scotland) Bill. I am writing in my capacity as Convenor of the Scottish Wholesale Association. The Association represents the interests of suppliers to the on and off licensed trades, and our members employ in excess of 8000 people.

I understand the Government’s desire to protect the public from passive smoking, and to support smokers in their attempts to quit. However, I am concerned that the Executive has not taken enough time to review all the necessary information in making its decisions, and in particular would like to bring the following points to your attention:

1. Haste with which the legislation is being progressed
2. Lack of public support
3. Poor preliminary research
4. Flawed consultation process
5. Underestimation of the economic impact
6. Inability to appreciate the need for concordance with UK legislation
7. Lack of communication with the licensed trade which is the public sector at the heart of this legislation
8. Inability of the Executive to consider that an outright ban may not actually be the best approach to safeguarding this nation’s health.
9. Poor appreciation of the policing issues of imposing the legislation
10. Underestimation of the effect this will have on one-pub villages/small communities

Expanded Arguments
1) The Executive is about to impose the most radical piece of health legislation the devolved parliament has seen - based on incomplete economic research; against overwhelming public opinion; with no idea of how to police the legislation; and no real guarantee that it will improve the nation’s health.

It is with absolute incredulity that I witness the speed at which the Executive has forced the Health and Social Care Bill through the Scottish Parliament. As I have said, I am totally in favour of increasing smoking restrictions but surely the Executive should take some more time to truly consider whether an outright ban is the most effective way to tackle the smoking issue. Given that the public is opposed to the move, it would be prudent to commission additional research and afford the decision due time and deliberation.

2) I believe that one of the most formidable arguments against the forthcoming legislation is that the public is opposed to it. The Executive’s own mruk opinion poll demonstrated that the majority of the Scottish public are not in favour of an outright ban on smoking in public places. This is not to say that they would not support increased restrictions on smoking policy - but they do not want, and are not ready, for an all-out ban.

In my opinion the government has wholly underestimated the importance of public support as part of the legal system. One of the vital assumptions made when imposing new laws is that the majority of individuals will comply. If there is evidence to suggest that the law will be rejected you create extreme policing difficulties and threaten to make a mockery of the legislation.

I could understand the government making a decision against public opinion if it was absolutely sure that it was in the nation’s best interest, but the Scottish Executive has rushed its research and failed to fully consider the possibility that the gradual introduction of smoking legislation, which would give the general public time to adjust, may make a more definitive move for public health.

3) As an interested party, naturally we have read through the economic research and health reviews used to guide the Executive’s decision. We were astounded to note the following points. Firstly, as far as the economic impact of a ban on smoking is concerned, the International Review conducted by the University of Aberdeen acknowledged that studies undertaken did not actually include an analysis of a total ban situation. Therefore, the conclusions drawn from smoking policy in foreign countries were non-transferable.
Secondly, the Executive did not take the time to properly assess the Irish situation, which is the closest benchmark we have – and even if it did it would have to assume that any negative impact would be felt more greatly in Scotland, which has a much less stable licensed trade industry.

4) I was extremely disappointed by the Scottish Executive’s management of the consultation process. This is the most important stage in the introduction of new legislation, where individuals and organisations can offer valuable advice and opinions on government proposals. There are certain guidelines that should be followed during any consultation to ensure a degree of scientific integrity. Consultation documents should present all the facts, should be simple, wholly unbiased, without presumption or implication. They should allow any individual to make an informed and objective judgement.

The document presented as part of the Executive’s consultation was a far cry from these guidelines. Both the First Minister and the Deputy First Minister pre-empted the consultation process by indicating firmly and clearly their preference for a total ban. The preface of the questionnaire was extremely heavily weighted towards the health issue and makes no attempt to introduce all necessary factors that need to be taken into account – the economy, jobs, compliance, policing. The questions were misleading, at no point making reference to public houses, which are at the heart of the matter. We would urge you to make reference to the consultation papers when considering these points.

5) The Scottish Executive seems to have underestimated the economic impact of an outright ban on smoking in public places on two levels. Firstly, it has underestimated the actual financial toll a ban will take on the Scottish economy. New independent research from the Centre for Economics and Business Research (London) reports, amongst other things, that the value of annual turnover in the licensed trade will decline by £105m, that employment in the licensed trade can be expected to decline by at least 2,300 jobs, that 142 average sized licensed premises may close as a result of decreased trade) and that the Chancellor of the Exchequer may lose out on a total of £59m in annual tax revenues from Scotland.

Secondly, it seems to have underestimated the importance of the economic impact in the debate on smoking policy. Many hold the view that the economic situation is largely irrelevant when one is considering the health of the nation. However, little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment.

6) Creating a divide in smoking policy between Scotland and England will put the nation at a significant competitive disadvantage. There is a strong possibility that tourists will choose English destinations - where one is free to choose between smoking and non-smoking venues, over Scottish destinations – where one is not. Our membership views this risk to the Scottish Tourism industry, both from a financial and geographic standpoint as being a significant threat to the future economic prosperity of the country.

One might also consider the implications this divide in policy may have on policing guidelines. Those on the border will feel legally torn, especially if they are loosing customers to neighbouring villages in the North of England.

7) The Scottish Licensed Trade Association has in fact been working with the government for many years in developing smoking policing. As an organisation, it was one of the founding members of the Voluntary Charter on Smoking. However, in this latest debate its opinions and guidance seem to have been marginalised. Perhaps this is because the trade has wrongly been portrayed as opposed to plans to increase restrictions on smoking in public places.

8) What we have found most surprising in this debate is the apparent assumption that a blanket ban is the best possible option to safeguard public health and benefit the economy. This debate seems to have been dominated by a ban / no-ban approach. At no point in the process would it seem that anyone has really sat down and looked for the best solution.

Certainly we must reach a stage where non-smoking is the norm in public places and it is smokers that must choose which venue to attend. But we must adopt a compromise position that will
safeguard the nation’s health, avoid the shift in smoking to the home, protect the hospitality and licensed trade industries and will prove enforceable.

There has been no Scottish Executive research into the potential consequence of smokers ceasing to visit licensed premises and switching their disposable spends into take home drinking. Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence.

9) Legislation should only be accepted and introduced when there exists an appropriate and viable strategy with which to enforce and police it. With regards to enforcement, the Executive has created itself a difficult task. It has chosen to impose an outright ban on smoking in public places regardless of the fact a) the public do not support it and b) it is in opposition with our neighbouring States. Do we really expect to be able to form a contingent of ‘smoking police’ that will stretch from Stranraer to Stornaway? Just like Ireland we will end up with one law for the country and another for the city, making a mockery of smoking legislation.

In addition, with smokers forced out into the street to indulge their habit, there is a real risk of increases in social disorder and violence which at present no organisation is claiming responsibility for. Once they leave the premises, customers of licensed establishments cease to be the responsibility of licensees. This brings significant issues for local authorities which the Executive has yet to address.

10) Many of our members’ customers own pubs in small rural villages of approximately 500 people. It is likely that these public houses and the communities around them will feel the impact of a smoking ban more acutely than most – and yet the Executive doesn’t seem to have afforded them a great deal of thought.

The pubs in question really form the heart of the local community, which is often made up of the retired and elderly. They depend on their regular clientele to keep the business afloat – and in turn their customers depend on the local venue for quality of life. To impose a ban in this area just seems ludicrous, you can’t expect the elderly smoking population to nip outside in the middle of winter, people are far more likely to choose, or to be forced, to stay at home.

We hope that you will take these points on board and consider taking a little more time to analyse the facts.

Yours sincerely,
Donald Campbell, Convener, Scottish Wholesale Association.

SUBMISSION BY SMOKEFREE LIVERPOOL

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? Yes
If yes, why?

Introduction
SmokeFree Liverpool is a partnership which comprises Central, North and South Primary Care Trusts, Liverpool City Council, the Roy Castle Lung Cancer Foundation, Liverpool Chamber of
Our aim is to restrict smoking in all enclosed workplaces in Liverpool – for the benefit of all who live and work in Liverpool. As you may know, Liverpool City Councillors voted in October by an overwhelming cross-party majority to seek the powers to restrict smoking in enclosed workplaces places, by a local Act of Parliament. This cross-party majority vote was confirmed by a further vote on the 26th January.

1. The Health Risks of Environmental Tobacco Smoke

Evidence of the health risks from smoking and of exposure to secondhand smoke demonstrate that working or living with smokers can increase the risk of lung cancer by between 20 to 30 per cent and heart disease by between 20 and thirty per cent.

Within the workplace bar workers and hospitality staff are a high-risk group because they are often exposed to high levels of secondhand smoke.

2. The Economic Impact of restrictions on smoking in public places

In 2002 an ONS Survey found that over 80% of people support the prohibition of smoking in shops offices and factories. 83% support the prohibition of smoking in restaurants, and 49% in pubs.

Many studies have indicated neutral or positive impacts on revenues for restaurants or bars where cities have introduced smoke free regulations. Studies which demonstrate a negative effect tend to be funded by the tobacco industry.

The experience of New York, where tax revenues from the hospitality trade were significantly higher in the year following the legislation to prohibit smoking in the workplace.

The report of the Scientific Committee on Tobacco and Health, identified bar workers as the occupational group at most risk from other people’s smoke.

3. The Impact of a ban in reducing the prevalence of smoking

It has been demonstrated that smoke free workplaces have an impact on smoking prevalence. A BMJ study recently found that if all UK workplaces were to be smoke free, this would result in a reduction in prevalence rate of 4 per cent and a reduction in overall tobacco consumption of 7.6 per cent.

Paragraphs 8 and 9 of the Regulatory Impact Assessment, published with the Government Public Health White Paper, estimate that ending smoking in all workplaces and enclosed public places would reduce overall smoking prevalence rates by 1.7%. 0.7% of this effect is estimated to result from the direct effect of ending smoking in employees’ own place of work, and 1% from more places outside smokers’ own place of work going smoke free.

4. The effectiveness of extractor fans and other ventilation equipment to remove tobacco fumes from the atmosphere

Studies have found that ventilation systems do not reduce the levels of the compounds in secondhand smoke. A report produced in Ireland concluded that ventilation is not a viable control option for secondhand smoke.

To use ventilation to attempt to address the problem of secondhand smoke is not only ineffective, but would also place an unnecessary financial burden on businesses.

5. Human rights arguments in respect of smokers and non-smokers
SmokeFree Liverpool believe that this is not about a person’s right to smoke, but about where and possibly when they smoke. It is the firm belief of smoke free Liverpool that no one should have to be exposed to harmful substances unnecessarily in order to earn a living and in workplaces where smoking is unrestricted this is exactly what is happening. No one should be allowed to argue that a worker’s right to clean air should be overridden to accommodate a smoker.

6. Enforcement

It is our opinion that, inspections should be undertaken by Environmental Health Officers and by Inspectors of the Health and Safety Executive, as is the case in Ireland. These two agencies should act in a co-ordinated way to help to ensure compliance with the legislation. Checking for compliance in proactive inspections should be backed up with a quick response to any complaints about non-compliance. It is also important to ensure that a number of proactive inspections take place outside normal office hours.

Evidence from Ireland is that there is an extremely high level of compliance (97%) with legislation there.

Fines / breaches of the legislation

A deterrent to breaking the law would be the imposition of a significant fine on any person found guilty of breaching the law. The owner, manager or person in charge of a workplace is legally responsible for ensuring compliance with health and safety and this is no different when enforcing legislation prohibiting smoking in the workplace. This means that owners, managers and people in charge would also be liable to significant fines for breaches of the law in the premises under their control. This might include non-compliance with the requirement to display signs or the allowing of smoking in the premises.

If not, why not?

Are there any other comments you would like to make?

If required, Smoke Free Liverpool will be happy to provide oral evidence to the committee.

SUBMISSION BY TENNENT CALEDONIAN BREWERIES

As the market leading drinks supplier, I felt it appropriate that Tennent Caledonian Breweries submit a response, as requested, to the aforementioned Bill.

Our main concern regarding the introduction of an outright smoking ban in pubs and clubs is the economic impact. There is little doubt that an eventual smoking ban will have a positive impact on the nation’s health, but there has been no regard for the economic health of those that rely on the drinks business to make a living.

To date, there has been no convincing argument from Government about why an instant and immediate ban is preferable to a phased approach.

Our organisation is an active member of the Scottish Beer & Pub Association, and I know they have sent in lots of statistics and facts about the potential impact of the proposed ban. I will not therefore regurgitate them, but would instead hope that the Scottish Executive and appropriate Ministers have taken the time to familiarise themselves with some very compelling arguments against an immediate and outright ban.

The Scottish Executive, Ministers and the Scottish Parliament as a whole would deserve full marks and all plaudits if successful in bringing about the death of smoking in Scotland – but not if it signed the death warrant for the licensed trade as well.

In addition, I think it is important for the Scottish economy that there is alignment with the rest of the UK on this issue leading to more consistency, less confusion and ultimately more time for publicans and consumers to get used to, and prepare, for the ban.
The fact is there is no evidence that the people of Scotland want this ban, but we also recognise why it is needed in the longer term. Work with and not against the industry for phased implementation, and I guarantee that all parties - including the people of Scotland - will be happier with the approach.

I now look forward to hearing the views of the First Minister and others after receiving all the submissions.

Yours sincerely

Mike Lees
Managing Director, Tennent Caledonian Breweries

SUBMISSION BY TOBACCO WORKERS’ ALLIANCE

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? No
If not, why not?

The TWA has already made clear its views on this policy area in submissions to Stewart Maxwell’s Prohibition of Smoking in Regulated Areas (Scotland) Bill and to the Executive’s consultation on Smoking in Public Places. The TWA opposes a total ban in public places. We believe that more needs to be done but that smoking can effectively be managed through restrictions and ventilation rather than draconian measures such as those in the Bill.

The TWA is concerned that many of the points raised in our previous submissions have not been taken on board. Arguments concerning the impact on jobs and the effectiveness of ventilation appear to have been dismissed entirely in the drafting of the Bill.

The TWA maintains that an outright ban on smoking in public places will have a negative impact on jobs, particularly in the hospitality industry.

More recent figures released by the Irish Government’s Central Statistical Office show a fall in hospitality trade employment of 6.0% in the six months following the ban. In the six months prior to the ban sector employment had increased by 3.2%. This represents a loss of some 7,600 jobs.

The TWA has little to add to the points made previously but would urge the Committee to revisit the submissions to seriously consider the arguments therein.
PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES - INDIVIDUALS

SUBMISSION BY ANONYMOUS

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? no
If yes, why?
If not, why not?
I do not support a total ban, I would prefer people to be allowed to smoke in some pubs.

As an individual non-smoking member of the public I think that it is a little unfair to present this as an issue of public health versus big business. There are business interests on both sides of the debate, but there are also interested individuals such as myself who genuinely believe that this is also an issue of striking a balance between public health gains and the restriction of personal freedoms. It is perfectly reasonable to restrict personal freedoms to improve public health, but the restrictions should be proportionate to the health gains. I do not believe that an all-out ban is a proportionate, and I don’t think that the majority of Scottish people do either if the recent polls are to be believed.

Executive proposal

In its policy memorandum for the Bill the Executive states that:

“Although there is much support for an approach that would create separate smoking or non-smoking areas within leisure and hospitality premises, such an approach is difficult to justify on public health grounds given that there is no defined safe level of exposure to second hand smoke. A complete ban on smoking in all enclosed public places would provide the most comprehensive protection to public health and also has the advantage of being simpler to implement.”

I believe that a compromise would effectively protect public health, and would not be much harder to implement.

Before I go on to make this case, a note on the expression “safe level of exposure”:

This expression can be misleading as it creates the impression that any level of exposure to a substance will automatically cause harm. This is not true. A safe level of exposure to a substance is a level of exposure which can be proven to be safe. There is no safe level of exposure for carcinogens, and as tobacco smoke contains carcinogens there is no safe level of exposure to it.

Equally then, there is no safe level of exposure to the city air which contains carcinogens from exhaust fumes, or from the smoke given off by barbeques and other fires.

What is true, and is stated in Executive-commissioned reports on smoking as part of the pre-bill work, is that there is a link between the level of exposure to carcinogens and the health risks associated with them. The greater the exposure the higher the risks, the lower the exposure the lower the risks.

Once exposure is reduced to a low enough level the risks become low enough to be acceptable, or negligible. A former employee of ASH admitted to me that the occasional cigarette was not likely to do someone harm, but it was persistent and long-term exposure that was of real concern.
Even if the full ban goes ahead, customers at pubs will inevitably walk past smokers on their way into and out of the pub, children will be exposed to smoke in pub gardens, and members of the public walking past pub entrances will be exposed to smoke too. Both common sense and statistical evidence leads one to conclude that this small level of exposure to tobacco smoke is not a particular health concern.

I believe that the legislation should therefore seek to reduce passive smoking to acceptably low levels (this is all it can do – it will fail to fully eliminate exposure), and suggest that this can be achieved without going as far as a full ban.

Compromise proposal

I believe that some pubs should be permitted to allow smoking.

I propose that there should be a presumption of non-smoking in all pubs, but where landlords are able to provide a separate smoking room away from the bar area, they should be allowed to apply for a licence to do so. In order to keep the balance in favour of non-smoking, legislation could require this area to be smaller in size than the non-smoking area.

Further regulations requiring ventilation of smoking rooms might be a good idea too.

The benefits of this partial ban would be almost exactly the same for non-smoking customers as they would be with a total ban – any member of the public would be able to go to any pub safe in the knowledge that they would not have to breathe in second hand smoke (probably not even on the way in to the pub as will happen under the legislation as it is currently drafted).

The impact on staff would be similar to that of a total ban – there would be no smoking at bars, and the only exposure to second hand smoke that a member of staff might have to face would be to go into the smoking room to collect empties, wipe tables etc. This would only be occasional and short-lived exposure, which would not pose a real health risk to the staff involved (especially if there were proper ventilation in smoking rooms).

The major difference would be for smoking members of the public. They would still be able to go to some pubs and smoke, just as they can do now.

Enforcement

It has been stated that a partial ban would be difficult to enforce. I disagree; the partial ban would be enforced in much the same way as a complete ban.

I believe that in Ireland the ban is enforced by way of inspection, and pubs can be fined if they do not comply. Someone inspecting a pub could just as easily check that the main (non smoking) area of the pub is smoke free as check the whole pub.

There is also a hotline that people can call to report smoking in Ireland – this could be run in the same way in Scotland, and so long as the smoking and no-smoking areas were clearly marked there would be no confusion.

There would also be an additional sanction under this system – pubs that allowed smoking to cross over from the smoking room to the non-smoking areas could have their smoking licences revoked. It would therefore be in the interests of pub owners who wished to allow smoking in their premises to ensure that their smoke free areas stayed smoke free.

Proportionate response

The Executive commissioned report estimates that a total ban would decrease overall smoking prevalence by 1-3%. In health terms clearly this small reduction in smoking is welcome, nevertheless it is small, especially in the context of the declining year on year tobacco sales that are already happening without a ban. It does indicate that the imposition of a total ban is perhaps a
disproportionate restriction on personal freedoms relative to the Scottish Executive’s own estimation of the likely benefit.

In any case, by allowing smoking to take place in a minority of pubs and ensuring that all pubs are either entirely or mainly smoke free, most of this 1-3% reduction would still take place, as the overwhelming majority of public places, including most pubs would be smoke free.

Changing Culture

My belief is that this move is about more than just the risk of passive smoking or reducing smoking by 1-3% in the short term, but is part of an attempt to change social attitudes to smoking. A major part of this is sending out the message to children and young people that smoking is not (or need not be) a normal part of social life. This will then hopefully discourage people from starting up in the first place and will encourage more people to give up over the medium-long term.

I do not believe that a partial ban would undermine the attempts to change Scottish cultural attitudes towards smoking. Children should not be allowed in smoking rooms, even in pubs which have licences to allow children in. Allowing smokers to go to a room away from young children may in fact be preferable to having them smoking just outside pubs or in pub gardens where children are playing.

The vast majority of pubs, and all other public places would still be completely non-smoking. And even in pubs with smoking rooms, the main areas would be completely smoke free.

Are there any other comments you would like to make?

Please treat my personal information in confidence, I am happy for you to make my response publicly available, but not my name or contact details etc.

SUBMISSION BY ANONYMOUS

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

Yes in broad terms it is an attempt to improve the present situation.

If not, why not?

Are there any other comments you would like to make? Yes, why are parents or anyone else not banned as part of this bill from smoking in the same enclosed space as their children. Seems spineless of the executive to stop an adult from entering a smoky pub of their own free will but allow adults to expose children who have no choice, to the dangers of passive smoking. Is the executive afraid to protect the most vulnerable in society as some parents might be a bit upset? If the argument is sound for a public ban why is it not sound for a ban in the same enclosed space eg. The home for children.

SUBMISSION BY ANONYMOUS

Do you agree with the main objective of this part of the bill? No

If yes, why?

I not, why not?

It is purely a question of property rights. Yes, public health is important, but the right of a property owner to allow a perfectly legal activity on his/her premises – even if it damages the health of
customers or employees – is more important. It is no more absurd to suggest banning loud music in discos due to the risk of hearing loss. Even if it cut down the number of smokers, the end does not justify the means. Not to mention the cost to this country: Job losses, fall in tobacco and alcohol tax revenue, closure of licensed premises, enforcing the draconian legislation, increase in children’s exposure to smoke due to more people smoking in the home (although the right of families to allow smoking in their private home must, of course, be defended).

Are there any other comments you would like to make?

The scientific community is divided over the risk of passive smoking. Some have branded it a “major public health hazard” whilst others have called it “statistically insignificant”. Why is the government biased towards the former viewpoint? Pubs, clubs and restaurants are places of adult entertainment. There cannot be a single, sane adult left in Scotland who is not aware of the supposed risks of passive smoking. Given that, it should be the responsibility of these informed adults to make the decision and not for the government – who seem to want to save people from themselves. This is what makes Dame Ellen MacArthur’s feat even more remarkable – she has exposed herself to incredible danger in an increasingly safety-conscious society. She is a true role-model for today’s namby-pambyed population.

I also think the government have been “economical with the truth” by not mentioning the smoking ban during the election, as late as September 2003 saying “there are no plans to introduce a smoking ban” and then doing a U-turn. A sly trick to keep smokers’ votes during the 2003 Election? I wouldn’t dream of accusing them of it

SUBMISSION BY MARK CADLE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill?

NO

If yes, why?
If not, why not?
The ban extends to far and removes people rights to choose, It should be limited to areas serving food and smoking at the bar where people are working, however an all out ban, due to the clear lack of true public consultation I strongly feel that this is an unjust approach.

SUBMISSION BY DAVID CATTANACH

As a long term smoker I feel I must submit my concerns about your proposals for an outright ban in all public places.

“For the sake of future generations who’ll be able to breath clean air” ….. Excuse me, but does this mean you will have to ban all cars….stop all planes from flying because they carpet bomb us with their spend fuel … close all nuclear reactors?
The list of killers on this Planet is endless… including Mother natures contributions. I find it hard to forget that our Government can foster exclusivity with such red herrings…..Join our caring club of subservient moralists and we will save the future for our children? This might be a valid argument in some fantasy novel; however we live in a world that sanctions bombs being dropped on Mothers and innocent children. The disappointing thing about the parliaments decision is that it merely distracts from more important issues… Where is the balance?

To conclude……If by some miracle everyone stops smoking, who are you going to tax next? What are you going to ban next?
I think you should have learned by now that it is not banning things that works but managing them.

SUBMISSION BY MARGARET ELLAM

Can I ask how many cases have come to the notice of the Police where someone who has had too many CIGARETTES has assaulted another person? I am disgusted with the Parliament's suggestion that smoking in public should be banned. "PRIORITIES". We are shown the amount of time and money spent by the Police, the Courts, the Hospitals, and other Emergency Services is down to alcohol related crime. Why don't we ban the intake of ALCOHOL in all public places and then we could cut all the related costs drastically. I might add that I smoke and drink, both in moderation, and I do not go out socialising very often, so the ban will not affect me very much, but I am sometimes terrified in my own house in the evenings when listening to the drunken ramblings of packs of revellers who have been drinking to excess. Maybe if the Police were able to get enough cash (or enough interest) we would feel safer in our homes. How many murders and assaults are committed by alcohol fuelled minds?

I really think it time the Parliament got the priorities sorted out and tackled the issues that your constituents are most concerned about - and I am sure that smoking in public places would be way down most people's list. Most of your constituents would, I am sure, be happier if our elected representatives carried out OUR wishes rather than your own. Is this not what an elected representative is supposed to do?

I live in a village in North Lanarkshire where every Friday and Saturday evening (without exception) between 20 and 40 drink fuelled youths roam, shouting and fighting and generally scaring all the residents sitting in their homes hoping that no one is killed or badly injured. I am also sure that this is not the only area where this is the case.

The Police do turn up when telephoned, but by that time the fracas is over and the youths have dispersed. If they do come immediately and the youths are still around, I have yet to see the officers get out of their vehicles and try to sort them out on foot. I can understand they might fear for their own safety, but that goes for everyone in the vicinity. Maybe if you gave the Police more resources, instead of wasting the cash on a smoking ban, there would be enough of them to make a significant difference to your constituents and the Police. Please take what I have said seriously, as the incidents are now seriously affecting all law-abiding people!!

SUBMISSION BY JOHN HEATHERILL

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

I have just come back from Dublin and I must say it was an absolute pleasure to go basically anywhere without ending up smelling stale and end up with a dry and irritated throat – food tasted better also. This is the best ever Bill to be put in place - congratulations.

My father died of lung cancer and it was a long painful process for him - I think anyone smoking in what should be our right for non polluted air, should give a thought for others. The strain on the health service due to smoking related problems is astronomical so it makes economical sense as well as from a societal health perspective.
Smoking at work is most annoying and difficult to control – nobody really makes up for smoke breaks and those who don’t smoke are then not treated the same i.e. non smokers are discriminated against as they have to keep working.

If not, why not?

Are there any other comments you would like to make?

Do not give in, in any way, shape or form – it will be difficult at first but through time, it will be fully accepted and nobody will look back on smoking days being “the good old days”

Great

SUBMISSION BY JOHN AND WINIFRED HUGHES

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

NO.

If not, why not?

The imposition of enforced bans - against the wishes of the people who have elected MP’s to represent their views - is completely undemocratic, and is an infringement of our basic rights to exercise freedom of personal choice.

Removal of those rights is a significant step towards the establishment of a dictatorship, and as such cannot and will not be tolerated by the British people.

Are there any other comments you would like to make?

The terms of the anti-smoking campaign, and those of the Bill itself, are based entirely upon severely flawed and biased evidence which is spurious at best, and indeed while many of the counter arguments are mentioned in the supporting documents, they are also completely ignored as if they are of no consequence.

The scientific “evidence” which is being used by the government, the media, and even healthcare professionals, has been selectively manipulated, and we are being assailed daily by propaganda which quite certainly – and demonstrably – does not reflect the true situation.

As a simple example, the public are being informed by our self-styled experts that “75% of the UK population do not smoke. Smokers are a minority group and so the ban is fully justified”.

This is so insulting to our intelligence, it defies belief. In terms of using these “statistics” to justify a ban, here is the reality of the position: {All figures are approximate, but fairly accurate according to government sources}.

Approximately 21 million are children under the ages of 16 and 18. The former group cannot legally buy cigarettes, and neither group can legally even BE in a pub, other than family pubs of course.

6 million are over the age of 70 – few from this group are still pub-goers at that age.

6 million are registered disabled – many of course do visit pubs like everyone else; however a significant number are in full-time care, and many either dislike, or are physically unable, to go out to pubs.
Over 2 million are forbidden by their religion to enter premises where alcohol is being sold.

Ignoring the many tens of thousands of other groups (such as long-term prisoners, etc), this yields a minimum figure of at least 23 million – from a population of under 59 million – who by definition cannot be classed as either smokers or pub-goers.

With 14 million smokers in the UK, this leaves only 22 million people who potentially “might” be non-smokers who object to smoking in pubs.

However, according to the polls, approximately 27% of non-smokers (roughly 5.9 million) would prefer to continue to have segregated smoking areas and improved ventilation. Even if we ignore any percentage at all from the 12 million disabled and over-70 groups, and others, this still clearly shows that the true figures are more in the order of 16 million non-smokers “versus” 14 million smokers.

The obvious ‘flaw’ here is that not all of these people will actually be pub-goers themselves; however it would be stretching our imagination to think that any smoker would vote for a ban whether they personally go to pubs or not. Of course some will, simply due to the overwhelming avalanche of misinformation which may have persuaded them that they really are in a socially unacceptable minority.

There is a wealth of scientific research which has shown repeatedly and consistently that the health implications of smoking have been vastly exaggerated and overstated, and yet this evidence is continually denied, disputed, and even ridiculed because it fails to accommodate political agendas.

Having said that, few people would suggest that smoking is actually good for you, and while the health risks are infinitely smaller and vastly less significant than with other environmental factors – such as car and industrial pollution – this debate actually has very little at all to do with smoking, or public health.

Non-smokers are already very well catered for in terms of no-smoking pubs, restaurants, taxis, buses, trains, airports, and other public places and buildings, and it is only fair, right, reasonable, and proper that they should continue to enjoy the right to smoke-free facilities. Nobody is disputing this right.

To deny those of us who choose to smoke a similar degree of choice however – and even in completely segregated areas – is again, simply a first step towards the imposition of a dictatorship which will subsequently move on to intrude in other areas of our lives.

People who are overweight should have particular cause for alarm, and yet (without wishing to wander off-topic, as this is also a very relevant point), the World Health Organisation have only just discovered that part of the reason we are currently seeing record levels of obesity, is because doctors have been using weight/growth charts for the last 40 years which are completely inaccurate.

They were constructed using government-approved data which, it turns out, were based on the wrong information, as they used statistics from groups of bottle-fed newborn babies instead of breast-fed children as we now know they should have been.

Smoking is in steady decline in most Western countries, and there is no evidence to suggest that it will not continue to do so. Hence there is no viable reason whatsoever for our elected representatives to be adopting such a draconian stance on an issue which will further alienate and penalise the most vulnerable and deprived sectors of our society.

It is certainly the remit of our government and public bodies to continue to advise and caution the public against the possible risks associated with smoking (and also drinking, and other far more socially debilitating activities); however – as will be clearly demonstrated in future elections, where our support will be given to any party who offer more democratic policies – this so-called initiative is crossing a line which has hugely wider implications for all of us.
All the darkness in the universe is not enough to extinguish the light from one small candle, or the
glow of a smoker’s cigarette, for that matter!

Please wield your political power wisely, and lastly – here is an analogy which I think is particularly
relevant:

“Most of us cannot imagine or visualise what “one million” of anything is. Let’s imagine then, what a
million Oxo cubes might look like – they’d probably completely fill a good-sized living room, yes?

In terms of the smoking debate, if ALL the smokers in North America were to continue to smoke for
20 years, they would produce one million tonnes of “toxic” waste substances, or – put another way
– one million Oxo cubes weighing one tonne each.

Meantime, cars in North America are producing 3.7 BILLION tonnes of exactly the same “toxic”
place not merely every 20 years, but EVERY SINGLE YEAR!!

That equates to 74 thousand million Oxo cubes, or 74 THOUSAND times as many cubes as
smokers produce in the same time period.

In reality then, our government is seriously proposing that by forcibly removing just ONE roomful of
Oxo cubes from a collection of 74 thousand, they will significantly improve public health.

Think about this for a moment – people who smoke 20 to 60 cigarettes per day may, or may not,
live well into their 40’s, 50’s, 60’s, or beyond.

People who run a hose from their car exhaust pipe into the passenger compartment and switch on
the ignition will be unconscious in under 90 seconds, and dead within minutes. So which is infinitely
the more lethal? But because car fumes are less visible than cigarette smoke, we delude ourselves
that car drivers are really OK – it’s not a big problem.

We’ll complain vehemently about someone who lights a cigarette in a bar, but are happy to inhale
traffic fumes, aerosols which smell nice, and ingest massive quantities of the SAME “toxic”
chemicals which are present in our food, water, milk, and bread as in cigarette smoke.

And while alcohol causes infinitely more social problems than cigarettes – for example violence,
vandalism, road accidents and traffic deaths, suicide, depression, personality disorders, physical
abuse of spouses and children and loss of employment, etc, not to mention liver, brain, and kidney
damage or the chronic burden on hospital and social services, somehow none of this is as big an
issue as smoking – even if smoking is strictly controlled by segregation and ventilation.

And yet are they similarly doing anything to restrict our drinking habits, or reduce the uncontrolled
growth of traffic on our roads? Or penalising industries which pollute the atmosphere to the order of
hundreds of thousands times more than smokers?

No, they’re not, and yet the overall result of all this collective pollution is that globally we are
irreversibly damaging the earth’s ozone layer – the one thing which protects us from the most
powerful carcinogenic agent in the universe, sunlight.

Priorities? You can count on your government to get it 100% wrong every single time”.

SUBMISSION BY LAURA LAMB

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? yes/no
If yes, why?

Absolutely yes. I am appalled that in my day to day life I am forced to put my life at risk on a daily basis from dangerous side stream smoke. It is almost unthinkable that there are no legal protections for non-smokers when the dangers of this are well known. There are countless pieces of research illustrating the dangers of passive smoking on people who can do very little to avoid inhaling it. It is not only cancer which is a problem, heart disease can also be caused by passive smoking in people who have never even had a cigarette in their mouth. How can any government let this happen? I also have a close friend who had an asthma attack last week while we sat in a café after someone started smoking beside her. What should non-smokers do? Stay at home? It is unacceptable. In view of Scotland’s ghastly state of health, which I have viewed first hand, as I am a registered nurse, please do the decent thing and make sure this bill is passed. There will be massive opposition to it, mainly from smokers! However, to protect people who choose not to smoke and who have no choice at the moment as regards inhaling smoke, it is the only option.


If not, why not?

Are there any other comments you would like to make?

To be honest, I don’t think that the proposals go far enough. I think that smoking should be banned in ALL public places. If people want to endanger their health in such a foolhardy way, they should do it out of the way of people who don’t so that they can’t be affected by it.

SUBMISSION BY COLLETTE LANDER

Main Objective: Prohibiting smoking in enclosed public places do you agree with the main objective of this part of the bill? NO If yes, why? If not, why not?

Total prohibition of smoking in enclosed spaces is unfair to those who have always enjoyed their freedom to smoke in places like bars and clubs.

Separate, enclosed, ventilated rooms would cater for those wishing to smoke, and would also afford a smoke free environment for those who do not smoke.

You work on the premise that all smokers wish to give up the habit but cannot, but this is simply not true.

There are many, like myself, who have smoked 10 cigarettes or less for all of their adult lives, and enjoy the habit, much as drinkers enjoy their drinks, but that does not automatically define them as alcoholics.

People who have had their smoking habits spiral out of control, or have health issues may wish to give up, just as an alcoholic might wish to, and of course they must be helped, but not at the expense of smokers like myself.

Would you ban drinking because some drinkers will inevitably become alcoholic?...

I feel that there is excessive spin at this point in time on smoking and health, when much of today’s poor health is due to environmental factors and sedantry lifestyles.
In the 60s and 70s when huge amounts of the population were smokers, there were fewer instances of asthma than there are now. Why should that be I wonder?...

Perhaps blaming it all on smoking will divert peoples' attentions away from the other, more pertinent causes?

If you carry on regardless of the smoking publics' opinion, what will be blamed next, when in 10 years time, you find that public health hasn't become significantly better?

People argue that as a smoker I may use up NHS resources as a result of my habit. Cigarettes carry a very high tax burden, so when you consider how much tax I have paid into government coffers, I'm sure you'll agree that my medical care will have been paid for in advance many times over.

Smoking, like drinking, can be very harmful when not taken in moderation, and especially when combined with a bad diet and lack of exercise.

Smokers also have the right to vote, and I am sure that an outright ban in Scotland will be reflect badly on Labour at the polling booths, but I guess the current government know this, which is why the prohibition is not scheduled until 2006.

If smoking is permitted in establishments with suitably equipped rooms, this would be to the benefit of public health, because the alternative under your proposals would be to smoke at home with friends, some of whom may be non-smokers. There would be little-to-no ventilation at home, so where do you imagine the non-smoking people would be better off socialising - at the well ventilated club, or their friend's home?

I have no objections to the creation of smoke-free environments, but let's use some common sense and logic, and improve conditions for everyone.

Not all smokers wish to give up. Help those who do wish to give up, but do not punish those who do not.

As adults we make our own lifestyle choices and take responsibility for the consequences.

I urge to consider less draconian legislation, and consider people like myself who wish to be able to enjoy a cigarette on a night out. If I can't smoke in a club, then I would rather stay at home than be forced to endure the ravages of the Scottish weather outside.

I can only hope that my feedback to your proposals will be considered with impartiality, when I suspect that my arguments are falling on deaf ears, but you asked for opinions and these are mine.

Regards,
Collette.

SUBMISSION BY KENNETH MACARTHUR

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? yes
If yes, why?
Smoking is an antisocial habit, which has both superficial and serious consequences for those exposed to it. People should only be allowed to do it in private areas.
SUBMISSION BY CHARLES MCCANN

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? NO

If yes, why?

If not, why not? I
It is an infringement on my civil rights to make my own choices. As I thought we live in a
democracy. It should be the landlord’s choice to whether or not they have smoking within their own
premises. The government has taxed smokers heavily over the years. What is next? You have
moved on to alcohol now trying to ban happy hours and to eradicate cheap alcohol. Will there be
any choices we make on our own in the future. This is how dictatorships begin.

SUBMISSION BY SHEILA MCQUEEN

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

I’ve just given up smoking – 3 weeks now, thanks to the help of my local medical centre. I’m
enjoying the advantages of having my senses of taste and smell returned, of not smelling like an
old ash tray, being able to breathe better, not being concerned as to when the next fag break is
due, not being a nuisance to other people, and all of this whilst saving money!!

I don’t want to go into pubs and restaurants – or anywhere – so that I can breathe someone else’s
fumes.

You have my full support.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY WENDY NGANASURIAN

Can I add my personal contribution to the mass of evidence that the committee will receive on this
issue. My childhood asthma was possibly re-kindled in adulthood through working in an extremely
smoke-filled environment as a nurse in the 1970s: namely, a psychiatric hospital where most of the
patients and many of the staff smoked almost continuously. I have found it impossible to eat in
certain places where the policy has either been to allow smoking or to allow it in so-called
designated areas which are as good as useless for preventing smoke moving throughout the area.
I never go into pubs which is a shame since although I’m not a big drinker it would be nice to have
the option of going in with friends when we are out for the day. Hotels, stations, airports all present
the same problem to an asthmatic who is hypersensitive to smoke since the smokers may be
confined but their smoke isn’t!
SUBMISSION BY ANDREW PEARSON

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes/no

If yes, why?

I believe it is the right of every person to breathe air which is as fresh and unpolluted as possible and in the context of enclosed public spaces this must include the absence of tobacco smoke.

In my experience areas of public spaces which are designated non smoking can still be affected by smoke from adjacent smoking areas even with ventilation systems in place. Therefore a total ban is what I would expect to be implemented.

Making it harder for people to smoke all the time may eventually lead to improved health for the Scottish population as more people quit.

If not, why not?

Are there any other comments you would like to make?

I do not trust any “evidence” supplied by the Tobacco industry. As the experience in the United States has proved they rely on misinformation to promote their case. Please visit this site: http://www.tobaccoscam.ucsf.edu/fake/index.cfm

I believe there are 3 groups who will have an effect on viability of commercial venues:
1. Pub & restaurant goers who are smokers
2. Pub & restaurant goers who are non-smokers
3. Non-smokers who currently avoid premises which allow smoking

Group 2 will continue to go to pubs etc, group 3 numbers will increase enormously as has been shown in the US. Group 1 may reduce in numbers but some, if not most, will still go and may smoke outside.

SUBMISSION BY ANDREW ROSE

Part of Bill: Part 1

Main Objective: Prohibiting smoking in enclosed public places

Do you agree with the main objective of this part of the bill? yes

If yes, why?

I welcome this part of the bill on a number of grounds.

• As a non-smoker, I don’t enjoy the smell or taste of second-hand smoke and as an asthma sufferer, I find the smoky environments cause me difficulty. The result is that I feel excluded from pubs and restaurants where smoking is permitted. Therefore, I welcome Part 1 of the bill as it will open up these places to me.
• I am fortunate to work in a smoke free environment. However, I don’t think it is reasonable for any employee to be subjected to a smoky environment. I welcome Part 1 because it will address this problem, at least in part.
• I am well aware of the negative impact that smoking has on the lives of many people in Scotland. I welcome Part 1 of the bill for the positive health implications that it has for Scotland.
Are there any other comments you would like to make?

I am disappointed that that the bill only makes it possible for vehicles, vessels, trains, etc. to be covered. I would like to see 4 (6) (b) reworded and moved to 4 (4) (e) so that such places are covered by default.

SUBMISSION BY MIKE THISTLE

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? NO
If yes, why?
If not, why not?
No objections to smoking bans in offices etc. but places of public entertainment should have both smoking and no smoking areas. Otherwise smokers are being effectively banned which is unfair. Alternatively, 50% of public houses could be smoking, or non-smoking, providing choice.

Are there any other comments you would like to make

SUBMISSION BY LOUISE WILSON

Part of Bill: Part 1
Main Objective: Prohibiting smoking in enclosed public places
Do you agree with the main objective of this part of the bill? yes
If yes, why?
Dangers of inhaling passive smoke are now well documented. Action needs to be taken to prevent passive smoking related health problems

PART 2: GENERAL DENTAL SERVICES, GENERAL OPHTHALMIC SERVICES AND PERSONAL DENTAL SERVICES

SUBMISSION BY MDDUS

I wish to make the following observations on the Dental Implications of the above Bill:

Dental Lists
1. The intention to expand the Dental Lists held by Health Boards to include the following is noted and endorsed.
Non-Principal Assistants.

Dental Bodies Corporate.

2. With regard to Dental Bodies Corporate, it is suggested that the Health Board record details of a "lead" dentist for the purposes of liaison at a local level.

Entry to, Control of and Operation of the Lists

1. The principle is accepted that the same jurisdiction in relation to Discipline Committees and the NHS Tribunal should include non-principals, but there is merit in giving further consideration to the implication of these proposals on the Vocational Dental Practitioner undergoing training in the Vocational Training Scheme.

Vocational Dental Practitioners are not truly independent Assistants and they are in fact employed by NHS Education Scotland. There is a high level of supervision and monitoring of clinical care and patient contact and it would therefore not be appropriate for such young and inexperienced practitioners to be deemed solely responsible for their clinical acts and omissions. Vocational Dental Practitioners should either be exempted from this process or alternatively special arrangements made to carry out a review within the Vocational Training Scheme.

2. With regard to the nature of the information to be provided by an applicant for inclusion on the Dental List, it is recommended that:

Specific guidance be given on the nature of the conviction and (particularly) non-conviction information to be provided.

That the relevance of this information be considered against stated criteria.

That all such information is circulated to the minimum number of people and is dealt with at the highest levels of confidentiality, particularly with regard to non-conviction information.

Discipline

1. Referral to NHS Tribunal
The NHS Tribunal no longer exists in England and Wales. No case has been made to justify the continued existence of the NHS Tribunal in Scotland.

2. Suspension by a Health Board (Local Suspension)

It may be appropriate, in certain unusual and rare circumstances, for a Health Board to have the power of local suspension, it would not be appropriate to suspend without good cause. The example quoted in the Policy Memorandum states that one circumstance for suspension would be "where there was suspicion of fraud being committed". Simple. "suspicion" is not in itself grounds for suspension, particularly with regard to allegations of fraud.

It is recommended that consideration be given to providing guidelines or criteria to govern the power of suspension by Health Boards. There is an equal obligation to protect the interests of the dental practitioner and the public and we have grave reservations about any power to suspend based upon "suspicion" or upon inadequate and incomplete information. Also there are no clear criteria establishing the mechanism by which this suspension can be undertaken. Before any such decision is made there must be a properly constituted review process from Non-Health Board sources.

The same conditions of entitlement to payment whilst suspended by the NHS Tribunal should apply to suspension by a Health Board.

Hugh Harvie
SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 2, sections 9-10
Main Objective: Free dental and eye tests

Do you agree with the main objective of this part of the bill? yes

If yes, why?
Given the rising incidence of oral cancer and Scotland’s poor dental health record we support Section 9 of the bill as a progressive means of improving oral and dental health in Scotland.

We also believe that the introduction of free eye examinations and sight tests will help to identify visual problems earlier which should help to reduce the number of serious sight problems experienced by people in Scotland in the long term.

If not, why not?

Are there any other comments you would like to make?
There are clearly workload and workforce planning issues to contend with in relation to this objective which we know the Committee is already well aware of following its recent Workforce Planning in NHS Scotland inquiry. While the problems relating to dental services are well documented, there are also nursing workforce issues connected to these sections. For example the number of clinical nurse specialists whose main area of work is ophthalmology in NHS Scotland currently stands at just 11.

Part of Bill: Part 2, sections 11-17
Main Objective: Changes to dental and ophthalmic services

Do you agree with the main objective of this part of the bill? yes

If yes, why?
We believe that the changes proposed in these sections will assist in developing access to appropriate dental and ophthalmic services in NHS Scotland. This is particularly important given the problems experienced by people in many parts of Scotland in accessing NHS dental services at present.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY WHICH?

Part of Bill: Part 2, sections 9-10
Main Objective: Free dental and eye tests

Do you agree with the main objective of this part of the bill? Yes

If yes, why?
We strongly support general moves to encourage preventive dentistry, which will be crucial to improving oral and dental health in Scotland. We welcome the Scottish Executive’s commitment to introduce free NHS dental checks by 2007 for all consumers. This will be important to encouraging
consumers to have regular dental check ups and seek on-going registration with a dentist, which is an essential part of a more preventive approach to dentistry and improving dental health. We do however wish to express concern that the dental examination will be thorough enough to provide a meaningful oral health check.

If not, why not?
Are there any other comments you would like to make?

Part of Bill: Part 2, sections 11-17
Main Objective: Changes to dental and ophthalmic services

Do you agree with the main objective of this part of the bill? Yes

If yes, why?
We consider significant reform is needed of the way dentistry is funded and paid for to promote improved access to NHS care and to ensure high quality care. Current arrangements do not support a modern approach to dental care and treatment, and act as disincentives for dentists to provide NHS care. Furthermore, the current system of patient dental charges act as a significant barrier to improving dental health in Scotland and ensuring that consumers get appropriate care and treatment.

New ways of remunerating dentists are needed that guarantee a minimum commitment to provide NHS care, using either sessional or block contract payments. We also consider that the remuneration system should provide incentives for preventative and high quality care and focus resources in areas of greatest need.

We also suggest that reform is needed to ensure that the NHS is able to adopt more rapidly new techniques and treatments of proven efficacy. We consider that any limits to the types of dental treatment available on the NHS should be determined by a systematic evaluation of the clinical efficacy of treatments that also incorporates consumers’ views as part of the process. This should be based on more than a rigid definition of what is needed to maintain oral health and dental fitness, and as such any treatments that have both clinical and cosmetic benefits are allowed if the dentist believes that they are necessary.

Urgent reform of the current system of patient charges for NHS dental care is needed. A simpler, more transparent and fairer charge regime is required to ensure that the cost of NHS dentistry (or the perception of its cost) does not act as a barrier to consumers, particularly those in greatest needs, seeking dental care. We suggest a simple three-band system of charges, with a much lower maximum charge than the current level, which should help to make dentistry more affordable. We also recommend a systematic review of the current groups of consumers that are exempt from dental charges.

Extent and nature of NHS dental services

Which? supports moves to adopt a more cohesive and integrated approach to primary care dental service provision. This is crucial to delivering high quality NHS dental services to all consumers that want and need them and to improving dental health across Scotland. We welcome moves to strengthen the local NHS Boards’ role in ensuring provision of dental services that meet local needs.

We recognise that new technology is bringing many changes to dentistry that can deliver significantly better outcomes for consumers. However, we are concerned that the NHS is often slow to adopt these changes and so the benefits of new treatments are often only available to those who are able or willing to pay for them privately. Abandoning the rigid fee for item of service remuneration for dentists should help to ensure that the NHS is able to adopt new treatments of proven efficacy more rapidly.

We accept that a balance has to be struck between allowing unrestricted adoption of new technologies and treatments, and ensuring that the costs of NHS dentistry do not escalate wildly. We support the systematic evaluation of new technologies in dentistry, as in other areas of health care, to ensure that treatments of proven efficacy are available on the NHS. However, we are concerned that this process can be slow and result in a significant time-lag in the adoption of new technologies by the NHS. Consideration should be given to how this process can be speeded up, and we strongly advocate that consumer views are an integral part of this process.
We acknowledge the debate about the availability of dental treatments which deliver primarily a cosmetic rather than therapeutic benefit. Some orthodontic care and treatments, such as crowns and bridges, may sometimes be judged as not strictly necessary to achieve oral health and dental fitness. However, Which? is concerned that a rigid approach that only allows the NHS to cover dental care and treatment to maintain oral health and dental fitness is overly restrictive and is a retrograde step. It treats dentistry differently from other types of health care, and ignores the important relationship between oral health and other elements of consumers’ health. Additionally, oral health and dental fitness are not states that can be rigidly and objectively defined, so such an approach is likely to result in significant differences of approach between dentists and therefore inequalities for consumers.

We are particularly concerned that too restrictive a definition of oral health and dental fitness may be used to justify exclusion of some treatments such as orthodontics, crowns and bridges. While these may have greater impact on the appearance of someone’s teeth rather than functionality or dental fitness, this can be a significant factor affecting their mental health and general well-being. Which? suggests that to exclude these treatments on the basis that they exceed what is needed to achieve oral health and dental fitness, is to treat dentistry differently from other aspects of health care such as treatment following accidents. It is also in danger of putting the quality of dental care available on the NHS back several decades and is significantly out of step with consumers’ expectations for modern dentistry.

Which? agrees that treatments which are of purely cosmetic value, such as tooth whitening, veneers etc, or are of unproven clinical efficacy should not be available on the NHS. However, there are many treatments that have both cosmetic and clinical benefits (not just dental health) that should be available on the NHS and open to dentists to prescribe them where they judge them necessary. We suggest that consumers should be actively involved in any definition of what treatments should be available on the NHS, particularly if it is to exclude treatments that are currently available.

On the balance between preventive and repair services, we suggest that the introduction of the Oral Health Assessment will help shift the balance towards a more preventative approach as will the introduction of free dental check ups. A key part of the regular dental check up should be advice on dental hygiene, tooth-brushing techniques etc. We advocate a much more proactive approach to encouraging better dental self-care through public information and education programmes aimed at children and adults, which should reap future benefits in terms of improved dental health. We also suggest that preventive treatments such as fissure sealing and topical fluoride that have clinical benefits should be offered as routine treatments on the NHS.

**The delivery of NHS services**

The current fee for item of service remuneration for dentists has been shown to be both complex and lacking in transparency. Consumers rarely know what treatment they can get under the NHS, and are often vulnerable to pressure from dentists to undertake treatment privately.

Dentists also cite this system as a major reason for switching from providing NHS to private care, which has resulted in thousands of consumers not having access to NHS dentistry when they want and need it. Moving away from this approach will not only prove popular with dentists, it should also lead to consumers having greater access to NHS dentistry and a clearer understanding of what treatment they are entitled to. Which? would therefore support the introduction of alternative ways of remunerating dentists for providing NHS care.

On balance, our preferred option for funding NHS dental services is sessional or block contract payments for dentists rather than item of service payments or capitation only. This should provide greater clarity and certainty for dentists about their levels of income from NHS dentistry, and encourage greater commitment to provision of NHS care, as well as greater focus on preventative dentistry.

While there are some merits in funding services on the basis of capitation, we do not support adoption of this on its own. If adopted, a capitation system would operate best combined with a simplified scale of fees related to the level and type of treatment provided.
Which? supports introduction of payments to promote better quality care, improved facilities and equipment, and to encourage dentists to provide services in areas of greatest need or which face the greatest shortages of NHS dental care. This is a key part of bringing dentistry into the twenty-first century. The future focus of funding should be on the dental practice rather than the individual dentist, which would support a more team-based approach to dentistry and recognise that in individual practices, certain dentists may specialise in providing particular types of treatment. Whatever methods of funding are introduced, we strongly suggest that these should be related to a minimum level of commitment to provide NHS care that is properly audited to prevent abuses of the system.

**Patient Charges**

The current regime for patient dental charges is extremely complex and grossly opaque for consumers. The actual level of charges that patients pay can be very high (80% of the cost of treatment up to a maximum of £378 for a course of treatment). Research from Citizen’s Advice (formerly NACAB) shows that dental charges act as a major barrier to many consumers receiving care and treatment.

The burden of charges falls hardest on those with the greatest needs, and for those on low incomes, the current charge regime represents a very real burden and disincentive to seeking treatment. This is particularly concerning given the close correlation between poor dental health and socio-economic status. Which? has argued previously that there is no real rationale why charges exist for dental care but not for other types of health care. There is very little difference for the consumer between the pain and health implications of an ear infection and those of a dental infection, but for one there is no charge to see the health care professional but for the other there is.

The discrepancy between dentistry and other aspects of health care in the NHS is further illustrated by the differences in the categories of patient that are exempt from charges. Some groups, such as children and women who are pregnant or within a year of having had a baby, are exempt from charges for both dentistry and prescriptions, but others, such as older people, are exempt from prescription but not dental charges. Additionally, for dental charges there are no categories of exemption that relate to clinical need or risk. Additionally, the low income rules are complex and opaque, such that many consumers do not know whether or not they are exempt from charges. Which? recommends that there should be a systematic review of the exemption categories for dental charges to ensure that charges do not act as a barrier to consumers with low incomes or significant dental health needs. There is some merit in completely abolishing patient charges for NHS dental care, but we recognise that the cost of this must be considered in the wider framework of all health priorities and needs. However, Which? considers that the basis for considering future systems of patient charges is that they should continue to generate a comparable level of income as is raised currently by patient charges. However, there is considerable uncertainty about the future levels of demand for and provision of NHS dental services, what it will cost and at what levels charges should be set. It is crucial that the Executive undertake some modelling to establish the cost implications of the different scenarios for patient charges and assesses that benefits and costs that may accrue not only in terms of the costs to the Executive but also their likely impact on dental health in Scotland. Which? suggests that any new system of charges should be based on the following principles:

- **Transparency and simplicity**, particularly to clarify the distinction between NHS and private care
- **Consistent and fair**
- **Affordability**, particularly for those on low incomes and with the greatest clinical need, such that charges do not act as a barrier to care
- **Supportive of preventive care**
- **Easy to administer**, including arrangements for paying for emergency treatment
- **Easy for patients to understand**

A major objective of the review of dental charges should also be to radically reduce the maximum amount that anyone has to pay for a course of treatment. Although only a few people pay the maximum charge, it acts as a major psychological barrier to consumers seeking treatment because of concerns about what treatment might cost. Which? suggests that it should be possible to
achieve a significant reduction in the maximum level of dental patient charges with a minor redistribution of charges at the lower levels.

Which? finds little merit in other suggestions for a new system of patient charges. A system of single, simple charges for specific procedures will be easy to understand and administer, but it will still mean that those with the greatest needs will pay the most charges. A fixed charge related to the length of time in the practice, will favour those who have been able to secure on-going registration with an NHS dentist and penalise those who are mobile or only seek dental care on an occasional basis, for whatever reason. Similarly, changes to the percentage or type of treatment depending on the nature of the service or the patient’s characteristics, will not bring greater clarity and transparency for consumers but will make the system more complex for dentists to administer. Which? considers that there should not be separate payment arrangements for dental appliances as these should be regarded as an integral part of the treatment plan. For people with particularly poor dental health, dentures are essential to enabling them to function as ordinary members of society. This would result in a major discrepancy between consumers needing this type of care and those requiring other prostheses for other types of health care.

While an insurance type system will enable consumers to make small regular payments to cover the cost of dental treatment, this will not work well for consumers who do not regularly seek dental care or who are unable to register with a dentist for on-going care. There may also be problems for consumers transferring between dentists, or who have to have emergency treatment. Which? is also very concerned that under this approach, what consumers would be expected to pay should be based on their status or dental health. We suggest that this would be complex to administer, lack transparency for consumers and potentially penalise those with the greatest needs or the most marginal groups.

Which? suggests that a simple banding system for dental charges which is related to the level of intervention and the complexity of treatment undertaken would most closely accord with the principles we have outlined above. A system of three or four bands would provide consumers with a clear indication of what they would have to pay. Much will depend on how the bands are determined and at what levels they are set. However, through detailed analysis of the charges consumers currently pay and modelling of different band levels, it will be possible to ensure bands are set at levels where some consumers continue to pay similar levels of charges to those they pay at present, but those with the greatest needs pay significantly less. We understand that the Department of Health has undertaken such modelling as part of their consideration of the new charge regime for England. We commend this approach to the Executive.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY ANDREW ROSE

Part of Bill: Part 2, sections 9-10

Main Objective: Free dental and eye tests

Do you agree with the main objective of this part of the bill? yes

If yes, why?

Dental and eye tests have significant preventative value in terms of related health problems. Particularly in the case of dentistry, those who cannot afford regular check-ups are often those who most need them. By making dental and eye tests free, this bill will help to alleviate suffering and may prevent the need for expensive treatment for more developed problems by early intervention.
Are there any other comments you would like to make?

As a tax payer I suspect this will have financial implications. However, I remain in favour of these sections of the bill despite any such implications.

In some (many?) areas, it is already difficult to find dental practises that are willing to take on NHS patients. Section 9 is likely to increase the number of dental appointments required, thus stretching the existing services even further. Without legislation to limit private dental practise or to recruit more dentists, it would seem difficult to implement section 9.

**PART 3 : PHARMACEUTICAL CARE SERVICES ETC**

**SUBMISSION BY BMA**

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

Introduction

The BMA supports the introduction of modern contracts for NHS professions to ensure the evolution of the provision of health services to meet the changing needs of the people of Scotland. However under proposals outlined in Part 3 – Pharmaceutical Care Services, the BMA is concerned about the impact this may have on dispensing doctors in Scotland.

Background - Dispensing Doctors

Dispensing doctors are a small group of doctors who provide pharmacy dispensing services within the practice in small communities who would not otherwise have access to a local community pharmacy.

There are currently 276 dispensing doctors in Scotland, an increase on previous years. This group of doctors dispense to 176,000 patients and provide care for 275,000 patients in total. Dispensing doctor practices exist in those areas of Scotland where the population density is too low to support a pharmacy. Therefore they are prevalent in more remote and rural communities.

However, it is also the case that in these small communities, the provision of medical services is only economically viable because of the dispensing income generated for GP practices.

Pharmaceutical Care Services

Section 2CB places a responsibility on Health Boards to secure pharmaceutical care services for their local communities based on local need. This seems to suggest that NHS Boards would be able to subsidise pharmacists in order to secure pharmaceutical services in areas that are currently serviced by a dispensing doctor.

The BMA does not oppose this principle and recognises the advantages of improving access to pharmaceutical care services, but this should not be at the expense of the provision of general medical services in these communities.

NHS Boards are required to provide for a range of primary care services to their local populations. Under the current drafting of this legislation, it would seem to conclude that when a plan for pharmaceutical care services is under consideration, a pharmacy contract should be entered into in any area where pharmaceutical care services are not provided if there is a contractor willing to provide it. There is a very real concern amongst dispensing doctors that the impact on the provision of medical services will not be considered when NHS Boards are considering entering into new contracts for pharmaceutical care services.
It is essential that drafting of this primary legislation reflects the requirement for NHS Boards to consider the impact that entering into a pharmaceutical care contract in these communities will have on the provision of general medical services to the local population.

For More Information Contact:

Gail Grant

SUBMISSION BY LLOYDSPHARMACY

Part of Bill: Part 3
Main Objective: Giving health boards responsibility and powers to provide pharmacy services

Do you agree with the main objective of this part of the bill? Yes

If yes, why?

- Lloydspharmacy supports the proposed legislative changes giving Health Boards new powers and responsibilities for pharmacy services, as it will set a framework for the implementation of a new contract for providers of pharmaceutical care services.

- Lloydspharmacy supports a more proactive strategic approach to service planning and delivery by Health Boards for the provision of appropriate pharmaceutical care services. We trust the strong opposition to “Holding Contract” expressed during the consultation has been reflected, as we believe this would lead to instability of the community pharmacy network.

- We agree with the principle of extending the Pharmaceutical list to include non principals as this will strengthen clinical governance and quality assurance of service delivery. We support and understand the need for pharmacists to be on Health Board’s list to provide pharmaceutical services. We are concerned that the mechanism for maintaining accurate lists works effectively, especially across Health Board boundaries.

- Lloydspharmacy understand and support the need for pharmaceutical care services contracts to be negotiated and agreed locally, but strongly supports the Scottish Executive’s intention to have a degree of uniformity across all health boards to reflect the fact that the new contract has been agreed at a national level.

If not, why not?

Are there any other comments you would like to make?

- Lloydspharmacy would welcome the opportunity to contribute further to the draft Bill as it progresses through the legislative process.

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 3
Main Objective: Giving health boards responsibility and powers to provide pharmacy services

Do you agree with the main objective of this part of the bill? yes

If yes, why?
Because we believe that pharmacy services are an essential community health service and should be properly provide for locally and this new power and responsibility will help to ensure that this happens.

If not, why not?

Are there any other comments you would like to make?

SUBMISSION BY ELIZABETH CALDER

The Ileostomy Association has drawn my attention to certain proposals in the above Bill and I would like to comment as follows.

1 Appliances are to be delivered exclusively by community pharmacists. Will this outlaw specialist firms like Allardyce in York Place. What happens where there is no community pharmacy or the community pharmacist does not want this new role?

2 NHS Boards are expected to ensure that the existing patients continue with their current appliance. Could I therefore be forced to change from my present, suitable appliance.? Will I still be able to receive the appliances I need, or will limits be placed on frequency of prescriptions and/or the number of appliance which can be prescribed at one time?

3 NHS Boards will be free to transfer to NHS employment stoma care nurses currently on contract sponsored by appliance makers. These nurses are sponsored by appliance makers because the NHS could not afford them. Will this service therefore disappear.

I hope you will bear these questions in mind when this Bill is debated, so that patients are not disadvantaged.

SUBMISSION BY FRANCIS FLYNN

APPLIANCE CONTRACTORS -FUTURE ARRANGEMENTS

I have received a copy of a letter written by Hamish Wilson, Head of Primary Care, concerning proposed changes in the way that ostomy equipment will be made available to those requiring it. Apparently the Executive hope to implement the new arrangements from April 2006, This is dependent on the progress of the new Pharmaceutical Care Service provision within the Smoking, Health and Social Care (Scotland) Bill.

As far as I can ascertain the proposed changes will involve the outlawing of agency arrangements, i.e. Appliance Contractors will no longer be allowed to supply ostomy equipment directly to a patient on presentation of a prescription. Instead, ostomists will be required to get their equipment from either community pharmacists who might be willing to provide the service or from a locally contracted service which would be staffed by NHS Board employees. As an ileostomist I find the proposed changes, within such a short timescale, most alarming. I, like many other ostomists, do not use off-the-shelf equipment. The appliance supplier that I use tailor-makes the flange part of my ileostomy bag to fit my stoma size. This involves cutting part of the flange so that it fits neatly around my stoma and so help to cut down problems associated with leakage and excoriated skin. A badly fitting appliance can be the cause of both leakage of faeces and excoriation of the skin. Apart from being both unpleasant and embarrassing these conditions can cause patients to develop psychological problems such as low self esteem and cause them to be effectively housebound out of fear of leakage from their appliance. In extreme cases a badly fitting appliance can result in the patient requiring further surgery. In addition to the above, many older ostomists suffer from arthritic and/or rheumatic conditions that mean they are unable to cut their flanges themselves and depend on this service being provided by the equipment supplier. Also, most
suppliers of ostomy equipment provide a free delivery service - a service that is extremely beneficial to the elderly and infirm.

I have spoken to our local community pharmacists and community nurses regarding the proposed changes. Neither was aware of these proposed changes and they expressed some concern about being able to provide a service comparable to the one that we enjoy at present.

Apparently one of the reasons for introducing the proposed changes is due to concern over the impartiality of the company-sponsored stoma nurses who work in hospital. I have checked with a number of the NHS funded stoma care nurses who work alongside the company-sponsored nurses and they all claim that the company nurses show no bias towards their own equipment - they all supply the best appliance for the particular patient. There is also the suggestion from the Executive that these sponsored nurses may be offered employment by the NHS. I find this very hard to believe - these nurses are in post because the NHS cannot afford to employ them and, as far as I am aware, most Health Boards spend over their budget at present.

All in all, I fear that the proposed changes to the Pharmaceutical Care Service provision within the Smoking, Health and Social Care (Scotland) Bill will result in a deterioration of the service that we ostomists enjoy at the present. I hope that you will be able to oppose these particular changes.

Francis P Flynn

**PART 4 : DISCIPLINE**

**SUBMISSION BY SCOTTISH NHS CONFEDERATION**

Smoking, Health and Social Care Bill: Part 4 – Discipline

I am grateful for the Committee’s invitation to the Scottish NHS Confederation to give oral evidence on part 4 of the Smoking, Health and Social Care Bill. On this occasion, however, we have indicated to the clerks that we felt that, as our evidence would be likely to be very brief, it would be more appropriate for us to provide it to you and the committee’s members in written form, rather than take up time that could be used by witnesses with more to contribute. We would of course be more than willing to elaborate further on the points that we outline below if any of the committee’s members wish us to do so. We have taken up the Committee’s invitation to give oral evidence on part 5, section 31 of the bill, on Joint Ventures, as this is a more complex issue.

The Scottish NHS Confederation is the independent representative body for Scotland’s NHS boards and special health boards. We fully support the bill’s provisions to strengthen the grounds and procedures for the discipline of Family Health Service Practitioners (FHSPs). We believe that these are sensible and logical changes which are necessary both to strengthen the protection of patients across Scotland and to meet the expectations of the public. The need for these changes has obviously been particularly highlighted by the Shipman case, but we believe that they are also necessary and useful in their own right. We believe that they provide clarity and fairness for practitioners and will strengthen the ability of NHS organisations both to ensure patient safety and protect the public purse.

Although there is an expectation that the annual number of local suspensions and/or referrals to the NHS Tribunal may rise slightly, mainly on the grounds of fraud, we do not believe that this rise will be so great that it will cause any significant administrative or financial burden to NHS boards. We accept that the wording of the new grounds for disqualification (“professional or personal conduct”) and suspension (“otherwise in the public interest”) may appear, on the face of the legislation, to be broad and potentially open to interpretation. However, we believe that this can easily be remedied through guidance and regulations, to ensure that these terms are understood and applied consistently by all NHS Scotland organisations.
Finally, we would point out that, although we fully support the requirement for FHSPs to provide additional information in order to be entered on to NHS board lists, this will require efficient cooperation with and timely action by Disclosure Scotland to ensure that the ability of FHSPs to practice is not delayed or hampered in any way.

Once again, we would be happy to clarify or add to any of these points or others which committee members may wish to ask us.

Susan Aitken
Policy Manager

PART 5: MISCELLANEOUS

Section 24: Payment to certain persons infected with hepatitis C as a result of NHS Treatment

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 24
Main Objective: Providing legal basis for making payments to Hepatitis C sufferers
Do you agree with the main objective of this part of the bill? yes
If yes, why?
An RCN Scotland representative was a member of the Expert Group chaired by Lord Ross which considered this issue. RCN Scotland is very supportive of such a scheme being introduced. However, we share the frustration of those people infected with Hepatitis C and their families at the delays and injustices which continue in their fight for the truth and adequate compensatory payments.
If not, why not?
Are there any other comments you would like to make?
RCN Scotland believes that the scheme should pay out at least as much as (allowing for inflation) the compensation paid to those who took proceedings under the Sale of Goods Act. We are also concerned that the Committee consider, and take evidence on the Clause 24 (1) (c) “did not die before 29th August 2003,” and whether this cut off date disadvantages families and partners who have had no access to compensatory payments from any fund or legal process.

Independent health care service

Section 25: Amendment of Regulation of Care (Scotland) Act

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, sections 25-26
Main Objective: Restricting definition of independent health care services + representations and right of appeal to Care Commission
Do you agree with the main objective of this part of the bill?
If yes, why?
If not, why not?
Are there any other comments you would like to make?
Section 25 provides that Ministers can except from the regulatory regime of the Care Commission those providers of independent health services by way of secondary legislation. This would mean that at the discretion of Ministers, they can remove certain providers of independent health services from the standards, inspection, and licensing of the Care Commission. The policy reason for this is set out in the policy memorandum at para 121.

The scope of the legislation currently goes further than the original policy intention. As it stands, once section 2(5) of the 2001 Act is fully commenced, the Care Commission's regulatory powers would encompass a wider area of the independent health care sector than that originally envisaged. For example, the Care Commission would be responsible for regulating services from a doctor or dentist provided under arrangements by a third party such as occupational health services or medical consultations and examinations for insurance companies. Any private services being provided by NHS general practitioners would also be covered by the current definition.

The changes to the 2001 Act are all technical and consultation was not considered to be necessary. The Care Commission and the Council are aware of, and support, the proposed changes to the 2001 Act. In relation to the change to section 2(5) of the 2001 Act the policy intention is that, prior to making regulations, consultation will be carried out on which, if any, services should be excepted from the definition of an independent healthcare service before these provisions are commenced. RCN Scotland would wish to be part of any consultation process.

RCN Scotland is unclear of the impact of these legislative changes and the accompanying policy memorandum gives little supportive information. It is unclear why the Care Commission, in implementing the broad principles of the original Act, would wish not to regulate indirect medical service provision. RCN Scotland would want to see that the public was safeguarded via a regulation process for the services outlined. The policy memorandum describes more about the desire of the Commission not to do something that the protection of the public duty for which they were established.

We have no comment to make on Section 26.

Section 27: Provision of information to the Scottish Social Services

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 27

Main Objective: Notifying Social Services Council of social workers misconduct

Do you agree with the main objective of this part of the bill? yes

If yes, why?

If not, why not?

Are there any other comments you would like to make?

Again, while acknowledging the need for this additional duty it is not clear what will happen to individuals not regulated by the Scottish Social Services Council (SSSC) but working within a registered service and thereby a social service worker. For example will a registered nurse or AHP be notified to the SSSC and if so for what reason? Would reciprocal arrangements not be needed within the Nursing and Midwifery Council (NMC), General Medical Council (GMC) and Health Professionals Council (HPC) etc? How would those who have been the subject of such a notification themselves be notified and have their rights protected? Again any notification to the NMC would need to be on the basis of a complaint which is shared with the individual and subject to statutory processes and rights of appeal. Equally notification onto the Vulnerable Adults List or similar for the protection of children includes rights and appeal mechanisms for the individual.
In short para 57A would require employers to notify the Council in circumstances where misconduct may have taken place but may not, and has not been investigated. Further the links to other regulatory bodies is not set out.

We believe that para 57B appears to be a reasonable duty.

Section 30: Authorisation of medical treatment

SUBMISSION BY BRITISH DENTAL ASSOCIATION

Part of Bill: Part 5, section 30
Main Objective: Easing authorisation of medical treatment for adults with mental incapacities.

Do you agree with the main objective of this part of the bill? Yes

The legislation to allow a dental practitioner to sign and issue a certificate under Section 47 of the Adults with Incapacity (Scotland) Act 2000 within his or her own professional area will facilitate the care of adults with incapacity, particularly when emergency relief of dental and oral pain and discomfort is required. Under the existing act, delays often occur in the treatment of patients suffering from dental pain whilst a Certificate of Incapacity is being sought.

In addition, the dental practitioner skilled and experienced in the care of patients with special needs may well have more understanding of the procedures and the ability to assess a patient’s capacity for consenting to specifically dental treatment than a medical practitioner.

Are there any other comments you would like to make?
No

SUBMISSION BY BMA SCOTLAND

Part 5: Authorisation of medical treatment

The BMA in Scotland represents doctors from all branches of medicine. It is a registered trade union and a voluntary association with more than 80% of practicing doctors in membership. The BMA represents over 13,000 doctors in Scotland and in the UK has a total membership of around 130,000.

The BMA would only wish to comment on the section of Part 5 of the Smoking, Health and Social Care (Scotland) Bill which relates to the authorisation of medical treatment (section 30) under the Adults with Incapacity (Scotland) Act 2000.

Authorisation of medical treatment

The BMA welcomes the protection afforded to the rights of vulnerable adults as outlined in the Adults with Incapacity (Scotland) Act 2000 and we continue to support the principles underpinning this legislation.

However, since the implementation of Part 5 (medical treatment) of the Act in 2002, the BMA has held concerns over certain practical aspects of the Act. Our concerns centred on the additional administrative burden and workload which have arisen as a result of the legislation and the constraints of the Act which, in our view, has not been to the overall benefit of patients.
The BMA welcomes proposals in the Bill to extend authority to grant a certificate under section 47(1) to health professionals who have relevant qualifications and training to assess the capacity of adults. Currently the Adults with Incapacity Act limits responsibility for the assessment of incapacity to medical practitioners only. The BMA believes this to be inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialist nurses and clinical psychologists.

The BMA is concerned about issues raised by the Health Committee during its early discussions on this Bill (11 January 2005). Extending the ability for other health professionals to issue certificates will not remove overall responsibility for the care of patients from the general practitioner or other doctor, rather it is intended that this amendment would prevent unnecessary delay and discomfort for patients requiring treatment. GPs would continue to issue certificates of incapacity for general authority to treat, but it would no longer be necessary for doctors to issue certificates for treatments provided by independent health professionals.

Many healthcare professionals, other than medical practitioners, have specific training and expertise in dealing with incapable adults and are in a position to judge an adult’s capacity for making decisions regarding treatment. In addition, doctors may not understand specific (e.g. dental) treatments in any detail and would therefore not be best placed to judge the capacity needed in those circumstances.

The broad definition of ‘medical treatment’ in the Adults with Incapacity Act potentially limits the access of incapacitated adults to routine treatment without formal assessment. Subsection (2)(b) lists those persons who will be able to issue a certificate, but only in respect of their own area of clinical practice. Care must be taken to ensure that terms such as dental treatment or nursing treatment are not interpreted narrowly. The essential requirement is that the practitioner doing the assessment is capable of assessing capacity and forming a view on the likely benefit to the adult of the treatment proposed.

The BMA acknowledges that the list of those persons who will be able to issue a certificate can be amended by regulations subject to consultation. The BMA would recommend that clinical psychologists be added to this list.

Duration of certificates

Certificates of incapacity giving the general authority to treat under section 47 of the Adults with Incapacity Act are currently valid for a maximum of one year. However, certificates issued for the purposes of other parts of the Act are valid for up to three years. The code of practice explicitly states that should the adult’s condition improve so that they regain capacity, a certificate should be annulled, regardless of its duration. There will be patients, for example those with severe learning disabilities and progressive dementia, for whom recovery is presently impossible. For these adults, an annual assessment, for the purposes of issuing a certificate is a solely bureaucratic exercise. Extension of the certificate for up to three years would be a sensible measure and reduce unnecessary bureaucracy.

Summary

The BMA welcomes the changes proposed in Part 5 of the Smoking, Health and Social Care (Scotland) Bill that amend the Adults with Incapacity (Scotland) Act 2000.

These changes will improve access to appropriate health care for incapacitated and will remove some of the bureaucracy that has resulted from the introduction of the legislation.

SUBMISSION FROM CHARTERED SOCIETY OF PHYSIOTHERAPY SCOTLAND

The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing physiotherapists, physiotherapy students and assistants. More than 98% of all
Physiotherapists in Scotland are members of CSP Scotland and physiotherapy is the fourth largest health care profession in the UK, and the largest of the allied health professions.

CSP Scotland has around 4,000 members in Scotland. Approximately sixty percent of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and with other employers, such as sports clubs or large businesses. Three Scottish universities offer degrees in physiotherapy. These are among the most over-subscribed university courses in the country. Approximately 150 newly qualified physiotherapists graduate in Scotland each year.

Physiotherapy involves the skilled use of physical interventions to promote, maintain and restore physical, psychological and social well being. Using problem solving and clinical reasoning, physiotherapists work to restore functional movement or reduce impairment utilising movement, exercise and the application of electro-physical modalities.

Part 5 Miscellaneous
Authorisation of medical treatment
30 Amendment of Adults with Incapacity Act (Scotland) 2000
The ‘Adults with Incapacity Act’ Part - Medical Treatment balances the need for timely intervention of treatment or therapy with the need to ensure that consent for any procedure is obtained. The Act is governed by regulations which determine this balance.

CSP Scotland has contributed to the Scottish Executive review of this part of the Act and is not opposed to the proposed amendments to the legislation. Nevertheless, CSP Scotland would make the following points concerning future regulations regarding treatment.
CSP Scotland would urge the importance of chartered physiotherapists to be included in the group of other health professionals to be prescribed by Scottish Ministers who should have access to training to assess the capacity of patients. The success of this extension to other health professionals in addition to ‘registered medical practitioners’ will depend greatly on the level and nature of qualifications and training envisaged.

Physiotherapists treat patients within the definition of adults with incapacity in both acute and primary care settings, and in the private sector. Working autonomously with patients of all ages and with a wide spectrum of conditions across physical and mental health. Physiotherapy may involve various procedures, including electrotherapy in the treatment of pain relief, respiratory care and restoration of function.

Some physiotherapists, in particular those working in rural isolation, may seek to access training to assess the capacity of patients. These professionals should not be excluded by omission from exclusive regulations. CSP Scotland would urge the Health Committee to impress on the Scottish Executive the need to ensure that future regulations do not prevent physiotherapists from gaining the necessary qualifications for those that wish to train in assessment of capacity.

The issue of appropriate qualifications and training is crucial to protecting the interests of patients and CSP Scotland would qualify its support until more information is available on the provision of training. In particular, who will provide training, what will be the level and nature of training and how professionals will access training are crucial to the success of this change.

CSP Scotland would broadly support the increase in the maximum duration of a certificate of incapacity to three years, dependent on the nature of incapacity. However this should be restricted to cases where there is little or no prospect of capacity being regained.

Conclusion
Chartered Society of Physiotherapy Scotland takes an active interest in the above legislative measures. Health promotion and safe effective practice are essential to the physiotherapy profession, and CSP Scotland is committed to patient centred services and continual measures to improve patient care.

CSP Scotland is also interested to learn more detail on the nature of training to be offered to health professionals to assess the capacity of patients.
SUBMISSION FROM THE LAW SOCIETY OF SCOTLAND

Section 30 Amendment of Adults with Incapacity (Scotland) Act 2000

The Mental Health and Disability Sub-Committee of the Law Society of Scotland welcomes the opportunity to submit written evidence on this Bill and has the following comments to offer:

The Sub-Committee agrees that it should be possible for healthcare professionals, other than doctors, to issue certificates of capacity. However, in the view of the Sub-Committee, it is essential that anyone certifying should demonstrably have appropriate expertise in the assessment of capacity as well as expertise in relation to the proposed medical treatment. Accordingly, the Sub-Committee suggests that the professional must obtain a qualification in such assessments. The Bill should therefore include this requirement.

The Sub-Committee has also been sent a copy of the additional briefings sent to the Health Committee by the Scottish Executive and notes that the briefings do not acknowledge the authority that the Adults with Incapacity (Scotland) Act 2000 gives to attorneys, guardians and persons authorised under intervention orders. For example, an attorney or a guardian may have the power to consent to medical treatment. If the scope of certification is to be widened, then it is important that the relevant professionals are advised of this authority. This must be on the basis that appropriate and accurate guidance will be issued.

I hope the foregoing comments are useful to the Committee.

Yours sincerely

Stuart Drummond
LAW REFORM OFFICER

Section 31: Joint Ventures

SUBMISSION BY PARTNERSHIPS UK

Joint Ventures and Investment in Scotland's Primary Health and Social Care Estate

1. Public Bodies and Joint Ventures

Joint ventures (JVs) between the public and private sector are becoming increasingly common. Typically, they are seen as an appropriate way for two or more parties to work together where each has complementary (but not necessarily identical) objectives and where each party has a contribution to make, but where that contribution is likely to be more effectively deployed if pooled. Equally, a JV may provide a more effective way of sharing the risks and rewards of certain actions where these are initially difficult to determine.

JVs are often seen in circumstances where change is unavoidable and where required outcomes are easy to determine, but the way in which the outcomes are best achieved is uncertain. By contrast, if the way in which two or more parties can make distinct contributions to the achievement of required outcomes is quite certain, then more straightforward contractual arrangements are preferable. Most of the commercial dealings between the public and private sector fall into this second category.

The Lift initiative in England has proceeded on the basis of a corporate JV model. JVs are introduced at both the national level (i.e. PfH is itself a JV between the Department of Health (DoH) and PUK) and at the local level (the "local LiftCo" is a JV between local public bodies, PfH and the private sector). The principal reasons that the JV model was adopted for Lift were:
At a national level, the DoH and PUK possessed different but complementary skills both of which were judged necessary to make the Lift initiative work but the product of this joint endeavour was impossible to predict for some time and required investment by both to ascertain.

At a local level, the outcomes being pursued are being achieved over an elongated period of time, they are likely to change over this period of time, they will require parties to respond flexibly and these circumstances will inevitably mean that the risks and rewards of the partners are impossible to define precisely at the outset.

A JV itself can take two principal forms. Perhaps the most common is the corporate JV. In this arrangement, the parties to the JV set up a separate company (JV Co) in which they own pre-agreed proportions of shares. As a company, JV Co is not set up for a pre-set period of time. Once JV Co is judged to have completed its work, shareholders simply implement well-understood winding-up procedures.

The relationship of the parties to JV Co is regulated principally by a Shareholders' Agreement. JV Co has a separate legal personality to and runs independently of its shareholders, although obviously significant influence can be brought to bear through rights and obligations (for example, to appoint directors to the Board of JV Co) established in the Shareholders Agreement and in the Companies Acts.

JV Co can own and deal in assets and it can employ people and enter into other contracts in its own right. A skilled independent management team can be put in place, staff can be incentivised to succeed and administrative processes that reflect the size and complexity of the business can be introduced. JV Co can therefore, be extremely flexible. However, this flexibility needs to be balanced against issues such as directors' liabilities, insolvency legislation and wider implications for public sector bodies such as public accountability, ministerial responsibilities and audit requirements.

Although they need to be dealt with properly and professionally, such matters have not proved to be a major impediment to public bodies establishing JV COSo The Lift initiative has required public servants to recognise when their responsibilities qua public servant or qua PfH company director (with fiduciary duties to shareholders) take precedence. At a local level where, in the Lift initiative, the public sector shareholding is in a minority, certain matters have been dealt with as special rights accruing only to public sector shareholders. Directors' personal liabilities that may arise under the Companies Acts are typically covered by professional indemnity insurance and insolvency law acts both to police and to protect the actions of directors of troubled enterprises.

Although rarer, it is also possible to establish a contractual rather than a corporate JV. Contractual JVs confer defined rights and obligations on the contracting parties. The contracting parties exercise their rights through direct participation in the activities of the JV (typically through membership of a JV Project Board).

The contractual JV tends to deal less efficiently first, with conflicts between the contracting parties (contract termination being the typical solution) and second, with issues that arise from time to time upon which one or both JV parties are unsighted. As such, they tend to be used a) where there is more certainty over the roles and contributions of the different parties, b) where the environment within which the JV operates is more predictable or c) where the period over which mutual benefit is to be derived is relatively short.

Over the years, PUK has entered into a number of both corporate and contractual JVs. Typically, PUK's contractual JVs represent short-term (perhaps two to three year) arrangements where it deploys its resources to support those of the public sector to achieve a clearly defined end.

Some of the critical factors that determine whether a corporate or a contractual JV is likely to be more suitable to any particular set of circumstances include:

1. The intended longevity and activities of the JV;
2. The level of certainty about the commercial issues that will be dealt with by the JV;
3. The importance of high quality, efficient and timely decision-making by the JV to achieve the JV's objectives;
The NHS Plan in England, published in July 2000, signalled the start of a major investment programme in the primary care estate in England. The Plan sought to avoid ad hoc premises development which had fostered a disjointed and anachronistic pattern of service provision. The Plan also recognised the need to add to traditional methods of investing with a more systematic approach which, when the two combined, would deliver the volume of investment required at the pace demanded.

Private capital already provides the bedrock for funding GP premises in England. However, this has been achieved in a piecemeal fashion, with little or no risk of asset performance being retained by the private sector and with punitive exit costs falling, in particular, to GPs. These have occasionally acted to obstruct the introduction of new models of primary care delivery. It is also clear that GPs acting alone or in partnership are less likely to accept the burden of property ownership of larger health centres now being planned to house multi-disciplinary and multi-institutional teams.

2.1 Factors Determining the Design of NHS Lift in England

The Lift initiative seeks to present the investment opportunity arising in primary health and social care in such a way that it is attractive to private capital on a systematic basis. Fundamental to the design of the Lift model is the presentation of a "pipeline" investment opportunity to the private sector. Lift creates a vehicle that is capable of delivering today's and tomorrow's investment needs, even where such needs cannot currently be defined in any detail.

Lift makes systematic investment of private capital in the primary and social care estate attractive by:

- Presenting larger investment opportunities, by bundling together individual requirements into larger packages;
- Establishing common (and therefore, easily recognisable) procurement processes and contractual terms by which the public and private sectors can do business;
- Introducing a single point of contact in the public sector through which investment opportunities can be pursued (the local LiftCo).

The Lift initiative in England has been pursued and operated at two levels, nationally and locally. The national vehicle, PfH, was created as a centralised procurement resource with the following main tasks:
- To develop standard procurement processes and contractual terms and thereby, to create a new market of private sector players interested in owning and operating England's primary health and social care infrastructure;
- To work as part of local procuring teams, providing procurement and negotiating expertise;
- To ensure that the standard tools developed were effectively applied at the local level;
- To collect, collate and apply best practice emerging and to ensure that experiences in other areas of the country were taken into account.
- To act as the direct interface with the DoH tracking progress on the delivery of policy objectives;
- To demonstrate commitment and drive on the part of Government.
In addition to procurement support, PfH also became an investor in the local JV companies (called "local LiftCos") which are established once the local procurement processes had been completed. Through its investment, PfH retains an enduring economic interest (set at 20% in England) in all local LiftCos and exercises its influence through its right to nominate one director to each board.

PfH was itself established as a corporate JV (owned 50:50 by the DoH and PUK). This was because both the DoH and PUK judged that the ongoing success of the Lift initiative would depend on their being an enduring (but light-touch) role in local LiftCos for non-local bodies. It also provided comfort to private sector partners that dysfunction and/or breakdown in the local LiftCo would register very rapidly at a national level.

Three waves of local LiftCos have now been procured. The success of the initiative has encouraged the DoH to sponsor a fourth wave, the first procurements of which commenced in December 2004. All competitions have, so far, attracted at least three credible bids from the private sector and contracts are currently being signed at a rate of about one per week. The competitions for LiftCo partners are now starting and finishing in around 18 months.

The public sector parties involved in a local Lift are known as Strategic Development Partners who enter into a Strategic Partnering Agreement to create, inter alia, a Strategic Partnering Board. Prior to the procurement of a private sector partner, the Strategic Development Partners and PfH create a project team, combining local (for example, clinical and managerial) and national (experts employed by PfH) resources, along with external advisers.

The competition is run effectively to find the private sector company that is most capable of acting as co-shareholder with the Strategic Development Partners and PfH in the local LiftCo and, through this shareholding, to provide long-term partnering services to the local primary health and social care system. In addition, the successful private sector partner is obliged to procure that the local LiftCo enters into contracts, either with it or with a quality-assured supply chain, that will complete investments endorsed by the local LiftCo. The first tranche of these investments will have been identified as part of the original competition but future investments will emerge and be implemented over time.

Continuing value for money must be demonstrated by LiftCo in order to secure the approval of the Strategic Partnering Board for each new project. This is achieved by demonstrating a reduction in rents (in real terms) over time for new investments, which reflect LiftCo capturing the efficiencies of the long-term partnering arrangements. LiftCo can use either benchmarking and/or market-testing techniques to demonstrate value for money. If benchmarking is used, the cost elements making up the rents must be measured against those being achieved, not only in the local area, but also in other cohort groups up and down the country. In addition, every five years, the entire supply chain of each LiftCo is subject to a formal market test to ensure that the price benefits of competition continue to be harnessed.

2.2 What Has Been Achieved

Like Scotland, primary legislation needed to be enacted in England to allow JV arrangements to be entered into. This was completed in May 2001. First generation procurement processes and contractual documentation were developed during 2001 and procurement of the first wave started in March 2002. Local Lifts were identified and prioritised into waves in Spring 2001. 1st wave Strategic Development Partners were identified, Strategic Partnering Agreements entered into and Strategic Service Development Plans (SSDPs - these set out the nature and size of local investment requirements looking forward a number of years) completed over the next nine to twelve months.

In summary, since the launch of the Lift initiative:

- 33 local LiftCos have been established in three waves with nine more still in procurement - a substantial number include Local Authorities, either as full Strategic Development Partners or as (Lease Plus) tenants;
Over £400 million of immediate and near term investment is now contracted for as part of the three waves, of which around £30 million is up and running and the remainder currently in various stages of construction.

Five LiftCos have identified their 2nd tranche of primary health and social care investment;

The 4th wave commenced work in December 2004 which will bring the total number of local LiftCos to 51;

The four waves will mean that 50% of all PCTs are now involved in Lift, covering over 75% of the population of England.

PfH continues to sponsor developments designed to make the process more efficient. Standard documentation has now reached a fourth generation (which, in particular, calibrates them for Local Authority requirements) and template supply chain and facilities agreements are being worked up. PfH is also increasingly involved in supporting organisational development aimed at cementing the new partnering relationships that arise at the local LiftCo level.

3. A JV Approach for Scotland’s Investment in its Primary Health and Social Care Estate?

A small number of critical factors determined the introduction of the Lift initiative in England and, subsequently, its shape and structure. Given that Scotland is seeking a systematic improvement in its primary health and social care estate, it would be prudent to consider whether the same factors obtain and in the same way.

Prima facie, the challenge to improving the primary health and social care estate in Scotland shares many of the features presenting in England. In neither country, is modernising facilities an end in itself, nor is the mechanism by which investment is delivered. In 2003, the Scottish Executive’s Short Life Working Group, comprising representatives of health providers, local authorities and the Scottish Executive, which looked at jointly occupied premises, concluded that the absence of good quality facilities from which services are provided was becoming a major obstacle to achieving service improvements in Scotland. The Short Life Working Group also recognised that the need to rapidly improve the quality of these key public services made tried and tested delivery mechanisms particularly attractive. The action to seek additional statutory powers for public bodies to enter into JV arrangements is prompted by the need to ensure that ways of achieving the desired end by means that are recognisable to the public and private sectors are readily available to Scotland’s service providers.

The Lift initiative can be considered in terms of a) its architectural framework and b) its detailed design. Its worth noting that the overall architecture of the initiative has proved resilient both over time and when transplanted across to the schools investment programme. Detailed design within this architectural framework though, is necessarily something that has been tailored to local and sectoral circumstances. Such design work is expected to be required if the framework is adopted in Scotland.

3.1 Architectural Framework

In England, the JV approach was adopted at the national level because the need for a central procurement resource to support local project teams was judged essential, and it was recognised that the core competencies required by this central resource could only be found by pooling the capabilities of PUK and the DoH. The corporate JV model was recommended because first, the risks and rewards of the joint endeavor were genuinely unknown and second, it was recognised that PfH would continue to enjoy a proactive and enduring role in the activities of local LiftCos well after their creation.

In Scotland, different conclusions could be drawn about, for example, the need for and complexion of a central procurement resource and the activities and lifespan envisaged for the central support body. The Scottish Executive has expressed its preference for short, medium and long-term involvement, direction and support from an expert central procurement and investment resource. This resource will provide a broad and stable platform of capabilities that can be drawn upon by
project teams establishing and implementing local investment plans. It will also give confidence to
the private sector that local decision-making will be supported by standard structural and
contractual approaches, prosecuted through a central support resource. This blend of local and
central capabilities was important to the success of the initiative in England.

Again, in England, the local LiftCo has been designed as a corporate JV. The need to pool the
respective expertise of the public and private sector argued heavily in favour of a JV solution. The
main factor dictating the development of a corporate JV model though, was the decision to
construct the opportunity presented to the private sector on a population basis and not as an asset
bundle.

The asset bundle provides a more certain (but constrained) set of requirements. This enables a
clearer delineation of responsibilities between the public sector client and the private sector
provider. The population-based opportunity presents less certainty but can accommodate new,
changing and elongated requirements. The corporate JV model is more flexible mechanism than
the contractual JV, relying on the co-incidence of commercial interests to incentivise behaviour
and performance rather than defining detailed requirements at the outset.

In England, meeting the challenge of improving primary health and social care involves a prolonged
campaign of recruitment, training and cultural change. Capital investment in new infrastructure is a
supporting and enabling tool that is being used, time and again, to catalyse the change needed. Its
contribution is being determined locally and over time but its availability is proving critical in
removing obstacles that would otherwise be used to impede progress.

If the challenge in Scotland is not one that will be addressed by a single, one-off injection of
investment, but is one that will be dealt with by carefully co-ordinating the role that investment plays
in transacting change with other development tools (such as recruitment), then the architectural
framework of Lift should be equally effective here as it has been in England.

3.2 Detailed Structural Design

Detailed structural design will determine such matters as the average size of a local investment
area, the scope of services that are to be required from the private sector and the degree of
influence that the public sector wishes to exercise over the running of the local delivery bodies.
These factors determine, amongst other things, the number of investment areas to be supported by
the central procurement resource, the number and nature of the Strategic Development Partners
involved and the shareholding required in each local JV Co.

The main factors that have determined the detailed design of local LiftCos in England are:

- The population size served by each local LiftCo (300,000 to 500,000) and, linked to this, the scale and nature of the immediate, near and long term investment opportunity available in each Lift area;
- The scope of the opportunity presented to the private sector over which the local LiftCo will
  preside, including some or all of primary health and social care premises, facilities and
  operational management, and information systems;
- The level of investment supportable by public sector capital, both at the outset- and on an
  ongoing basis;
- The nature and level of co-ordinated working achieved or achievable by the Strategic
  Development Partners;
- The capacity and capability of public sector shareholders to act effectively as parties to the
  long term JV and, in particular, to play their part in translating their SSDPs into investment
  requirements.

There is every reason to believe that the detailed design of local investment areas would be
different in Scotland to England. The population of Scotland is around 5 million and is served by 15
Health Boards. The population of each Health Board though varies considerably, with the smallest
being 19,000 and the largest 635,000.
Prima facie, this suggests that, for a small number, the Health Board may represent too large a planning and contracting unit and for many others, it is certainly too small. 46 Community Health Partnerships work alongside the 15 Health Boards and the 32 Local Authority bodies in Scotland and together, they define and provide a wide range of primary health and social care services.

The detailed design of local investment areas in Scotland would need to be influenced by, inter alia;

- The scale of investment required in each Health Board;
- The state of readiness of the Health Board and its partnering agencies to become Strategic Development Partners and to embark on and support the procurement of a private sector partner;
- The capabilities of the Strategic Development Partners to identify a rolling programme of investments arising from local service developments;
- The appetite of the Strategic Development Partners to have an enduring involvement in the management and governance of a corporate JV.

As in England, federated arrangements between different Health Boards and other public sector partnering bodies in Scotland would probably be determined by a mix of historic relationships and service inter-dependencies. The pace at which different federations came together and proceeded with the Lift initiative in England varied, but the flexibility of the Lift model to cope with this was judged one of its great strengths.

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 31

Main Objective: Allowing Scottish Executive to participate in joint ventures to provide services and to exploit intellectual property.

Do you agree with the main objective of this part of the bill?

If yes, why?

If not, why not?

Are there any other comments you would like to make?

The Committee may wish to ask for evidence from England on the uptake and outcome of such schemes and whether policy realisation flows from this funding model. RCN Scotland is not convinced.

SUBMISSION BY UNIVERSITIES SCOTLAND

Comment on Joint Ventures

Universities Scotland is the representative body of Scotland’s 21 universities and colleges of higher education. Many of our members are involved in areas of academic research which are directly relevant to the National Health Service in Scotland. The sector also has strong experience in the successful exploitation of academic research for real-world purposes. Every institution will be involved in joint ventures with other partners to aid this knowledge transfer process, and some are directly involved in partnerships with NHS bodies.

Section 31 of the Smoking, Health and Social Care (Scotland) Bill gives Scottish Executive Ministers the ability to take equity in spin-out companies formed on the basis of intellectual property developed in the NHS in Scotland. This enables them to become partners in any joint ventures established to further the use of any such intellectual property. The law in England was changed
some time ago but was not modified in the same way in Scotland. Westminster Ministers can already take equity stakes in joint ventures so this is largely a catching-up exercise.

The aim – to enable, or rather remove the potential restriction on, the NHS in commercialising inventions arising from its research base – is one that we fully support. The ability of Ministers to take equity in science parks and other similar initiatives is also welcomed.

The only circumstance in which this provision would give the higher education sector any concerns would be if it granted the Scottish Executive any new or additional powers over intellectual property right and their ownership. However, as it clearly does not do this, this section of the Bill has the support of Universities Scotland.

Section 32: Scottish Hospital Endowment Research Trust

SUBMISSION BY RCN SCOTLAND

Part of Bill: Part 5, section 32

Main Objective: Converting Scottish Hospital Endowments Research Trust from a Non-Departmental Public Body to an independent charity

Do you agree with the main objective of this part of the bill? yes

If yes, why?
We agree in principle with the policy intention of converting SHERT from an NDPB to an independent charity but have some questions about the detail of the way in which the charity will function.

If not, why not?

Are there any other comments you would like to make?
RCN Scotland notes that this organisation has funds of around £26.5 million yet only awards around £1m per annum. We note that despite the funds being accrued from the public and endowments the criteria are very restricted to medical research and the treatment of diseases (named on its website).

This is despite there being considerable numbers of medical research funding bodies, but very few for nursing and multidisciplinary or routes other than disease treatment to improve health.

RCN Scotland would ask the Committee to question the Minister on widening the remit of the research areas from the current 8 disease specific areas to a wider range of health criteria.
Smoking

1. All of the evidence gathered by the Executive during the consultation is now available on the Smokefree Scotland website, http://www.smokefreescotland.com/.

2. The MRUK public opinion survey (Omnibus Survey can be found on the following link, http://www.scotland.gov.uk/library5/health/smipp-00.asp. It is recommended that this survey be viewed in conjunction with the Evidence Report. This was previously circulated to members in hard copy and can be accessed electronically via this link.

Free eye and dental examinations

3. We understand from discussions with Optometry Scotland (OS) that their concerns simply relate to the current NHS sight test being made available to all in its existing form. They wish to pursue an approach which would give all patients the opportunity for an eye examination tailored to their needs, which would include a sight test for those who may need glasses/contact lenses. The proposed eye examination would give optometrists more flexibility in how they treat and give advice to patients in the community under general ophthalmic services.

4. This issue is being considered as part of the Eyecare Services review which the former Deputy Minister established last year. An initial report of the Group is likely to be presented to Ministers in the near future. During the review meetings, OS have confirmed that there is sufficient workforce in the community to take on the new arrangements which are under discussion. They have, however, indicated that if we simply make the existing NHS sight test available to all, some optometrists might decide to withdraw from providing NHS sight tests.

5. The Executive will submit to the Committee revised costs for the Financial Memorandum accompanying the Bill should there be a change in the examination fees on which the estimated costs of free eye and dental examinations be based.

Shipman 5

6. The fifth report of the Shipman enquiry is currently being considered by the Executive. As yet, no requirements for legislation that would require amendments to the Smoking, Health and Social Care (Scotland) Bill have been identified.

Adults with Incapacity

7. A comprehensive response to the points raised by the Committee on adults with incapacity is included in Annex A.
Joint Ventures - Facilities and Services

8. A list of respondees to the Consultation on the Use of Joint Ventures to Deliver Primary Care/Joint Premises is listed in Annex B. The Consultation Summary Report (September 2004) can be found at: http://www.show.scot.nhs.uk/pfou/PDFs/LIFTCnsltRpt.pdf.

9. A list of NHS Local Improvement Finance Trust (LIFT) schemes in England is provided at Annex C along with links to websites that can provide more detail on a number of specific projects.

Joint Ventures - Intellectual Property

10. The Executive was asked if there were examples from England where there are similar powers to those proposed in the Bill for Scotland. The Department of Health have advised that they have recently approved two proposals from NHS organisations to set up spin-out companies, but are not aware of income being generated from them.

11. It is pointed out that a novel technology, likely to follow this exploitation route, may take a number of years to progress from being an innovative idea to the point at which it can generate income as a marketable product. In the interim, issues such as prototyping, regulatory approval and manufacturing processes may need to be addressed.

12. On an historical basis, income generated from exploitation of NHS IP in Scotland in the financial year 2002-03 was £86k and £10k in 2003-04. Figures are not yet available for the current financial year (but we are aware of one licensed innovation which has generated £40k). The equivalent figures in England are £557k in 2002-03 and £870k in 2003-04.
Dear Sir/Madam

THE SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) ACT 2005
(PROHIBITION OF SMOKING IN CERTAIN PREMISES) REGULATIONS 2005: DRAFT

I am writing to invite comments on proposals for regulations under powers contained in The Smoking, Health and Social Care (Scotland) Bill 2005, which is currently before the Scottish Parliament, and the Regulatory Impact Assessment of this legislation. Responses are requested by Thursday 26 May, at the latest, although earlier responses would be helpful.

Background

The issue of smoking in public places was subject to extensive public consultation from June to September last year. Following consideration of the findings of the consultation and other evidence gathered on the health effects of passive smoking and the health and economic impact of regulation on smoking in public places, Ministers introduced the Smoking, Health and Social Care (Scotland) Bill in December 2004. The Bill and its progress through Parliament can be viewed at [http://www.scottish.parliament.uk/business/bills/billsInProgress/smokehealthcare.htm](http://www.scottish.parliament.uk/business/bills/billsInProgress/smokehealthcare.htm)

The Bill contains measures to prohibit smoking in certain wholly enclosed public places, and indicates that detailed provisions, including exemptions, will be prescribed through regulations. The First Minister stated that the scope of the ban was intended to be comprehensive, although it was recognised that there would be a need for some very specific exemptions for places where people reside or where there are clearly established humanitarian or practical considerations.

These twin principles of comprehensive scope and limited exemptions continue to underpin Ministers’ approach and have informed the drafting of the regulations, on which your comments are now invited. We have also undertaken a Regulatory Impact Assessment (RIA) to assess the likely impact of the proposed legislation, which is also attached. Your comments are also invited on this.

The regulations, RIA and consultation process

The following documents are attached:

Annex A: Draft regulations
Annex B: This explains the effect of the provisions of the regulations and seeks views on a number of specific issues
Annex C: Regulatory Impact Assessment (RIA)
Annex D: Respondent Information Form (to be completed by all respondents)
Annex E: Scottish Executive Consultation Policy
Annex F: List of consultees

Responding to this consultation

We are inviting written responses to this consultation paper by Thursday 26 May, although early responses would be helpful. Annex B poses questions about specific matters on which we are seeking the views of consultees. This does not, however, preclude consultees from commenting on any other aspects of the proposals, or the RIA (Annex C). We would be grateful if respondents could clearly indicate in their responses the questions or parts of the consultation paper to which they are responding, as this will aid our analysis of the responses received.

Please send your response to:

John.glen@scotland.gsi.gov.uk or John Glen
Scottish Executive Health Department
Tobacco Control Division
3 E(R)
St Andrew’s House
Regent Road
EDINBURGH
EH1 3DG

If you wish to access this consultation online, go to www.scotland.gov.uk/smokingregulations
You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is, if you prefer to submit your response by e-mail.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the Respondent Information Form at Annex D as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Executive are subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, these will be made available to the public in the Scottish Executive Library by Thursday 23 June and on the Scottish Executive consultation web-site by Thursday 30 June. We will check all responses where agreement to publish has been given for any potentially defamatory material before logging them in the library or placing them on the website. Annex E contains additional information about Scottish Executive consultation policy, including about access to consultation responses.
What happens next

Ministers and officials will give careful consideration to all comments before finalising the regulations and laying them before Parliament in due course. Comments will also inform Parliament as it considers and debates the Smoking, Health and Social Care (Scotland) Bill in the next few months. Subject to the outcome of the parliamentary process, the legislation will come into effect in Spring 2006.

Comments and complaints

If you have any comment about how this consultation exercise has been conducted, or if you have any other queries, please contact John Glen at the above address or call 0131 244 5660.

Yours sincerely

SARAH DAVIDSON
The Scottish Ministers, in exercise of the powers conferred by sections 3(3), 4(2), 4(7) of, and paragraphs 2, 5(1), 6(2), 13 and 14 of Schedule 1 to, the Smoking, Health and Social Care (Scotland) Act 2005(a) and all other powers enabling them in that behalf, after consulting such persons as they consider appropriate in accordance with section 34(4) of that Act, hereby make the following Regulations, a draft of which has, in accordance with section 34(3) of that Act, been laid before and approved by a resolution of the Scottish Parliament:

Citation, interpretation and commencement

1.—(1) These Regulations may be cited as the Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005.

(2) In these Regulations—

“the Act” means the Smoking, Health and Social Care (Scotland) Act 2005;

“adult” means a person who has attained the age of 16 years;

“adult care home service” means an establishment providing a care home service exclusively for adults;

“adult hospice” means a hospice providing care exclusively for adults;

“alcoholic drink” means a drink consisting of or containing alcohol;

“bar” includes any premises exclusively or mainly used for the sale and consumption of alcoholic drink;

“care home service” means a care home service within the meaning of section 2(3) of the Regulation of Care (Scotland) Act 2001(b);

“club premises” means any premises which are used by and for the purposes of a club or other unincorporated association, whether for profit or not;

(a) 2005 asp [ ]
(b) 2001, asp 8
“council” means a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994(a);

“designated hotel bedroom” means a bedroom in a hotel which has been designated by the person having the management or control of the hotel as being a bedroom in which smoking is permitted;

“designated police room” means –

(a) any interview room within a police station;
(b) any detention room within a police station;
(c) any cell accommodation within a police station; and
(d) any legalised police cell;

“educational institution” means –

(a) a school within the meaning of section 135(1) of the Education (Scotland) Act 1980(b);
(b) a school care accommodation service within the meaning of section 2(4) of the Regulation of Care (Scotland) Act 2001;
(c) a college or other institution providing further education within the meaning of section 1 of the Further and Higher Education (Scotland) Act 1992(c) and section 1(5)(b) of the Education (Scotland) Act 1980;
(d) a university or other institution providing higher education within the meaning of section 38 of the Further and Higher Education (Scotland) Act 1992; and
(e) any other educational and vocational institution;

“employee” has the same meaning as in section [ ] of the Act; \[NB it is intended that the following meaning of “employee” be inserted into the Bill at Stage 2, in relation to the use of the word “employees” in section 4(4)(b) of the Bill, namely – ““employee” means a person who performs any work for or supplies any service to an employer and includes a volunteer and a person who is self employed.”]\n
"health centre" means premises provided by the Scottish Ministers in accordance with the provisions of section 36(1)(b) of the National Health Service (Scotland) Act 1978(d);

"hospice" means an establishment the whole or main purpose of which is to provide palliative care for persons resident there who are suffering from a progressive disease in its final stages;

“hospital” means -

(a) any institution for the reception and treatment of persons suffering from illness;
(b) any maternity home; and
(c) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and any institution for providing dental treatment maintained in connection with a dental school,

and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution;

“hospital unit” means any part of a hospital which is treated as a separate unit;

“hotel” means a hotel, boarding house, guest house, inn or hostel containing at least two apartments set apart exclusively for the sleeping accommodation of travellers;
“illness” includes mental disorder within the meaning of the Mental Health (Care and Treatment) (Scotland) Act 2003(a) and any injury or disability requiring medical or dental treatment or nursing;

“legalised police cell” means a police cell within the meaning of section 14 of the Prisons (Scotland) Act 1989(b);

“no-smoking notice” means a notice displayed in accordance with section 3(1) of the Act;

“oil rig” means any offshore installation within the meaning of section 1 of the Mineral Workings (Offshore Installations) Act 1971(c);

“premises” includes -
(a) any land;
(b) any building or part of a building;
(c) any structure or part of a structure, whether moveable or otherwise;
(d) any installation on land (including the foreshore and other land intermittently covered by water), any offshore installation within the meaning of section 1 of the Mineral Workings (Offshore Installations) Act 1971, and any other installation (whether floating, or resting on the seabed or the subsoil thereof, or resting on other land covered with water or the subsoil thereof); and
(e) any tent, marquee or stall;

"private vehicle" means any vehicle which is used primarily for the private purposes of the person who owns it or of a person otherwise having the right to use it, provided always that such right to use a vehicle does not, in relation to a motor vehicle, include a reference to a person whose right to use the vehicle derives only from having paid, or undertaken to pay, for the use of the vehicle and its driver for a particular journey;

“public transportation vehicle” means any vehicle available to the public as a means of transportation;

“public transportation facilities” includes waiting rooms, ticket offices and terminal buildings provided in connection with any public transportation vehicle;

“psychiatric hospital” means a hospital the whole or main purpose of which is to treat persons with a mental disorder within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003, and includes a state hospital;

“psychiatric unit” means a hospital unit the whole or main purpose of which is to treat persons with a mental disorder within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003;

"public house" includes an inn, ale-house, victualling house or other premises in which alcoholic drink is sold by retail for consumption either on or off the premises;

"residential premises" means so much of any premises as is for the time being occupied or used by any person for residential purposes or otherwise as living accommodation, (including hotel accommodation that is occupied or used as a person’s principal place of residence), but not including a reference to so much of any premises as constitutes any common area to which the person has or is allowed access in connection with the person's use or occupation of any accommodation, nor including a reference to an adult care home, an adult hospice, a psychiatric hospital, a psychiatric unit or a secure accommodation service;

“restaurant” includes a café, bistro and snack bar and any other premises exclusively or mainly used for the sale and consumption of food;

(a) 2003, asp 13
(b) 1989, c.45
(c) 1971, c. 71
“secure accommodation service” means a secure accommodation service within the same meaning of section 2(10) of the Regulation of Care (Scotland) Act 2001;

“sports centre” means any gymnasium, health spa, swimming pool, roller or ice rink, bowling alley and other similar premises used to engage in sports, athletics or recreational activities or to witness sports, athletics, recreational or similar activities;

“state hospital” means a state hospital provided under section 102(1) of the National Health Service (Scotland) Act 1978; and

"vehicle" includes any train, bus, taxi and any vessel (whether navigable or not), boat or hovercraft.

(3) A reference to premises may include premises within premises.

(4) These Regulations shall come into force on [       ] 2006.

Display of no-smoking notices

2.—(1) A no-smoking notice shall –
(a) be a minimum size of 230mm by 160mm;
(b) display the international “no smoking” symbol, consisting of a graphic representation of a burning cigarette enclosed in a red circle with a red bar across it, at least 85mm in diameter; and
(c) display the name of the person to whom a complaint may be made by any person who observes another person smoke in the no-smoking premises in question and state that a complaint may be so made or, in relation to vehicles, the holder of a particular post to whom a complaint may be made and that a complaint may be so made.

(2) A no-smoking notice shall be displayed by the person having the management or control of the no-smoking premises in such a manner that it is protected from tampering, damage, removal or concealment.

“No-smoking premises”

3.—(1) The premises or classes of premises prescribed(a) under section 4(2) of the Act as being “no-smoking premises” for the purposes of Part 1 of the Act are the premises or classes of premises specified in Schedule 1 to these Regulations, being premises or classes of premises which are wholly enclosed.

(2) The premises or parts of premises or classes of premises or parts of premises prescribed under section 4(3) of the Act which are excluded from the definition of “no-smoking premises” are the premises or parts of premises or classes of premises or parts of premises specified in Schedule 2 to these Regulations.

(3) For the purposes of section 4(2) of the Act, the following expressions shall have the following meanings respectively assigned to them –
(a) “premises” includes -
(i) any land;
(ii) any building or part of a building;
(iii) any structure or part of a structure, whether moveable or otherwise;
(iv) any installation on land (including the foreshore and other land intermittently covered by water), any offshore installation within the meaning of section 1 of the Mineral Workings (Offshore Installations) Act 1971, and any other installation (whether floating, or resting on the seabed or the subsoil thereof, or resting on other land covered with water or the subsoil thereof);

(a) Section 35 of the Act defines “prescribed” as meaning prescribed by regulations made by the Scottish Ministers
(v) any tent, marquee or stall; and
(vi) any vehicle.

(b) “wholly enclosed” means –
(i) for premises other than a vehicle or part of a vehicle, having a ceiling or roof and, except for doors, windows and passageways, wholly enclosed, whether permanently or temporarily; or
(ii) for premises that are a vehicle, or part of a vehicle, having a top or roof and, except for doors, windows or exits, wholly enclosed, whether permanently or temporarily; and

(c) “has access” means has access whether on payment or otherwise, and whether as of right or by virtue of express or implied permission.

Fixed penalty time limits, amounts and payments

4. — (1) The time limit prescribed under paragraph 2 of Schedule 1 to the Act relating to the offence after which a fixed penalty notice may not be given shall be 7 days.

(2) The amount of the fixed penalty prescribed under paragraph 4(1) of Schedule 1 to the Act is –

(a) £200 for an offence under section 1 of the Act;
(b) £50 for an offence under section 2 of the Act; and
(c) £200 for an offence under section 3 of the Act.

(3) The discounted amount prescribed under paragraph 5(2) of Schedule 1 to the Act for a fixed penalty is -

(a) £150 for an offence under section 1 of the Act;
(b) £30 for an offence under section 2 of the Act; and
(c) £150 for an offence under section 3 of the Act.

Application by councils of fixed penalties and account keeping

5. (1) Paragraphs (4) and (5) apply in relation to the application by councils of fixed penalties paid under Schedule 1 to the Act.

(2) Paragraphs (3) and (6) apply in relation to the keeping of accounts, and the preparation and publication of statements of account, by councils in relation to fixed penalties under Schedule 1 to the Act.

(3) Councils shall keep an account of their income and expenditure in respect of the administration and enforcement of section 5 of, and Schedule 1 to, the Act.

(4) At the end of each financial year any deficit in the account shall be made good out of the council’s general fund, and (subject to paragraph 5 below) any surplus shall be applied to purposes connected with the improvement of the amenity of the area of the council or any part of that area.

(5) If the council so determines, any amount not applied in any financial year, instead of being or remaining so appropriated, may be carried forward in the account kept under paragraph 1 above to the next financial year.

(6) Each council shall, as soon as possible after the end of each financial year, prepare and send to the Scottish Ministers a statement of account to include the account of their income and expenditure kept under paragraph (3) above and an account of any action taken by them, pursuant to paragraph 4 or 5 above, in respect of any deficit or surplus in their account for the year.
DRAFT

Authorised to sign by the Scottish Ministers

St Andrew’s House, Edinburgh
2005
Regulation 3(1)

**NO-SMOKING PREMISES**

1. Restaurants.
2. Bars and public houses.
3. Shops and shopping centres.
4. Hotels.
6. Cinemas, concert halls, theatres, bingo halls, casinos, dance halls, discotheques and other premises used for the entertainment of members of the public.
7. Premises used as a broadcasting studio or film studio or for the recording of a performance with a view to its use in a programme service or in a film intended for public exhibition.
8. Halls and any other premises used for the assembly of members of the public for social or recreational purposes.
11. Club premises.
12. Offices, factories and other premises or vehicles in which more than one employee works.
13. Educational institutions.
14. Premises providing secure accommodation services.
15. Hospitals, hospices and health centres.
16. Creches, day nurseries, day centres and other premises used for the day care of children or adults.
17. Premises used for, or in connection with, public worship or religious instruction, or the social or recreational activities of a religious body.
19. Airport passenger terminals and any other public transportation facilities.
20. Public transportation vehicles.
DRAFT

SCHEDULE 2

Regulation 3(2)

EXEMPTIONS

1. Residential premises.
2. Adult care homes.
3. Adult hospices.
4. Psychiatric hospitals and psychiatric units.
5. Oil rigs.
6. Private vehicles.
7. Designated hotel bedrooms.
8. Designated police rooms.
These Regulations make further provision under Part 1 of, and Schedule 1 to, the Smoking, Health and Social Care (Scotland) Act 2005 (“the Act”) in relation to the prohibition of smoking in certain wholly enclosed premises.

Regulation 1 contains the citation, commencement and interpretation provisions to be applied to the Regulations, and gives the date (xxxxx 2006) on which they come into force.

Regulation 2 makes provision in relation to the display of no-smoking notices, providing further requirements in addition to those already stipulated under section 3(1) of the Act as to the minimum size, content and manner of display of such notices.

Regulation 3(1) gives effect to Schedule 1, which sets out the premises or classes of premises which are to be no-smoking premises for the purposes of Part 1 of the Act, being premises or classes of premises which are wholly enclosed. These are: restaurants; bars and public houses; shops and shopping centres; hotels; libraries, archives, museums and galleries; cinemas, concert halls, theatres, bingo halls, casinos, dance halls, discotheques and other premises used for the entertainment of members of the public; premises used as a broadcasting studio or film studio or for the recording of a performance with a view to its use in a programme service or in a film intended for public exhibition; halls and any other premises used for the assembly of members of the public for social or recreational purposes; conference centres, public halls and exhibition halls; public toilets; club premises; offices, factories and other premises or vehicles in which more than one employee works; educational institutions; premises providing secure accommodation services; hospitals, hospices and health centres; crèches, day nurseries, day centres and other premises used for the day care of children or adults; premises used for, or in connection with, public worship or religious instruction, or the social or recreational activities of a religious body; sports centres; airport passenger terminals and any other public transportation facilities; and public transportation vehicles, the majority of which terms are defined in regulation 1.

Regulation 3(2) gives effect to Schedule 2, which sets out the premises or parts of premises or classes of premises or parts of premises which are excluded from the definition of “no-smoking premises” for the purposes of Part 1 of the Act. These are: residential premises; adult care homes; adult hospices; psychiatric hospitals and psychiatric units; oil rigs; private vehicles; designated hotel bedrooms; and designated police rooms, all of which terms are defined in regulation 1.

Regulation 3(3) defines and elaborates the meaning of certain expressions (“premises”; “wholly enclosed”; and “has access”) used in section 4(4) of the Act, as provided for under section 4(5).

Regulation 5 provides for the application by councils of fixed penalties and account keeping.
ANNEX B

DRAFT: THE SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) ACT 2005 (PROHIBITION OF SMOKING IN CERTAIN PREMISES) REGULATIONS 2005

This paper explains the meaning of the provisions of the draft regulations. Whilst we welcome comment on any aspect of the regulations, your views are sought on a number of specific issues.

Regulation 1: Citation, interpretation and commencement

Regulation 1 provides the definitions of words and phrases used in the regulations and the commencement date of the regulations.

Q.1. Do the definitions of words and phrases ensure clarity of what premises are covered or exempted from the regulations? If not, how might they be improved?

Regulation 2: Display of no smoking notices

This regulation makes further provision in relation to the display of no-smoking notices, in addition to the requirements already stipulated under section 3(1) of the Bill. The regulation sets out the minimum size of a no-smoking notice (230 mm x 160 mm) and specifies that it should include an international “no smoking” symbol of at least 85 mm. in diameter. The sign must also specify the person to whom complaints should be addressed and be displayed so that it is protected from tampering, damage, removal or concealment.

Q.2. Views are invited on this approach.

Regulation 3: “No-smoking premises”

Paragraph (1) of regulation gives effect to Schedule 1, which sets out the premises or classes of premise which are to be no-smoking premises, whilst paragraph (2) gives effect to Schedule 2, which sets out the premises or parts of premises or classes of premises or parts of premises which are excluded from the definition of no-smoking premises. The “no-smoking premises” listed at Schedule 1 and the exemptions listed at Schedule 2 are discussed in more detail below.

Paragraph 3 of regulation 3 defines and elaborates on the terms ‘premises’, ‘wholly enclosed’ and ‘has access’ as they are used in the Bill.

We are continuing to examine whether the given definition of “wholly enclosed” delivers the policy intention, which is to designate as no-smoking premises all those premises listed in Schedule 1 to the regulations, provided that they are either wholly enclosed or, where they are not wholly enclosed, the extent to which they are not wholly enclosed is not significant.

Q.3. Your comments are invited on the existing formula and on how it might be improved.
Regulation 4: Fixed penalty time limits, amounts and payments

Regulation 4 provides further detail on fixed penalties. The regulations provide that an enforcement officer can only serve a fixed penalty notice up to 7 days after the event. It sets out the amounts of fixed penalty associated with the various types of offence. The fixed penalties are: £200 for permitting others to smoke in no-smoking premises; £50 for smoking in no-smoking premises; £200 for not conspicuously displaying warning notices in no-smoking premises.

Where an offender pays the fixed penalty within 15 days, discounted amounts are charged. The discounted amounts are: £150; £30 and £150 respectively.

Q4. Views are invited on the level of fixed penalties and time limits for payment.

Regulation 5: Application by councils of fixed penalties and account keeping

This regulation requires councils to keep accounts of their income and expenditure in respect of the administration and enforcement of Fixed Penalty Notices. Any deficit will be made good by the council and any surplus used to improve the “amenity” of the council area. Councils will be required to send an annual statement of the accounts they have kept to Ministers along with an explanation.

Q5. Views are invited on the general approach outlined here.

Schedules to the Regulations

Schedule 1 sets out the definitive list of those premises that will be no-smoking premises for the purposes of the Act. This is required by Section 4(2) of the Bill which provides that Ministers will make regulations prescribing premises, or classes of premises, as “no-smoking” premises. Section 4(4) of the Bill limits the kinds of premises that can be prescribed as being no-smoking premises by making it a condition that they must be wholly enclosed and also fall within one of 4 stipulated categories.

Schedule 2 lists the premises or parts of premises or classes of premises or parts of premises which will be exempted from the no-smoking regime.

There are a number of issues in relation to Schedule 1 and 2 on which your views are sought:

Schedule 1: No-smoking premises

Under Section 4(4) of the Bill, the kind of premises which can be defined as no-smoking are those which are wholly enclosed and –
(a) to which the public or a section of the public has access;
(b) which are being used wholly or mainly as a place of work by persons who are employees;
(c) which are being used by and for the purposes of a club or other unincorporated association; or
(d) which are being used wholly or mainly for the provision of education or of health or care services.
It is therefore intended that the list of premises included in Schedule 1 to the regulations be definitive. Ministers will have the power to add to the list of no-smoking premises by way of amendment of the regulations if it proves to be deficient in any way.

**Q.6 Your views are sought on whether there are any premises which fall into the definition of no-smoking premises at section 4(4) of the Bill [(a)-(d) above], but which have been omitted from the list in Schedule 1.**

**Schedule 2: Exemptions**

**Adult care homes**

Ministers recognise that there are a number of issues which make it desirable to exempt adult care homes from the scope of the legislation, not least that these are effectively the homes of their residents.

However, Ministers also recognise that safety and other considerations mean that in many such establishments smoking is not permitted in residents’ own rooms, the places which most closely equate to their private place of residence. For this reason, particular consideration must be given to the impact of second hand smoke on non-smoking residents and on staff. In order to address this, we will investigate the best way of ensuring that care homes implement smoking policies which provide smoke-free social areas for non-smoking staff; and the targeting of cessation services and funds on those groups where it would have the greatest benefit.

**Q.7 Your views are invited on:**

- the general merits of this approach;
- the development of smoking policies for residential care homes; and
- the targeting of cessation services on these groups.

**Psychiatric hospitals and psychiatric units**

The position of patients in psychiatric hospitals and units, whether they are there voluntarily or on the basis of a compulsory order, is different to general members of the public. They do not have a private room and may have limited access to the outdoors. For those reasons, among others, we would for now intend to exempt these locations. We will explore with those involved in the care and treatment of people with mental illness as well as advocacy groups and patients themselves whether arrangements might be developed to allow the legislation to extend to some or all psychiatric hospitals and units in due course.

Ministers recognise that the physical health profile of those with mental illness in Scotland is poor and smoking rates are traditionally high. Ministers are committed to reducing the health inequalities experienced by this group of patients and plan to implement a programme of targeted cessation across the sector in support of this aim.

**Q.8 Views are invited on:**

- the general merits of this approach; and
- the targeting of cessation services at this group.
Hotel, guest house and B & B bedrooms
The regulations have been drafted to include hotels, guest houses and B & Bs within the scope of the law, but to allow proprietors the ability, if required, to designate bedrooms in which smoking may be permitted.

Q.9 Views are invited on the merits of this approach.

Omissions from Schedule 2

Q.10 Are there any premises which, taking into account humanitarian, practical or other considerations, are omitted from the exemptions list in Schedule 2?
Draft Regulatory Impact Assessment

1. Title of Proposal

The Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005

2. Purpose and intended effect of measure

Objective

To protect public health by introducing comprehensive legislation on smoking in certain enclosed places to which the public or a section of the public has access. These measures lie at the heart of the Scottish Executive’s wider drive for health improvement set out in Improving Health in Scotland: The Challenge, which is aimed at bringing about a more rapid rate of health improvement in Scotland and narrowing the gap between Scotland’s poorer and better off communities.

Background

Smoking has long been recognised as the most important preventable cause of ill-health and premature death in Scotland. It is estimated to be associated with 13,000 deaths and 33,500 hospital admissions each year in Scotland. In January 2004 the Scottish Executive published the first ever action plan designed specifically for Scotland: A Breath of Fresh Air for Scotland with the stated goal of reducing this unacceptable toll on Scotland’s health. The Plan offers a comprehensive programme of action to tackle smoking. This includes a clear commitment to take firm action to extend smoke-free provision within all enclosed public places in order to protect non-smokers from the health risks posed by exposure to second-hand smoke.

The scientific evidence of the health risks associated with second-hand smoke is clear and irrefutable. The Report of the UK Scientific Committee on Tobacco and Health (SCOTH), published in 1998, highlighted the risks. The report concludes that exposure to second-hand smoke: is a cause of lung cancer and, in those with long-term exposure, the increased risk is 20-30%; is a cause of heart disease and represents a substantial public health hazard; can cause asthma in children and may increase the severity of the condition in children already affected.

SCOTH recently reviewed the evidence of the health risks of exposure to second-hand smoke to emerge since 1998 and this report, published on 16 November 2004, reinforces the earlier findings. Research commissioned by the Scottish Executive and NHS Health Scotland in 2004 suggests second-hand smoke is associated with some 865 deaths per year among life-long non smokers in Scotland. Taking ex-smokers into account it is estimated that some 1500 to 2000 deaths per year in Scotland are associated with environmental tobacco smoke exposure. Further modelling by Aberdeen University suggests that of the smaller number, i.e. 865 deaths of never smokers, at least 120 are attributable to non-domestic exposure.
Given the unacceptable health impact of second-hand smoke and the need to accelerate progress, specifically in the leisure and hospitality sector where progress in smoke-free provision through voluntary action has been less pronounced (7 out of 10 pubs still allow smoking throughout). It is clear to the Executive that statutory action is now required to increase smoke-free places in order to protect public health. Having weighed up all the evidence, including the fact that there is no defined safe level of exposure to second-hand smoke, the Executive decided that only the pursuit of smoke-free legislation in all enclosed public places would provide comprehensive protection to public health. The Smoking, Health and Social Care Bill was introduced to Parliament on 16 December 2004.

More detailed information on the Bill is set out in Appendix 1. The introduction of a smoke-free policy is one of three options considered below. Continuation of the current voluntary approach and legislation with dispensation for the hospitality sector (i.e. partial restrictions) are the other 2 options.

Risk Assessment

Tobacco is a uniquely dangerous product and, as indicated above, smoking is one of the most damaging factors in Scotland’s poor health record. Measures to protect individuals and society from the impact of tobacco, through legislative and other forms of regulation and control are a vital component to any tobacco control strategy. There is no safe level of exposure to second-hand smoke and, while much progress has been made in smoke-free environments in public places through voluntary action, the evidence clearly indicates that progress has been much slower in the hospitality sector, particularly in the pubs sector. It is clear that legislation is the only way to make significant progress to protect public health.

The policy takes account of the fact that the majority of Scots (70%) do not smoke and that survey results suggest that the majority of smokers wish to give up. It also takes into account that there is no safe level of exposure to second-hand smoke and that restrictions encourage existing smokers to give up or to reduce their consumption and encourage children and young people not to start in the first place.

A large number of studies have been undertaken on the specific risks associated with Environmental Tobacco Smoke (ETS) and the results of these studies are considered in more depth under the potential costs and benefits of the various options. Risks associated with the successful implementation of the policy itself fall into the two main areas of compliance/enforcement and the economic impact on businesses, particularly in the hospitality sector.

3. Options

A number of options were considered with a view to meeting the objectives of the policy stated above. This consideration included both legislative and non-legislative options.

Option 1 – Voluntary Approach

The Executive would continue to pursue the Tobacco Control Action Plan, which sets out a programme of action to tackle smoking, particularly in deprived communities. More details on the action plan are set out in appendix 2. This is effectively a do-minimum approach,
which would pursue policy objectives through non-legislative means, such as The Voluntary Charter on Smoking in Public Places, which has made some progress in developing smoke free areas. Efforts would be made to continue this through promotion of the Scottish Licensed Trade Association’s 5 voluntary targets under which:

- Smoking would be banned at the bar counter in all licensed premises;
- Smoking would not be permitted in any area where and when hot food is being served;
- All licensed premises would be required to allocate a minimum of 30% total floor space as a non-smoking area rising to 40% in year two and 50% in year three. A further review would then take place at the end of this period.
- Every licensed premise would be required to display a smoking policy at the entrance in order that customers can see the facilities available when they enter; and
- Smoking would be prohibited in any area of licensed premises from which the public are excluded.

**Option 2 – Smoke Free Legislation**

All enclosed public places would be smoke free. Exemptions would be permitted only on humanitarian grounds. This approach would be complemented by a range of other actions to tackle smoking as set out in the Tobacco Control Action Plan.

**Option 3 – Legislation but with Exemption for the Hospitality Sector**

Smoking would be generally restricted in public places but the licensed hospitality sector would be completely exempt. Consultation responses suggested there was some element of support for exemptions to legislation in this respect. Once again, The Executive would continue to pursue the wider action set out in the Tobacco Control Action Plan.

4. Costs and Benefits of Options

**Overview**

The following paragraphs set out the expected range of costs and benefits associated with each of the policy options considered. Economic impacts are in many cases based on recent work carried out by the Health Economics Research Unit (HERU). Prior to publication the HERU work was peer reviewed. Full details of this study and its results are set out in appendix 3. Additional work has been carried out to explore other cost and benefit elements relevant to the RIA but not considered in the HERU report, e.g. implementation costs.

- **Reduced exposure to ETS in the workplace**

Studies of the effect of smoking restrictions on exposure to ETS show a reduction in exposure to ETS from both smoke free policies and partial restrictions, with the greatest
reductions in exposure resulting from smoke free policies rather than partial restrictions. More details are provided in appendix 3.

- **Reduction in smoking/increase in quit attempts by active smokers**

Smoke free policies and partial restrictions are both associated with reductions in smoking and increases in quit attempts by smokers. The evidence below suggests that the impact is stronger with smoke free policies.

- **Reduction in number of deaths from major disease types**

There is strong evidence that exposure to ETS increases mortality and morbidity from lung cancer and coronary heart disease. There is also weaker evidence of an effect in relation to stroke and respiratory diseases.

Estimates of mortality attributable to past exposure to ETS are derived from a study commissioned by NHS Scotland\[^viii^\]. This gives an estimate of the number of deaths per annum attributable to ETS, based on past information on exposure to ETS 30 years ago. The HERU study took a cautious estimate of the proportion of those deaths that might be averted by smoke free policies. The full effect of reduced exposure to ETS may take up to 30 years to be realised, though some effects will be realised earlier than others. The HERU study took a conservative estimate that a smoke free approach would result in 219 deaths being averted each year after 20 years. The study ignored benefits to those who continue to be exposed at home and only included deaths averted from lung cancer and CHD as these diseases have the greatest amount of supporting evidence. The HERU study assumed that benefits will accumulate in a straight line over an average 20 year period (that is, benefits in year 1 are \(1/20^{th}\) of the full benefit).

Estimates of mortality attributable to active smoking are based on a 2% fall in smoking prevalence associated with smoke free policies. Deaths caused by smoking in Scotland are approximately 13,000 per year. On this basis, it has been assumed that complete smoking restrictions would result in 260 deaths per year being averted. As with passive smoking health benefits, it has been assumed that benefits will accumulate in a straight line over an average 20 year period.

More details on the calculation of these effects are provided in appendix 3.

- **Never starters**

This analysis focuses on the impact of the various options on both active and passive smoking. However we have been unable to cost the differential impact of the options on starting rates. Intuitively it seems likely that a comprehensive option which “denormalises” smoking will have a markedly greater impact on the start smoking rates than an option which partially restricts smoking.

- **Reduced costs of treating smoking related diseases**

In 1999 it was estimated that Scotland spent up to £140m every year on treating 35,000 people for smoking-related disease\[^vii^\]. Inflation in the costs of treatment will have increased this figure since 1999 – using an index of health cost inflation since 1999 would suggest this
figure is now around £200m. However, this will be counter-balanced by a fall in smoking prevalence since 1999. Therefore, it may be prudent to assume that current spend on smoking-related disease is at least £140m per annum.

- **Resource Savings**

The voluntary introduction of smoking restrictions in some public places would yield benefits from: productivity gains as a result of reduced smoking breaks; cost savings from reduced fire hazards and; reduced cleaning and decorating costs.

Productivity gains resulting from reduced smoking breaks are derived from a survey of existing smoking policies in workplaces in Scotland. Research based on this survey suggests that a complete restriction on smoking in workplaces would, on average, lead to employees taking fewer and shorter smoking breaks, resulting in a gain in productive time of £73m per annum. This estimate is net of any additional breaks that would take place in workplaces where there are presently no restrictions. The discounted value of productivity gains is very large. However, we have included the same value for productivity gains in both options 2 and 3 below and this factor does not affect the choice between these options.

Benefits would also arise from reduced sickness absence levels in the workplace associated with restrictions on smoking.

- **Economic impacts on the hospitality sector**

It has been argued that smoke free policies may have a disproportionately large impact on the hospitality sector compared to other sectors of the economy. A smoke free policy may act as a deterrent to smokers who see such restriction as an additional cost to visiting a pub or restaurant. Non-smokers may be attracted to pubs or restaurants by the absence of smoke as the amenity of these services will be increased by the removal of ETS. Given these opposing effects, it is not possible to state definitively whether the impact on the hospitality sector will be positive or negative without empirical evidence. Therefore, the extent, quality and results of empirical evidence are considered below.

- **Costs to the Scottish Administration**

The introduction of smoke free legislation or partial restrictions in smoking in public places will impose certain implementation and enforcement costs on the Scottish Administration. As with any major policy development, certain monitoring and evaluation costs will also be incurred to establish the impact of the policy.

In order to inform the public and businesses of the forthcoming legislation and the steps that should be taken, Scottish Ministers will establish a communications programme in advance of the regulations coming into force.

Enforcement costs of any legislation will depend on the design of the legislation and the approach chosen for enforcement of the provisions at the implementation stage. Enforcement costs will also depend on acceptance and compliance levels by the public and Scottish businesses.
International experience has shown that introduction of either smoke free policies or partial restrictions leads to significant numbers of smokers quitting with consequential increasing demand for smoking cessation services.

- **Costs to Local Authorities**

In evidence prepared for submission to the Scottish Parliament Finance Committee, COSLA set out financial estimates for the cost of implementing complete restrictions on smoking\[viii\]. Implementation costs will be highest in the first 2 years following legislation, but will not be limited to these 2 years. However, enforcement costs will be expected to diminish over time. These costs have not yet been finalised and will be subject to further discussion between the Department and COSLA.

Income generated from fines has been assumed to be minimal due to expected high compliance rates based on experience in other areas where similar legislation has been introduced and has not been included in any option either as a benefit or as an offset against implementation/enforcement costs.

- **Costs to the UK Exchequer**

Based on an estimated 2% reduction in smoking prevalence due to a smoke free policy, the latest taxation data suggests that duty levels on tobacco in Scotland would fall by £15m-£30m. However, in line with government guidance “Green Book: Appraisal and Evaluation in Central Government”, we have assumed that a reduction in consumer expenditure on tobacco would be offset by an increase in expenditure elsewhere in the economy with broadly equivalent macroeconomic effects. There may be a distributional effect in that losses to the exchequer are offset by gains elsewhere in the economy.

- **Costs to Other Bodies, Individuals and Business**

Limited information is available at this stage on signage costs and other costs of implementation to businesses. Costs of signage will vary significantly between type and size of workplace. For the purposes of this RIA, signage costs have only been included where they will apply to the hospitality sector.

The impact of the proposed legislation on individuals is not limited to the impact on individuals’ health. For smokers, there may be a reduction in utility\(^1\) from smoking restrictions as a result of being prevented from smoking in public places, though some smokers may actually prefer a smoke-free environment. For non-smokers there will be increased utility from being able to enter public places without being exposed to ETS. These changes in utility will be reflected in changes in patronage of hospitality venues. No work has been done to establish the extent and value of these non-marketed costs/benefits.

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\(^1\) An economic measure of satisfaction / happiness
ANNEX C

5. **Detail**

*Option 1  Voluntary Approach*

**Health Benefits**

In the absence of legislation, it is expected that reductions in both active and passive smoking levels would be minimal. The trend reduction in smoking prevalence between 1995 and 2004 is around 0.45%, though in recent years there does seem to be a flattening of this trend. As the voluntary code has been in place since 2000 we have assumed the impact of the code is reflected in this trend. Based on existing trends, we might expect active smoking levels to fall marginally and as such, any economic benefits in terms of the value of lives saved or savings in morbidity costs will be only a fraction of those achieved through legislation.

**Active smoking**

In order to produce a rigorous comparative analysis of the options, no additional fall in smoking prevalence has been assumed under option 1. This is not to say that there would not be any further fall in smoking prevalence under a continued voluntary approach. The Tobacco Control Action Plan may lead to some further fall in smoking prevalence with attendant health benefits and resource savings. However, the Tobacco Control Action Plan will be pursued in every option and such benefits may for the most part be common to all options. Furthermore, in considering the legislative options we have taken a prudent interpretation of the available research when estimating benefits from reduced smoking prevalence.

**Passive Smoking**

Benefits from reduced exposure to ETS would be marginal. A continuation of the voluntary code would lead to some public places that presently allow smoking to become smoke free. On this basis it has been assumed that option 1 will produce only a marginal economic benefit from reduced mortality and morbidity associated with ETS, on the basis that 22 deaths would be averted each year from a continuation of the voluntary code.

**Resource Savings**

Reduced NHS treatment costs would arise as a result of reduced levels of ETS. On the basis that this option only averts 10% of deaths averted under a smoke free policy, we have assumed resource savings are 10% of those achieved under a smoke free policy.

The voluntary introduction of smoking restrictions in some public places would yield benefits from: productivity gains as a result of reduced smoking breaks; cost savings from reduced fire hazards; and reduced cleaning and decorating costs. Such savings would be small compared to the other options. There is no clear evidence, but we have assumed that benefits under this option would be 10% of those estimated for a smoke free policy.

Benefits from reduced sickness absence levels in the workplace have been assumed to amount to 10% of the benefits associated with complete restrictions.
Hospitality Sector Impacts

A continuation of the existing non-legislative option would be expected to have a minimal impact on the hospitality sector. Restrictions on smoking in pubs, restaurants and other locations would be left to local discretion.

Costs to the Scottish Administration, Local Authorities and Other Bodies, Individuals and Business

For the purposes of comparing the three options, only costs additional to those associated with the do-minimum, non-legislative option have been included in the assessment of the relative impact of the three options. Therefore, a zero cost has been included for option 1 for these potential cost elements.

Option 2  A Smoke Free Policy

Active Smoking

One of the key benefits of a smoke free policy is that such a step would help to “de-normalise” smoking within society and create a culture under which smoking is no longer the social norm. Making public places smoke free is likely to result in a significant reduction in active smoking levels.

The HERU study reviewed evidence from a number of studies on the impact of restrictions on cigarette consumption and smoking prevalence. The report concluded that a 2% fall in smoking prevalence would be a conservative estimate of the impact on smoking prevalence of complete restrictions on smoking.

This would lead to up to 260 deaths per year from active smoking being averted. A value has been attached to the deaths averted using DOT estimates of the value of life, see appendix 3. Using a value of life allows us to make comparisons of the economic costs and benefits of each option. The value of life we have used is a conservative estimate based on an average labour value per year of life lost due to car accidents. The average age of deaths by car accident is well below that of deaths caused by smoking and we have adjusted the estimates to take account of this factor. More details are included in appendix 3.

Passive smoking

The HERU report suggests complete restrictions on smoking in public places would produce significant health benefits from reduced exposure to ETS. The HERU study estimated that up to 219 deaths a year would be averted by comprehensive legislation on smoking in Scotland. Again, this figure has been converted into an economic value using a value of life.

Resource Savings

Reductions in mortality and morbidity associated with comprehensive legislation to restrict smoking would produce savings in NHS Treatment Costs. The value of benefits from reduced sickness absence levels has also been included.
The literature considered by the HERU study suggested that overall there would be productivity gains from reduced smoking breaks though whether any individual business gained or lost from the introduction of complete restrictions on smoking would depend on the extant smoking policy for those premises. The study also derived estimated cost savings from reduced absenteeism due to reduced passive smoking, reduced fire hazards associated with complete restrictions on smoking and reduced cleaning and decorating costs.

**Hospitality Sector Impacts**

The HERU study estimated the impact of smoking restrictions on the hospitality sector with reference to research studies carried out on the restaurant, bars and hotels/tourism sectors. Evidence from these studies was not as robust as the evidence available on health effects. In particular, only one study of the effects of legislative restrictions on bars was found. This study had looked at the effects of restrictions on bars in California, which suggested that the sector would gain from a complete prohibition on smoking through increased levels of patronage.

Given that the estimated economic impact on bars was based on a single study and this study was not located in a directly comparable location, for the purposes of this RIA, a more prudent view of the likely economic impact on bars has been adopted than that taken in the HERU report. A zero figure has been included under the central estimate for bars, rather than the positive impact on bars of £104m per annum estimated by HERU. Turnover in the hotels sector is forecast to fall by £10m, whilst turnover in the restaurants sector is forecast to increase by £4m. The overall impact on the hospitality sector is estimated to be a fall in turnover of £6m per annum.

This projected £6m decrease in turnover is equivalent to 0.1% of total turnover in the hospitality sector, based on the IDBR data for 2003. The Scottish Input-Output Model for 2001 has been used to estimate the knock-on effects (suppliers, linkage chain etc.) of the potential changes in consumption as a result of smoking legislation in public places for each scenario. The £6m decrease in turnover under the central estimate is equivalent to a loss of 176 direct jobs. After including knock-on effects in key suppliers and business services, output lost would be expected to be £7.3m with a total loss of 190 jobs across the economy.

This assumes that expenditure reductions in the hospitality sector by consumer switching their behaviour are not spent elsewhere in the economy. Standard economic theory suggests that consumers are likely to switch consumption to other consumer goods in the economy. To account for this, we maintain the aggregate level of household consumption in the economy, but adjust the distribution of expenditure to reflect a switch away from the hospitality sector to other consumption goods. In such a scenario, changes in terms of output and employment within the economy will be determined by the degree of linkage of suppliers and the labour intensity of different sectors of the economy.

After accounting for switching in expenditure, the net effect of a smoke free policy on the economy is a loss of £1.4m per annum. A fall in employment of around 100 across Scotland would be expected, given this loss in expenditure.

Given the less robust nature of the evidence on the impact on the hospitality sector, the low and high estimates of the potential impact are particularly relevant here. Calculations suggest that the net effect on the economy could be a fall of as much as £24.2m per annum (with a net
ANNEX C

loss of 1,500 jobs) under the low estimate and a benefit of £31.9m per annum (net increase of 2,000 jobs) under the most optimistic scenario.

These figures have been assumed to apply over a 30-year period and have been adjusted and discounted to give net present values in 2005 prices.

Costs to the Scottish Administration

Costs associated with a communications programme are anticipated to be in the region of £2 million in 2006 leading up to the regulations coming into force with a further £1 million per year and for the next 3 years 2007-09 following introduction of smoke-free public places.

It is anticipated that a compliance phone-line would be established to assist with enforcement of the legislation, which may be particularly important in the hospitality sector. Based on experience in Ireland, a broad estimate would suggest a cost of £50,000 to £100,000 to establish a Scottish compliance line. For prudence, a cost of £100,000 has been included in 2006 and 2007.

A reduction in smoking prevalence of 2% might be expected to result in additional costs of £13.5m in 2006 and £6.7m in 2007. This is based on an assumption that expenditure in 2006 will be treble existing expenditure on NRT and that expenditure in 2007 will be double existing expenditure on NRT.

Monitoring and evaluation of the policy will also have a cost attached to it. This cost may be up to £500k in total. The costs of monitoring and evaluation for option 1 have been assumed to be zero, although some of this cost may be incurred even in the absence of legislation. The full £500k cost has been included in 2007 for options 2 and 3.

Costs to Local Authorities

Based on detailed data provided by COSLA in support of the £6m estimate, a cost of £1m in 2006 and £5m in 2007 has been included\(^2\). COSLA noted that this figure must be regarded as approximate as, in the absence of detailed Regulations, they were not able to provide a more precise figure. It has been assumed that this cost will fall to £2.5m in 2008 and £1m thereafter for the rest of the 30 year period.

Costs to Other Bodies, Individuals and Business

Signage costs will apply to the hospitality sector. There are 13,000 enterprises in the hospitality sector in Scotland. Assuming a cost per enterprise of £50 for signage, this would amount to about £750k. This cost has been included in 2006 for option 2. No costs for signage have been included for businesses outside of the hospitality sector.

\(^2\) The £1m represents the initial costs associated with training and recruitment before the introduction of legislation.
Option 3 Legislation but with Dispensation for the Hospitality Sector

Health Benefits

This option provides for a restriction on smoking in public places but with complete exemption for the hospitality sector.

Active Smoking

Research on smoking restrictions introduced elsewhere\(^\text{x}\) has identified a differential impact on active smoking between clean air laws and workplace restrictions. The research suggests that clean air laws deliver a 20% fall in cigarette consumption levels, compared to a 4-8% reduction associated with lesser, workplace-based restrictions. Neither of these scenarios is exactly equivalent to the legislative options considered here and these studies measure falls in cigarette consumption rather than smoking prevalence. Nevertheless, a prudent interpretation of these results would suggest that the reduction in smoking prevalence associated with partial restrictions might be about half that of a smoke free policy i.e. a reduction in deaths due to active smoking of around 130 by 2024. This is consistent with the expectation that smoking legislation which continues to allow smoking in the hospitality sector, would have a much weaker impact on smoking rates.

Passive Smoking

Partial restrictions would undoubtedly deliver a proportionately higher increase in smoke-free places in comparison with option 1. However, bars and clubs are places where there is particularly heavy exposure to ETS\(^3\). These locations would be exempt under this option.

The Scottish Health Survey 1998 shows the proportion of adults reporting exposure to ETS by location. The survey shows that 64% of individuals reported that they were exposed to ETS (the remaining 36% reported that they were not exposed to ETS at any location). Of all individuals surveyed, 4% reported exposure to ETS only in the workplace and 10% reported exposure to ETS only in pubs. A further 3% reported exposure to ETS in both pubs and the workplace. This suggests that a restriction on smoking at work but with exemption for pubs would increase the proportion of individuals not exposed to ETS at any location by 4%. A restriction on smoking in both workplaces and pubs would increase the proportion of individuals not exposed to ETS at any location by 17%. There will also be some additional benefit to other individuals from a reduced level of exposure to ETS\(^4\). However, as noted above, the dose-response to levels of ETS for CHD is low, suggesting that benefits from reduced levels of exposure to ETS are low. Therefore, we have assumed that 55 deaths from ETS are averted by this option, equivalent to one-quarter of the number of deaths averted from a smoke free policy.

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3 Six out of ten workplaces in the leisure and hospitality sector require employees to work in areas where smoking is permitted and seven out of ten public houses allow smoking throughout.

4 A further 28% of individuals are exposed to ETS elsewhere (e.g. in other people’s homes) as well as at work, in pubs or both at work and in pubs. These individuals will not benefit from a complete removal of exposure to ETS.
Resource Savings

The reduction in NHS treatment costs has been assumed to reflect the deaths averted due to reduced active and passive smoking. On the basis that the active smoking deaths averted are 50% of the smoke free option we have assumed the resource savings will be 50% of the smoke free option. Similarly, with passive smoking the deaths averted are 25% of the smoke free option and we have assumed resource savings will be 25% of resource savings in that option. There is no evidence to differentiate the impact of smoking breaks on productivity in this option or option 2 and we have assumed the impact to be the same in each case.

Cost savings from reduced fire hazards and reduced cleaning and decorating costs would accrue under partial restrictions. Whilst the hospitality industry may account for a disproportionate share of these costs, restrictions on the non-hospitality sector will produce most of the benefits likely to be realised under option 2. As such, we have assumed these to be the same as for option 2 though in reality they are likely to be slightly less.

Hospitality Sector Impacts

Legislation on smoking but with the licensed hospitality sector exempt would see smoking policy in this sector largely left to local discretion. Where a decision to restrict smoking continues to be left to local discretion, there may be some shift in revenue between bars, restaurants and hotels, but the overall impact on the sector might be expected to be zero. As such, this option might be expected to have a minimal impact on the hospitality sector.

Costs to the Scottish Administration

Costs associated with a communications programme are anticipated to be in the region of £1 million in 2006 leading up to Regulations coming into force with a further £500k per year for the next 3 years 2007 - 2009 following introduction of smoke-free public places.

International experience has shown that the introduction of smoking restrictions leads to significant numbers of smokers quitting with consequential increasing demand for smoking cessation services. A reduction in smoking prevalence of 1% might be expected to result in double existing expenditure on NRT in 2006 and one-and-a-half times existing expenditure on NRT in 2007. This is equivalent to additional costs of £6.4m in 2006 and £3.2m in 2007.

Monitoring and evaluation of the policy will also have a cost attached to it. This cost may be up to £500k in total and this figure has been included in 2007.

Costs to Local Authorities

Based on detailed data provided by COSLA in support of the £6m estimate, a cost of £1m in 2006 and £5m in 2007 has been included⁵. COSLA noted that this figure must be regarded as approximate as, in the absence of detailed Regulations, they were not able to provide a more precise figure. It has been assumed that this cost will fall to £1.5m in 2008 and £0.5m in 2009 and for the rest of the 30 year period.

⁵ The £1m represents the initial costs associated with training and recruitment before the introduction of legislation.
Costs to Other Bodies, Individuals and Business

No costs have been assumed for signage costs for option 3 as the hospitality sector will be exempt.

Costs and Benefits of Options - Results

Net present value is considered to be the best method of expressing the benefits associated with each option. This approach is also consistent with IRIS guidance[xi] (part 2, section 2). It is the Department’s view that the assumptions made in the HERU report in support of the central estimate represent a prudent forecast of the expected outcome from pursuing comprehensive legislation on smoking, excepting the adjustments made to the hospitality sector impact as set out above and additional work done to calculate costs not considered as part of the HERU study.

The following table shows the relative scale of costs and benefits for each of the three options. Each of the NPV figures has been calculated from forecasting the economic impact of each option over a 30 year period:

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NPV in 2005 prices (£m)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>based on 30 year appraisal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(I) Health Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Economic Value of Lives Saved</td>
<td>Reduced Exposure to ETS</td>
<td>108</td>
<td>1,076</td>
</tr>
<tr>
<td>Reduced Active Smoking</td>
<td>-</td>
<td>1,278</td>
<td>639</td>
</tr>
<tr>
<td>Morbidity Saving (Human Cost of Ill Health)</td>
<td>Reduced Exposure to ETS</td>
<td>15</td>
<td>151</td>
</tr>
<tr>
<td>Reduced Active Smoking</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(II) Resource Savings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Treatment Cost Savings</td>
<td>Reduced Exposure to ETS</td>
<td>6</td>
<td>63</td>
</tr>
<tr>
<td>Reduced Active Smoking</td>
<td>0</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>Reduced Sickness Absence Savings</td>
<td>Reduced Exposure to ETS</td>
<td>5</td>
<td>49</td>
</tr>
<tr>
<td>Reduced Active Smoking</td>
<td>-</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Productivity gains as a result of reduced smoking breaks</td>
<td>147</td>
<td>1,474</td>
<td>1,474</td>
</tr>
<tr>
<td>Cost savings from reduced fire hazards</td>
<td>10</td>
<td>99</td>
<td>50</td>
</tr>
<tr>
<td>Reduced cleaning and decorating costs</td>
<td>23</td>
<td>234</td>
<td>117</td>
</tr>
<tr>
<td>(III) Hospitality Sector Impacts</td>
<td>-</td>
<td>-28</td>
<td>-</td>
</tr>
<tr>
<td>(IV) Implementation and Enforcement Costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Costs to the Scottish Administration</td>
<td>-</td>
<td>-25</td>
<td>-13</td>
</tr>
<tr>
<td>Costs to Local Authorities</td>
<td>-</td>
<td>-25</td>
<td>-15</td>
</tr>
<tr>
<td>Total NPV</td>
<td>315</td>
<td>4,387</td>
<td>2,607</td>
</tr>
</tbody>
</table>
Social Benefits

*Improving Health in Scotland: the Challenge* makes it clear that efforts to improve health are inextricably linked to the pursuit of social justice. Furthermore, some of the highest rates of smoking are to be found amongst the most disadvantaged communities in Scotland.

In Scotland, in 2003, the smoking rate of adults (aged 16-64) in the most deprived areas was 42.1%, compared to 19.7% in the most affluent areas\[\text{xii}\]. This means adults in the most deprived areas are more than twice as likely to smoke than those in the most affluent areas. The inequality in rates of women smoking during pregnancy is even greater, with 35.8% in most deprived areas compared to 13.6% in most affluent areas, which is more than two and a half times more likely. The benefits in reduced smoking prevalence brought about by smoke free policies will therefore accrue to the most deprived areas.

The table below shows the average number of adult smokers between 2001-2003 by deprivation quintiles. The quintiles are used to rank the smoking population using the Carstairs Deprivation index with the 5th quintile being the most deprived 20% of the population and the 1st being the least deprived 20% of the population.

<table>
<thead>
<tr>
<th>Deprivation Quintile (DQ)</th>
<th>DQ 1</th>
<th>DQ 2</th>
<th>DQ 3</th>
<th>DQ 4</th>
<th>DQ 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Smokers</td>
<td>139,075</td>
<td>203,332</td>
<td>228,831</td>
<td>268,850</td>
<td>312,229</td>
<td>1,152,316</td>
</tr>
<tr>
<td>Adult smoking rates[\text{vi}]</td>
<td>19.2%</td>
<td>27.9%</td>
<td>31.2%</td>
<td>36.2%</td>
<td>41.9%</td>
<td></td>
</tr>
<tr>
<td>Average Life Expectancy - Male[\text{v}]</td>
<td>77.03</td>
<td>75.49</td>
<td>73.85</td>
<td>72.08</td>
<td>69.08</td>
<td></td>
</tr>
<tr>
<td>Average Life Expectancy - Female</td>
<td>80.86</td>
<td>80.32</td>
<td>79.09</td>
<td>77.79</td>
<td>76.34</td>
<td></td>
</tr>
</tbody>
</table>

A number of conclusions can be drawn from this data:
- Prevalence of smoking varies widely across quintiles;
- The most deprived 20% of the population (DQ5) has an adult smoking rate (41.9%) of more than double the least deprived 20% (DQ1) of the population (19.2%);

Distributional Effects

Tobacco Industry Impacts

As there are no tobacco manufacturing or production activities based in Scotland, any reduction in smoking prevalence will have no associated impact on turnover or employment in Scotland.

Retail Sector Impacts

Based on an estimated 2% reduction in smoking prevalence due to smoke free legislation, there is likely to be some impact on the retail sector in Scotland. However, as retail mark-up accounts for around only 2.5% of tobacco sales, the impact is estimated to be in the range of -£4m and -£6m, with a central estimate of -£5m. In a sector with annual turnover in excess of

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\[\text{vi}\] Relates to period 2001-2003
\[\text{v}\] Life expectancy figures relate to period 2000-2002
£20bn, impacts of this scale are extremely small. In addition, we would assume that any reduction in consumer expenditure on tobacco would be substituted for spending elsewhere in the economy, some of which may be on other consumer goods from the retail sector. The proposed legislation may however impact disproportionately on certain businesses such as specialist suppliers.

**Small and rural businesses**

The impact on small and rural businesses has also been considered. It is possible that small and/or rural businesses in the hospitality sector might be disproportionately affected by the legislation and any subsequent reduction in revenue.

6. **Equity and Fairness**

As the figures shown above demonstrate, smoking more than any other identifiable factor contributes to the gap in healthy life expectancy between those most in need and those most advantaged. The highest rates of smoking are found amongst our most disadvantaged communities with people living within the most deprived areas being more than twice as likely to smoke as those living in the least deprived (i.e. 41% and 18% respectively). The constituency profiles which have been published by NHS Health Scotland underline the links between high smoking rates and lower life expectancy. It is perhaps not surprising; therefore, that surveys would suggest that 98% of bars in areas of deprivation have no smoking policies at all.

In addition, businesses involving blue collar working are less likely to have robust workplace smoking policies. The legislative controls will therefore create a level playing field for all businesses and ensure that those living and working in poorer areas have the same access to smoke-free facilities than everywhere else.

7. **Small and Micro Business Test**

The legislation will impact on the vast majority of businesses in Scotland, including small and micro firms – ie those with less than 5 employees. The impact on small and micro firms including those in the hospitality sector could be significant. We will further develop our consideration of the likely impact of the legislation on small and micro businesses during the consultation.

8. **Competition Assessment**

No significant competition issues outside of the hospitality sector have been identified with any of the options. The two legislative options apply equally to all workplaces outside the hospitality sector and therefore are unlikely to have any significant competition implications. Similarly, both option 2 and option 3 will provide a level playing field across all businesses within the hospitality sector, as under option 2 the smoke free legislation will be universal, and under option 3 the hospitality sector will be exempt.
9. **Enforcement and Sanctions**

*Will the legislation impose criminal sanctions for non-compliance?*

The Bill (see summary in Appendix 1) creates offences, sets out the penalties to be imposed, defines the kind of premises which are capable of being prescribed as no-smoking premises under the regulations, and gives local government officers powers of entry in order to enforce the prohibition. It will be an offence to smoke in no-smoking premises and it be an offence for a person who, having management or control of no-smoking premises, knowingly allows someone to smoke or fails to display the required notice. It is also an offence to fail to give your details to an enforcement officer. These offences attract penalties of up to level 4 on the standard scale. The Bill also provides for a regime of fixed penalty notices as prescribed in the regulations.

*How will the proposal be enforced?*

Approaches to enforcement will depend to a large extent on the general acceptance and compliance levels by the Scottish public and businesses. Steps will be taken to build compliance in the run in to the measures coming into force but it is envisaged that to a large extent the restrictions will be self policing with venue operators or other members of the public drawing a smoker’s attention to the restrictions in place. There will also be a provision made for a Smoke-Free Areas Compliance Helpline to allow the public to phone and report breaches of the legislation to enforcement authorities. (see below)

*Who will enforce this legislation?*

It is intended that authorised officers of the Council will have principal enforcement responsibility. In practice, this is likely to fall to Environmental Health Officers and we will be discussing with COSLA the implications of this, including the need for training

10. **Monitoring and Review**

A detailed evaluation plan will be drawn up. The proposed programme will ensure that the mechanisms are in place to monitor and evaluate the health, economic and behavioural/cultural impact of the legislation.

11. **Consultation**

(i) Within government

Apart from Health Ministers a number of other Scottish Executive Ministers have a portfolio interest in the proposed smoking restrictions and were involved in the decision making process. All the evidence gathered to inform the policy through commissioned research and the public consultation process was presented by the Health Minister to the Scottish Cabinet on 10 November 2004. Having weighed up all the evidence, the Scottish Cabinet decided that comprehensive legislative action was required to protect public health.
(ii) Public Consultation

A written public consultation\(^{\text{xiii}}\) received 52,441 personal responses to the consultation and 1,033 responses from groups, organisations and businesses. Analysis of these responses indicated that 82% of all respondents thought that further action was needed to reduce people’s exposure to second-hand smoke, 80% of all respondents would support legislation to make enclosed public spaces smoke-free, and 56% of all respondents did not think that there should be any exemptions if such legislation was introduced, although 35% indicated that there should be. Only 24% of those who indicated that they would support a law were in favour of exemptions. Whilst the general public and hospitality sector tended to focus on pubs, clubs and restaurants in terms of exemptions, organisations also referred to long-stay care facilities, prisons and workplaces that are also homes of looked after individuals.

A total of 15 public seminars were held throughout Scotland in order to listen directly to the views of people in their own communities. The events stimulated a broad range of views and the majority of participants supported the need to increase smoke-free provisions, although there were differing opinions about how that might be achieved. Licensed trade representatives were totally opposed to the proposed legislation at this time, mostly on economic grounds, although some were relaxed about such restrictions in restaurants. There was strong support amongst trade representatives for better ventilation and a staged approach to greater restrictions. Health professionals in particular spoke in favour of the proposed legislation on the basis of the health evidence, personal experiences of treating smoking-related conditions and the perceived need to de-normalise smoking within society.

An opinion poll conducted for the Executive by MRUK in September 2004, consisting of a total of 1026 in-home interviews, suggested that just over half of respondents would support a law to ban smoking in public places, with around a third opposing such a measure. Overall, two thirds of those that would support a law thought that exemptions should be considered, with 57% citing pubs and 21% citing restaurants as places where such exemptions should apply.

Additional elements of the consultation included a national conference with international speakers, a youth consultation run by Young Scot, and focus group work. There was a general consensus that the time had come for increased smoke-free provision in public places.

12. Summary and Recommendation

Results

Option 1 makes minimal progress towards objectives. Experience to date suggests that without statutory backing, a significant further decrease in exposure to ETS in the workplace is unlikely, with exposure levels in the hospitality sector being particularly resistant to further reduction.

Option 2 involves comprehensive restrictions on smoking in public places and is expected to lead to a sharp fall in exposure to ETS and a significant reduction in active smoking. Benefits from the restrictions will be concentrated on the hospitality sector where presently there are likely to be high rates of exposure to second hand smoke compared with other public places. Additionally, such an approach has the advantage of being easier to implement.
Option 3 would be likely to result in a reduction in both active and passive smoking. However, such reductions would be expected to be smaller than for comprehensive legislation and the benefits of the policy would be concentrated outside of the hospitality sector. Given the clear advantages of reducing ETS in the hospitality sector, this would fall short of achieving the policy objectives. From a public health perspective, therefore, this option is weaker than option 2.

Table 1 shows the economic impact of the various options to restrict smoking, based on the assumptions and evidence set out in this paper. Resource savings and health benefits associated with option 1, the voluntary approach, are estimated to have a net present value in 2005 prices of £315m. Option 2, smoke free in public places, is expected to result in significantly higher health benefits and resource savings. Although these are partially offset by implementation and enforcement costs and an assumed negative impact on the hospitality sector, option 2 gives a much higher NPV of around £4,387m. Finally, option 3, which allows for the hospitality sector to be exempt from legislation, would deliver health benefits and resource savings somewhere between options 1 and 2. Although these benefits are partially offset by lower implementation and enforcement costs than under option 2, option 3 gives a much lower NPV of around £2,607m.

In value for money terms, option 2 is the preferred option, with option 3 ranked second and option 1 ranked last.

Sensitivity Tests

Throughout this appraisal, a prudent view has been taken as to the benefits associated with complete restrictions on smoking. Based on this cautious approach, the preferred option in value-for-money terms, option 2, has a significantly higher NPV than the second-ranked option.

The HERU study included extensive testing of the robustness of the results. As part of the study, a range of possible impacts was considered for the health benefits, resource savings and hospitality sector impact associated with complete smoking restrictions. The low end of this range combines all of the worst estimates about the benefits and the highest negative impact on the hospitality sector. Using these ‘low’ estimates rather than the central estimates above and including the worst-case loss to the economy arising from the impact on the hospitality sector, the NPV of option 2 is reduced to £355m. Using the same estimates of the health benefits and resource savings associated with smoking restriction legislation and a zero estimate for the impact on the hospitality sector, the NPV of option 3 is reduced to £311m. On this basis, option 2 remains the preferred option in value-for-money terms.

In order to reverse the ranking of options 2 and 3, we would need to assume not only that the health benefits, resource savings and hospitality sector impact associated with smoking restrictions were at the low end of the range proposed by HERU but also that the health benefits from reduced exposure to ETS as a result of partial restrictions were 35% of those assumed for complete restrictions, rather than the 25% assumed above.

Given the conservative assumptions used in estimating the impact of comprehensive legislation restricting smoking and the assumptions required to reverse the ordering of the
options in value-for-money terms, the conclusion that option 2 is the best value for money option can be considered to be robust.

13. Declaration

I have read the regulatory impact assessment and I am satisfied that the benefits justify the costs.

Signed

Date 3 March 2005

Andy Kerr, Minister for Health and Community Care
ANNEX C

Sources:

[i] “Improving Health in Scotland: the Challenge”
Scottish Executive: 2003

Scottish Executive (2004)

Department of Health

Department of Health, Scientific Committee on Tobacco and Health (SCOTH)

David Hole, Professor of Epidemiology and Biostatistics, University of Glasgow

Health Economics Research Unit (HERU) 2004, Anne Ludbrook, Sheona Bird, Edwin van Teijlingen

CM 4171  http://www.archive.official-documents.co.uk/document/cm41/4177/4177.htm

[viii] COSLA  http://www.cosla.gov.uk

[ix] Input-Output Tables and Multipliers for Scotland 2001
http://www.scotland.gov.uk/about/FCSD/OCEA/00014713/index.aspx
Scottish Executive (2004)

[x] "Clean Indoor Air Laws and the Demand for Cigarettes",

The Scottish Executive Improving Regulation in Scotland Unit

[xii] Scottish Health Survey 1998
Scottish Executive (2001)

ANNEX C

Appendix 1 The Smoking, Health and Social Care Bill

The Bill makes provisions for a ban on smoking in enclosed premises which are prescribed in regulations as “no-smoking premises” by:

- creating an offence of permitting others to smoke in no-smoking premises;
- creating an offence of smoking in no-smoking premises;
- creating an offence of failing to display warning notices in no-smoking premises;
- setting out the powers of enforcement officers to enter no-smoking premises and for the regime of fixed penalty notices; and
- creating an offence of failing to give their name and address on request by an enforcement officer.

The Bill also lists the kind of premises which are capable of being prescribed as “no-smoking” under the regulations. These are premises which are wholly enclosed and

- to which the public or a section of the public has access;
- which are being used wholly or mainly as a place of work by persons who are employees;
- which are being used by and for the purposes of a club or other unincorporated association; or
- which are being used wholly or mainly for the provision of education, health or care services.

This approach provides for clear action on public health and for a comprehensive ban, whilst providing Scottish Ministers with the power, by regulations, to add or remove a kind of premises from the above list.

The Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005

Sections 3(3), 4(2), 4(7) of, and paragraphs 2, 5(1), 6(2), 13 and 14 of Schedule 1 to the Bill confer powers on Scottish Ministers to provide for:-

- the types of warning notices to be conspicuously displayed inside and outside no-smoking premises;
- definition of “no-smoking” premises under the Act, including any exemptions which may be prescribed; and
- details of how the fixed penalty system, introduced by section 5 of the Bill, will work.

The scope of the smoke free legislation is intended to be comprehensive. The premises or classes of premises prescribed as being “no-smoking premises” are specified in part 1 schedule 1 to the draft Regulations. Those excluded from the definition are specified in part 2 of the schedule. Exclusions are confined to Registered Care Homes and Psychiatric Hospitals facilities. However, while the legislative controls will not have effect in these areas at this stage, all such facilities will be expected, of course, to have robust smoking policies in
place to ensure that non-smokers—staff and patients—are protected from the health impact of second-hand smoke. Guidance will be issued to assist those responsible for running these facilities to develop and implement tobacco policies, including offering targeted cessation advice and support to those who wish to give up smoking.

While prisons fall outwith the scope of the Bill, it also the Executive’s intention for restrictions to extend to them. The policy is to carry out these restrictions through altering prisons rules, which are governed by statutory instrument. It is intended that prison rules will be amended contemporaneously with the introduction of the smoking provisions of the Bill.

The regulations also prescribe the manner display, form and content of no-smoking signs which are required under the Bill to be conspicuously displayed inside and outside the no-smoking premises. These provisions are intended to ensure that it is clear to all concerned that smoking is prohibited on the premises.

In addition to setting the level of fixed penalty for offences under the Act, the regulations prescribe the methods of payment, and the account keeping arrangements required by Councils.
ANNEX C

Appendix 2 Tobacco Control Action Plan

The Tobacco Control Action Plan was launched on the 13 January 2004. Key features of the plan are:

- development of a coherent, integrated long-term communications strategy to guide future prevention activity at national and local levels.
- additional funding to smoking cessation services of £1 million in 2003/04, £1 million in 2004/05 and £5 million in 2005/06, £7 million in 2006-07 and £9 million in 2007-08 bringing total investment to £11m per annum.
- a national advertising and communications campaign about the dangers of second-hand smoke.
- work closely with the UK Government to promote tobacco control policies at UK and international level.
- a target to reduce smoking rates amongst adults (aged 16-64) from 35% in 1995 to 29% by 2010; targets for reducing smoking among young people from 14% in 1995 to 11% in 2010 and to reduce the proportion of women smoking during pregnancy from 29% in 1995 to 20% by 2010.
- Sponsorship of major public debate on smoking in public places to test public support for options including legislation or strengthened extension of current voluntary approach.
ANNEX C


This Scottish Executive funded study was commissioned by NHS Health Scotland to provide a review of the latest evidence as to the impacts of smoke free legislation and restrictions. This study is the most up to date and comprehensive analysis of the likely impact of smoking legislation in Scotland and as such forms the basis of much of the cost-benefit analysis in this paper.

The results of the HERU study focus on the impact of a comprehensive ban on smoking in public places as initial study work found that there was little evidence base available that would allow a full estimate of the health and economic impact of lesser restrictions. However, given that option 3 as set out above is somewhere between a do-nothing option and smoke free legislation, for the purposes of this RIA an estimate of the costs and benefits of the ‘intermediate’ options has been calculated with reference to the available statistical evidence and the results for smoke free legislation.

The study combined a literature review with a modelling exercise to determine the likely impacts of restrictions on smoking in public places in a Scottish context. As the study was not intended to be a full cost-benefit analysis it did not look at implementation costs, compliance costs or the costs of any legislative process and these costs are considered in more detail elsewhere in this paper.

Based on the available literature, the study considered a range of impacts from restrictions on smoking:

- Reduced exposure to ETS in the workplace;
- Reduction in smoking/increase in quit attempts by active smokers;
- Reduction in number of deaths from major disease types;
- Reduced costs of treating smoking related diseases;
- Economic impacts on the hospitality sector.

The HERU study found strong evidence that exposure to ETS increases mortality and morbidity from lung cancer and coronary heart disease. There is also weaker evidence of an effect in relation to stroke and respiratory diseases. These results were found to hold true even after taking account of possible confounding factors and other potential sources of bias.

The HERU study reported on a US review that identified 17 studies of the effect of smoking restrictions/bans on exposure to ETS. These studies showed a reduction in exposure to ETS from both restrictions and bans, but an important distinction could be made, namely that the greatest reductions in exposure resulted from complete bans rather than partial restrictions. Though the studies covered a narrow range of workplaces, this was not expected to bias the results.

The study reviewed a large number of studies on the impact of smoking restrictions on cigarette consumption and smoking prevalence. Studies of the impact on smoking prevalence provided a wide range of estimates. This range may in part be due to the fact that smoking restrictions studied were in many cases accompanied by other smoking cessation interventions. The HERU study used a conservative central estimate (2% reduction) of the impact on smoking prevalence of smoke free policies.
As with reduction in exposure, the HERU study found that while bans and restrictions were associated with reductions in smoking and increases in quit attempts by smokers, greater reductions in active smoking were associated with smoke free policies than with partial restrictions. The study concluded that health gains in Scotland from reductions in active smoking may be at least as great as those from reduced passive smoking.

On the basis of available estimates, the HERU study forecast that a complete ban in Scotland would result in 219 deaths per year being averted from reduced incidence of lung cancer and CHD associated with exposure to ETS. Based on 13,000 deaths from smoking related diseases in Scotland per annum, reductions in active smoking were estimated to lead to a further 260 deaths per year being averted due to reduced incidence of lung cancer and CHD. These figures represent the best central estimate of lives saved after 20 years, with lives saved increasing in a straight line from zero to 219/260 over this period. Over the 30 year forecast period chosen by HERU, 4,490 lives would be saved from reduced exposure to ETS and 5,330 lives would be saved through reductions in active smoking. Furthermore, these figures represent a conservative estimate as only reduced deaths from lung cancer and CHD were included and not reduced deaths from a variety of other disease types.

The HERU study converted lives saved into an economic impact based on studies of the value of life produced by the Department of Transport. The latest estimate provided by the Department of Transport for the value of a life is £1,249,150 (2002 prices). HERU adjusted this figure to account for the fact that deaths from smoking-related illnesses typically occur at a later age than road traffic accident fatalities. This gave a value per life saved of between £300k and £500k depending on disease type.

The economic impacts of restrictions on smoking in public places were considered. The literature considered by the HERU study suggested that overall there would be productivity gains from reduced smoking breaks though whether any individual business gained or lost from the introduction of a complete ban would depend on the extant smoking policy for those premises. The study also derived estimated cost savings from reduced absenteeism due to reduced passive and active smoking, reduced fire hazards associated with a ban on smoking and reduced cleaning and decorating costs.

The HERU study gave separate consideration to the effect of smoking restrictions on the hospitality sector. Hospitality sector impacts were considered in terms of the impact on trade and split into impacts on restaurants, bars and hotels/tourism. Evidence from studies on the impact on hospitality sector was not as robust as the evidence available on health effects. In general it was found that studies had failed to find any statistically significant results. However, where evidence was available the results of the studies were reasonably consistent. The impact on the hospitality sector was calculated with reference to these studies and this figure was adjusted to account for expected offsetting expenditure elsewhere in the economy. This gave a net annual impact on the hospitality sector which was used in estimating the overall economic impact of a smoking ban.

As part of the HERU study a model of the overall economic impact of a smoking ban in Scotland was constructed. The model was based on the evidence obtained on the various types of impact resulting from the smoking ban, as set out above. For each type of impact for which a monetary value could be established the study projected the future value of costs and benefits in each year over a 30 year appraisal period. Future values of costs or benefits were then discounted to give net present values (NPVs).
An economic value was placed on the following impacts of the smoking bill (\textit{NPV (\text{} m) of central estimate in brackets}):

(I) Health Benefits
- The Economic Value of Lives Saved: a) as a result of reduced exposure to ETS (1024) and; b) as a result of reduced levels of active smoking (1216)
- Savings in the human cost of ill health (morbidity savings) as a result of reduced exposure to ETS (144). (Savings in the human cost of ill health, aka morbidity savings, as a result of reduced levels of active smoking were not valued)

(II) Resource Savings
- Reduced NHS Treatment Costs: a) as a result of reduced exposure to ETS (60) and; b) as a result of reduced levels of active smoking (31)
- Reduced Sickness Absence Savings: a) as a result of reduced exposure to ETS (46) and; b) as a result of reduced levels of active smoking (9)
- Productivity gains as a result of reduced smoking breaks (1403)
- cost savings from reduced fire hazards (94)
- reduced cleaning and decorating costs (222)

(III) Hospitality Sector Impacts
- Impact on the hospitality sector (369)

The robustness of the study results was extensively tested by HERU. In addition to the central estimate, ‘low’ and ‘high’ scenarios were tested based on much less, and much more, advantageous outcomes of a smoking ban.

The total NPV for the central estimate is +\text{}4,620m. This suggests that the introduction of the smoking ban might be expected to have a significant positive impact in Scotland over a 30 year period. The total NPV for the low’ and ‘high’ scenarios were +\text{}55m and +\text{}7,395m.

The HERU report concluded that a negative NPV would only be found “under an unlikely combination of circumstances” and that “under reasonable assumptions the NPV will be positive.”
Appendix 4: Impact on the Hospitality Sector and Knock-on Effects on the Economy

The HERU study estimated the impact of a complete ban on the hospitality sector with reference to research studies carried out on the restaurant, bars and hotels/tourism sectors. Evidence from these studies was not as robust as the evidence available on health effects. In particular, only one study of the effects of legislative restrictions on bars was found. This study had looked at the effects of restrictions on bars in California, which suggested that the sector would gain from a complete smoking ban through increased levels of patronage.

Given that the estimated economic impact on bars was based on a single study and this study was not located in Scotland, for the purposes of this RIA, a more prudent view of the likely economic impact on bars has been adopted than that taken in the HERU report. A zero figure has been included under the central estimate for bars rather than the estimated positive impact on the bars sector of £104m per annum.

The following table shows the estimated impact on each of the restaurant, bars (adjusted as described above) and hotels/tourism sectors and on the hospitality sector as a whole.

### Potential impact on hospitality sector turnover (2003 prices)

<table>
<thead>
<tr>
<th></th>
<th>Central estimate</th>
<th>Low Estimate</th>
<th>High estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hotels</td>
<td>-10</td>
<td>-21</td>
<td>28</td>
</tr>
<tr>
<td>Restaurants</td>
<td>4</td>
<td>-26</td>
<td>5</td>
</tr>
<tr>
<td>Bars</td>
<td>0</td>
<td>-58</td>
<td>104</td>
</tr>
<tr>
<td>Total</td>
<td>-6</td>
<td>-104</td>
<td>137</td>
</tr>
<tr>
<td>Total Sector Turnover</td>
<td>5,113</td>
<td>5,113</td>
<td>5,113</td>
</tr>
</tbody>
</table>

| % of turnover | -0.1% | -2.0% | 2.7% |

Sources: Scottish Executive, ONS (IDBR)

The aggregate consumption effects of -£104m, -£6m and £137m for the low, central and high scenarios are equivalent to percentage decrease in turnover -2.0%, -0.1% and 2.7% based on the IDBR data for 2003.

The Scottish Input-Output Model for 2001 has been used to estimate the knock-on effects (suppliers, linkage chain etc.) of the potential changes in consumption as a result of the smoking ban in public places for each scenario. The figures reported in the table below were subsequently uplifted to 2003 prices to provide proportionate estimates of the likely impacts.

The simulation for the low scenario is equivalent to a reduction in consumption in the hospitality sector of £72 million with a loss of around 3,100 direct jobs. After including knock-on effects in key suppliers and business services, output lost would be expected to be £88m with a total loss of 3,300 jobs across the economy.

<table>
<thead>
<tr>
<th></th>
<th>Central</th>
<th>Low Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct change in hospitality sector output</td>
<td>-£3.6m</td>
<td>-£72.0m</td>
<td>£97.2m</td>
</tr>
<tr>
<td>Direct change in hospitality sector employment</td>
<td>-154.2</td>
<td>-3083.2</td>
<td>4162.3</td>
</tr>
<tr>
<td>Direct &amp; Indirect output change in economy</td>
<td>-4.4</td>
<td>-87.6</td>
<td>118.3</td>
</tr>
<tr>
<td>Direct &amp; Indirect Employment change</td>
<td>-165.3</td>
<td>-3307.0</td>
<td>4464.4</td>
</tr>
</tbody>
</table>
ANNEX C

The above analysis assumes that expenditure reductions in the hospitality sector by consumer switching their behaviour are not spent elsewhere in the economy. Standard economic theory suggests that consumers are likely to switch consumption to other consumer goods in the economy. In the table below, we maintain the aggregate level of household consumption in the economy but adjust the distribution of expenditure to reflect a switch away from the hospitality sector to other consumption goods. In such a scenario, changes in terms of output and employment within the economy will be determined by the degree of linkage of suppliers and the labour intensity of different sectors of the economy.

<table>
<thead>
<tr>
<th>Balanced Consumption Impact</th>
<th>Central</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct &amp; Indirect output change in economy</td>
<td>-1.4</td>
<td>-24.2</td>
<td>31.9</td>
</tr>
<tr>
<td>Direct &amp; Indirect Employment change</td>
<td>-100</td>
<td>-1500</td>
<td>2000</td>
</tr>
</tbody>
</table>

Note that even with balanced consumption we get a reduction in output as a result of the switch away from the hospitality sector in the low and central case results. This is simply because the hospitality sector has stronger local linkages within the economy and is relatively labour intensive relative to other sectors which supply household consumption such as wholesale/retail sectors.

In the high scenario, where consumption in the hospitality sector increases as a result of the ban in smoking, we adjust consumer expenditure elsewhere in the economy to adjust for this increase. Note that this leads to a positive increase in consumption and employment again simply because of the characteristics of the hospitality sector.
ANNEX D

RESPONDENT INFORMATION FORM
THE SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) Act 2005
(PROHIBITION OF SMOKING IN CERTAIN PREMISES) REGULATIONS 2005

Please complete the details below and return it with your response. This will help ensure we handle your response appropriately. Thank you for your help.

Name:

Postal Address:

1. Are you responding: (please tick one box)
   (a) as an individual □ go to Q2a/b and then Q4
   (b) on behalf of a group/organisation □ go to Q3 and then Q4

INDIVIDUALS

2a. Do you agree to your response being made available to the public (in Scottish Executive library and/or on the Scottish Executive website)?

   Yes (go to 2b below) □
   No, not at all □ We will treat your response as confidential

2b. Where confidentiality is not requested, we will make your response available to the public on the following basis (please tick one of the following boxes)

   Yes, make my response, name and address all available □
   Yes, make my response available, but not my name or address □
   Yes, make my response and name available, but not my address □

ON BEHALF OF GROUPS OR ORGANISATIONS:

3 The name and address of your organisation will be made available to the public (in the Scottish Executive library and/or on the Scottish Executive website). Are you also content for your response to be made available?

   Yes □
   No □ We will treat your response as confidential

SHARING RESPONSES/FUTURE ENGAGEMENT

4 We will share your response internally with other Scottish Executive policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Executive to contact you again in the future in relation to this consultation response?

   Yes □
   No □
THE SCOTTISH EXECUTIVE CONSULTATION PROCESS

Consultation is an essential and important aspect of Scottish Executive working methods. Given the wide-ranging areas of work of the Scottish Executive, there are many varied types of consultation. However, in general, Scottish Executive consultation exercises aim to provide opportunities for all those who wish to express their opinions on a proposed area of work to do so in ways which will inform and enhance that work.

The Scottish Executive encourages consultation that is thorough, effective and appropriate to the issue under consideration and the nature of the target audience. Consultation exercises take account of a wide range of factors, and no two exercises are likely to be the same.

Typically Scottish Executive consultations involve a written paper inviting answers to specific questions or more general views about the material presented. Written papers are distributed to organisations and individuals with an interest in the issue, and they are also placed on the Scottish Executive web site enabling a wider audience to access the paper and submit their responses. Consultation exercises may also involve seeking views in a number of different ways, such as through public meetings, focus groups or questionnaire exercises.

Copies of all the written responses received to a consultation exercise (except those where the individual or organisation requested confidentiality) are placed in the Scottish Executive library at Saughton House, Edinburgh (K Spur, Saughton House, Broomhouse Drive, Edinburgh, EH11 3XD, telephone 0131 244 4565).

All Scottish Executive consultation papers and related publications (eg, analysis of response reports) can be accessed at: Scottish Executive consultations (http://www.scotland.gov.uk/consultations).

The Scottish Executive now has an email alert system for consultations (SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx). This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). SEconsult complements, but in no way replaces SE distribution lists, and is designed to allow stakeholders to keep up to date with all SE consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

The views and suggestions detailed in consultation responses are analysed and used as part of the decision making process, along with a range of other available information and evidence. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

Final decisions on the issues under consideration will also take account of a range of other factors, including other available information and research evidence.

1 http://www.scotland.gov.uk/consultations
While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.
CONSULTATION LIST

Business (General)
CBI Scotland
Federation of Small Businesses
McLarens Wholesale
Scottish Retail Consortium
Scottish Business in the Community
Scottish Chamber of Commerce
Scottish Grocers’ Federation
National Federation of Retail Newsagents

Business (Leisure, Gaming and Hospitality)
Association of British Bookmakers
Bar, Entertainment and Dance Association
BAT (British American Tobacco)
Bell Filter Solutions Ltd
Bingo Association
British Casino Association
British Greyhound Racing Board
British Horseracing Board
British Hospitality Association
Carlton Clubs Plc
Cowells Arrow Bingo
Gala Leisure Ltd
National Association of Bookmakers Ltd
National Greyhound Racing Club Ltd
Rank Group Gaming Division
Scottish Beer and Pub Association
Scottish Football Association
Scottish Independent Bookmakers Association
Scottish Licensed Trade Association
Scottish Premier League
Scottish Rugby Union
Sportscotland
Scottish Tourism Forum
Stanley Leisure Plc
Tobacco Manufacturers’ Association
Visit Scotland
William Hill Plc

Business (Transport)
Airport Operators Association
BAA Scottish Airports
British Ports Association
Caledonian MacBrayne Ltd
Confederation of Passenger Transport
Dundee Airport
Edinburgh Private Hire Association
First ScotRail
Glasgow Prestwick International Airport
GNER
Highlands and Islands Airport Ltd
Northlink Orkney and Shetland Ferries Ltd
Orkney Ferries
P&O Irish Sea
Railway Policy and Projects Branch
Scottish Taxi Federation
Seacat
Stena Line Ltd
Strathclyde Passenger Transport
The Chamber of Shipping
The Greater Glasgow Private Hire Association
UK Major Ports Group
Virgin Trains
Western Ferries (Clyde Ltd)

Children and Young People
Barnardos
Children First
Children in Scotland
Save the Children Scotland
Scottish Youth Parliament
Youthlink Scotland

Disability
Capability Scotland
Disability Rights Commission
Enable
Inclusion Scotland
Scottish Association for Mental Health
Scottish Disability Equality Forum Scotland
Mental Health Foundation
Mental Welfare Commission
National Schizophrenia Fellowship (Scotland)

Enterprise
Highlands and Islands Enterprise
Scottish Enterprise

Equality and Ethnic Groups
Commission for Racial Equality
Equality Opportunities Commission
Strategic Group on Women

Justice
Faculty of Advocates
Scottish Police Federation
Sheriff’s Association
The Association of Scottish Police Superintendents
The Association of Chief Police Officers in Scotland
The Law Society of Scotland

Local Authorities
COSLA
Chief Executives, Local Authorities
City of Glasgow Licensing Board
Edinburgh Licensing Board
VOCAL (Voice of Chief Officer of Cultural, Community and Leisure Service)

NHS Scotland/ Other Health
Asthma UK
British Dental Association (Scottish Branch)
British Heart Foundation
British Lung Foundation
British Medical Association (Scottish Branch)
Cancer Research UK
Care Commission
Chest, Heart and Stroke Scotland
Chief Executives, NHS Boards
Chief Executives, Special Boards
Diabetes UK, Scotland
Directors of Public Health
General Managers, State Hospitals
Health Promotion Managers
MacMillan Cancer Relief
Marie Curie Cancer Relief
RCGP
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal Society of Edinburgh
The State Hospitals Board for Scotland
UK Departments of Health

Older People
Age Concern
Alzheimer Scotland
Help the Aged
Scottish Care

Parliament
Clerk of Committees
MEPs

Prisons
APEX Scotland
ANNEX F

HM Inspectorate of Prisons
SACRO
Scottish Prison Officers Association
Scottish Prison Service

Private Clubs
British Legion
Coal Industry Social Welfare Organisation
CIU (Scottish Rep)
CIU – Working Men’s Club and Institute Union Ltd
CORCA – Committee of Registered Clubs Association
Grand Lodge of Scotland
Grand Orange Lodge of Scotland
National Union of Students
Scottish Bowling
Scottish Golf Union

Sustainable Development
Friends of the Earth Scotland
Keep Scotland Beautiful

Unions
STUC (for all Unions)

Voluntary
Aberlour
ASH Scotland
Association of Chief Officers of Voluntary Organisations
Community Service Volunteers
Oxfam in Scotland
Salvation Army
Scottish Council for Voluntary Organisations
Scottish Human Rights Centre
The Poverty Alliance
The Roy Castle Lung Cancer Foundation
Voluntary Action Fund
Volunteer Development Scotland
Who Cares Scotland
Women’s Royal Voluntary Service

Other
Association of Scottish Community Councils
CAB (Citizens Advice Bureau)
Centre for Tobacco Control Research
Copyright Libraries
FOREST
Highland Users Group
Ministerial Working Group on Tobacco Control
National Smoke-free Areas Implementation Group
Royal Environmental Health Institute of Scotland
ANNEX F

Scotland’s Health at Work
Scottish Civic Forum
Scottish Consumer Council
Scottish Tobacco Control Alliance
Society of Chief Officers of Environmental Health in Scotland
Society of Chief Officers of Trading Standards in Scotland
SUPPLEMENTARY WRITTEN SUBMISSION FROM THE STUC TO THE HEALTH COMMITTEE

I refer to your letter of 18 March and now return the witness questionnaire duly completed.

We would also like to bring to the Committee's attention additional information that we could not introduce on the day.

Prior to giving evidence, we had discussions with the Prison Officers Association (Scotland) who, at the time, were unaware that these proposals would define prisons as a public place.

This does raise a number of concerns for our affiliate, not least the risk to the safety to their members who will be tasked with enforcing this legislation within Scottish Prison Service establishments.

The SPOA are aware that a number of establishments already have their own smoking policies that restricts areas where prisoners can smoke, that would appear to be effective and do not place increased risk on staff.

We would therefore ask that the SPOA are involved in any future consultation, especially in relation to the inclusion of prisons as a prescribed enclosed public place in this legislation.

Ian Tasker
Consultation

1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?

Response: The British Dental Association (BDA) is responding to Part 2 of the Bill. In this regard, we took part in and provided a comprehensive response to “Modernising NHS Dental Services in Scotland” in April of 2004. We also responded to “Towards Better Oral Health in Children” in December 2002.

The BDA still awaits formal responses from the Scottish Executive on both of these consultations.

The BDA noted the current level of expenditure on General Dental Services, outlined in “Modernising NHS Dental Services”. We also noted the level of funding that had been made available for dental practice improvements in the 3 years up to 2003.

In our response to that consultation, the BDA highlighted serious shortfalls in funding in both primary and secondary care dental services. In particular, we believe that the cost of funding the NHS General Dental Services at the current level of provision of service should be in the region of £520m, ie a threefold increase. Our estimation is based upon expenditure figures published by NHS Highland’s “Oral Health Strategy” in 2002, which shows the levels of expenditure across primary care dental services in the area. These figures highlighted a significant under-investment in the independent contractor services (the GDS), compared with the costs of providing a salaried general dental service.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?

Response: We do not believe our comments on the financial assumptions have been reflected in the Bill. For this reason, it is almost impossible for the BDA to comment in more detail. The Bill will enable legislation to take forward “Modernising NHS Dental Services in Scotland” before the Scottish Executive has announced its detailed policy intentions to address the shortcomings of the current system.

3. Did you have sufficient time to contribute to the consultation exercise?
Response: The original deadline of 5th March 2004 proved very difficult to meet and we welcomed the extension of the consultation to 2nd April 2004. We would suggest that consultations of this nature should extend over a minimum period of 4 months.

Costs

4. If the bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial memorandum? If not, please provide details.

Response: Not applicable

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

Response: Not applicable

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?

Response: Not applicable

Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

Response: With regard to the policy intentions outlined in Part 2 of the Bill, the BDA has serious reservations on two grounds; (a) funding and (b) workforce. For the purposes of this submission to the Finance Committee, our comments and evidence here relate solely to the funding aspects, but includes reference to the funding implications with regard to workforce.

In the BDA’s response to “Modernising NHS Dental Services” we set out our recommendations for a way forward for improving oral health, and a shift towards a preventive based service.

The funding of general dental practices is mostly from item of service fees. This system generates the “treadmill” effect, which the Scottish Executive mentions in the Bill.

The BDA believes that if NHS dental services are to be truly modernised, then financial provision needs to be made to facilitate a preventive approach to dental care. This allows general dental practitioners to spend more time with patients discussing their oral health, their general health and agreeing individual management regimes. This increased time commitment must be recognised and appropriately remunerated. The current range of GDS
allowances have been welcomed, however, the eligibility criteria of these are almost totally based on levels of GDS earnings, which is “output” based, rather than “outcomes” based; thus compounding the “treadmill” effect.

As long as the current system does not recognise this time and focuses mainly on funding reparative and restorative work, modern dental services will not be delivered. Examples of where additional support might come from would be direct support for premises and infrastructure that would include things such as equipment and materials, as well as direct reimbursement for some staff costs.

The impact of the current NHS system requires dentist to work at a pace that is increasingly difficult to sustain in order to provide adequate dental care. The result is that many dentists have had to withdraw from the NHS and seek support for running their practice through the provision of dental services on a private basis. In doing so, it also enables them to allocate greater time to their patients, which they are unable to do by working under the current NHS system.

The Scottish Executive has confirmed that since 1999, 93 practices in Scotland have ceased to provide general dental service, ie NHS treatment. In many cases, this has been as a result of dentists choosing to retire early. According to the findings of the “Toothousand Project”, a survey of General and Community Dental Practitioners carried out by the Scottish Council for Postgraduate Medical and Dental Education, two thirds of GDPs planned to retire early. Half of this group planned to reduce their clinical hours in the years before retirement. The “piecework” nature of the GDS was cited as one of the main reasons; furthermore, a third of GDPs identified stress as a reason for early retirement.

Many dentists (practice owners) have found it difficult, if not impossible, to sell their practices as “going concerns”. The current criteria of the Scottish Dental Access Initiative does not allow for funding to be allocated towards the purchase of established practices. The BDA believes that if the criteria were expanded in this way, it would help address the problems associated with practice closures, not least continuation of care for patients.

Free Dental Examinations

The funding of this initiative is of major concern to the BDA. In its response to “Modernising NHS Dental Services in Scotland”, the BDA favours the development of a fully funded, comprehensive oral health assessment as part of basic oral healthcare provision. The existing dental examination 1(a) in the Statement of Dental Remuneration is insufficient to identify the needs of patients and to identify and discuss and agree with them the care regimes that they should receive as part of a modern dental service.

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1 Answer to Parliamentary Question S2W-12427; answer presented by Rhona Brankin on 6 December 2004
Dental workforce shortages in Scotland will also affect the ability to deliver this initiative. Evidence to support this statement is contained in NHS Education for Scotland 4th Workforce Planning Report “Workforce Planning for Dentistry in Scotland” published in June 2004. The Report states that in 2003 “Potential gaps in service provision may be identified by comparing the supply and utilisation model projections and the principal results suggest a current shortfall of 215 GDPs.”

The Scottish Executive has based its costs for the implementation of this initiative on the current system and “on an increase of up to 25% on the numbers of people who currently pay for dental check-ups.” The BDA finds it difficult to see how this increase in numbers of patients will be realised, more especially with current evidence showing the numbers of patients being de-registered in some areas. Evidence of a downward trend in adult and child registrations is contained in the Scottish Dental Practice Board’s annual report of 2003/2004, figures that the Scottish Executive recently presented to Parliament.

In addressing workforce shortages, the Scottish Executive must also recognise and take action on the funding of under-graduate and post-graduate education and training.

In 2000, a recommendation was made by the Scottish Advisory Committee on the Dental Workforce (SACDW) to standardise the output of the two dental schools in Scotland by setting an output target of 120 dental graduates (70 from Glasgow and 50 from Dundee), over the 5 year period 2000-2005. (Reference: “Workforce Planning for Dentistry in Scotland – A Strategic Review”).

The Scottish Executive Health Department has set a revised output target of 134, which is reflected by an intake target in 2004/2005 of 151.

The BDA believes that without significant investment in the two dental schools in Scotland, then this increase in intake will be difficult to support. The BDA understands that some of the education and training of dental students is likely to take place in a primary care setting (outreach). However, once again, this will require major investment in facilities and staff training and recruitment.

The BDA acknowledges that the proposed increase in Professionals Complementary to Dentistry (PCDs) may help to free up dentists’ time (although it has not been made clear as to how these numbers are to be increased). This is more likely to be the case if PCDs have enhanced roles within the dental team - a trend that will be facilitated under the planned new regulatory regime for PCDs. However, we note that the Section 60 Order (under the Health Act 1999) that is required to amend the Dentists Act 1984 so as to enact this change has been delayed by six months and the GDC now expects the PCD reforms will not be implemented until 2006.
Moreover, an article published in the British Dental Journal (Vol.198 No 2 Jan 2005 page 105)\(^2\), showed that the majority of registered dental hygienists in Scotland do not work in wholly NHS practices, but in either wholly private practice or in mixed NHS/private private (39% and 41% respectively).

**GDS**

The Bill is measuring and costing the current system. The BDA is unable to comment on this aspect of the Financial Memorandum, as we do not yet know the Scottish Executive’s plans for “Modernising”.

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

Yes, there will be future costs associated with the Bill. The modernisation of NHS dental services in Scotland cannot take place without significant increase in the level of funding. The BDA has already provided an estimation of the investment required (as outlined above).

\(^2\) “Educational needs and employment status of Scottish dental hygienists” by M K Ross (Senior Lecturer, Edinburgh Postgraduate Dental Institute), R J Ibbetson (Professor of Primary Dental Care and Director, Edinburgh Postgraduate Dental Institute) and J S Rennie (Postgraduate Dental Dean, NHS Education for Scotland).
This questionnaire is being sent to those organisations that have an interest in, or which may be affected by, the Financial Memorandum for the Smoking, Health and Social Care (Scotland) Bill. In addition to the questions below, please add any other comments you may have which would assist the Committee’s scrutiny.

**Consultation**
1. Did you take part in the consultation exercise for the Bill, if applicable, and if so did you comment on the financial assumptions made?
   
   Did not take part.

2. Do you believe your comments on the financial assumptions have been accurately reflected in the Financial Memorandum?
   
   Not applicable

3. Did you have sufficient time to contribute to the consultation exercise?
   
   Not applicable

**Costs**

4. If the bill has any financial implications for your organisation, do you believe that these have been accurately reflected in the Financial Memorandum? If not, please provide details.

   The financial implications as stated do provide an accurate reflection of the cost implications to the Care Commission.

   Services which are excepted by regulations and that are not required to register with the Care commission will not incur regulatory costs in the form of Care Commission fees that are set to recover the full cost of regulation.

5. Are you content that your organisation can meet the financial costs associated with the Bill? If not, how do you think these costs should be met?

   There are no material financial costs to the Care Commission associated with the Bill.

6. Does the Financial Memorandum accurately reflect the margins of uncertainty associated with the estimates and the timescales over which such costs would be expected to arise?
Wider Issues

7. If the Bill is part of a wider policy initiative, do you believe that these associated costs are accurately reflected in the Financial Memorandum?

Not applicable

8. Do you believe that there may be future costs associated with the Bill, for example through subordinate legislation or more developed guidance? If so, is it possible to quantify these costs?

No future costs that would impact on the Care Commission can be identified.

SUBMISSION FROM COSLA

Purpose

The purpose of this paper is to provide the Scottish Parliament’s Finance Committee with an outline estimate of the costs associated with the introduction, implementation and continuing enforcement of a ban on smoking in wholly enclosed public spaces as proposed by the Smoking, Health and Social Care (Scotland) Bill. The Committee is asked to note that these are preliminary costs that COSLA will refine with its member councils. The costs will, in addition, be discussed with the Scottish Executive.

Principles

1. COSLA supports the principle of the ban on smoking in enclosed public spaces and regards it as a major step in advancing the health improvement agenda which is one of our member councils’ priorities.

2. Support for the principles and goals of the Bill is dependent on the Scottish Executive providing full funding to allow for the successful implementation of the Act. This is standard COSLA policy and was reiterated as part of our spending review submission in 2004.

The Financial Memorandum

3. As usual, as required by the Parliamentary process, the Financial Memorandum was published with the Bill itself but in the absence of the detailed Regulations that will accompany the new legislation. This has caused practical problems in costing the implementation of the smoking ban and means that, at best, COSLA’s current estimate can only be an estimate. Costing new legislation is an important part of the legislative process, for all parties involved, but it is particularly important to ensure the integrity of any new legislation and its efficacy. Against this background COSLA’s member councils have provided the best estimates possible. The Committee is asked to recognise this and also the fact, that, at this stage, the interpretation of
costs will vary between authorities. Any inconsistencies in approach will be addressed as estimates are refined.

4. Work with COSLA member councils has produced an initial first year estimate for the implementation of the ban of smoking in public places. Based on figures available, we believe that the total cost in 2005/6 and 2006/7 is in the region of £6 million.

5. With regard to the other elements of the Bill, the financial memorandum states that no major financial implications have been identified for local government at this stage. However, the cost neutral description of the section relating to Joint Ventures should be treated with some caution. It is felt that, in the long term, this could have implications for local authorities and COSLA would wish to reserve its position on this element of the Bill.

6. The commentary in Executive’s Financial Memorandum on the banning of smoking in public places reflects the uncertainty which all parties feel surrounds the financial elements of the Bill. It rightly states that the implementation costs for local authorities have yet to be determined and will be linked to the detail of the Regulations which have yet to be drafted. It also recognises that additional costs in the early years are likely, an open acknowledgement that is welcome. It is therefore against this background that this evidence has been prepared and the Committee will recognise that the figures used are estimates only. However, experience does indicate that where councils have given detailed estimates, the outturn costs are unlikely to vary significantly.

7. The evidence has been prepared within a short timescale to meet the Committee’s deadline and there has been little opportunity for cross checking, either at Council or COSLA level. When the Regulations are available, it is intended to repeat this exercise against the more detailed background the Regulations will provide and COSLA will be happy to make the information from this available to the Committee.

8. As indicated in the introduction to this paper, COSLA will also be working with the Scottish Executive on these financial estimates.

9. One specific point emanating from the Financial Memorandum that COSLA would like to raise relates to the generally held view that enforcement costs will diminish over time. This is accepted, but there are concerns that it may take longer than anticipated for opposition to the ban to fade. To ensure the success of the ban therefore ongoing commitment is needed from all parties involved. The ban is not a ‘quick fix’ but the beginning of what will be a sustained campaign against the damaging effects of smoking on health. The investment of sufficient resources both initially and on an ongoing basis will be essential.

10. What will not be available with the Regulations and in the next year or so with actual experience of implementation is firm evidence of the financial benefits of the legislation. Some of these benefits to health will be long term.
and COSLA would prefer to leave it to statisticians to attempt to quantify the cost benefits to employers, the NHS and individuals, of living and working in a smoke free environment. What is clear, however, is that there will be real benefits which must be borne in mind when considering the cost of implementing the legislation.

**Individual Issues**

11. COSLA would wish to comment on and highlight a number of individual issues with financial implications. These are:

**Staff**

12. There is already an acknowledged shortage of Environmental Health Officers – a situation likely to be exacerbated given the age profile of the profession. This is an issue the Scottish Executive has already agreed to discuss. It is a fact, however, that the enforcement needs of the smoking ban will create further demands and difficulties on council staff with considerable efforts being required for recruitment. It is recognised that fully qualified EHOs will not necessarily be required for all elements of the resulting workload and enforcement officers will be employed too – typically authorised/technical officers. This will very much be a matter for individual authorities to determine and current staffing arrangements will be a factor.

13. The possibility of combining smoking legislation duties with existing EHO officer work and with enforcement officers to be responsible for liquor license standards work will be considered by individual authorities, but decisions here will be on an individual authority basis. (For example, in one authority it is not envisaged that the Liquor Licence Standard Officer will be involved in the enforcement of the smoking ban in licensed premises. This post is considered to be a liaison and advisory link between the Licensing Board and licensees and accordingly will at most report breaches of licensing conditions to the Board. It is considered that a direct involvement in enforcement would compromise this link.) Discussions are also taking place between COSLA and the HSE regarding respective responsibilities, possible cross over etc but these discussions are at a preliminary stage.

14. There are concerns that the Executive will only fund enforcement for an initial period and that funding will then decrease with revenue consequences for councils.

15. ‘Lone working’ will not be an option given the need for corroboration and the nature of the premises to be visited allied to the police position that they are not able to commit resources to assist in the enforcement of a ban.

16. Much of the work will be of an ‘out of hour’ nature – overtime payments will be the norm.

17. For rural councils, (and notably islands authorities) given the geography of their areas, there will be particular organisational issues to be addressed and extra expenses incurred.
18. The introduction of the new legislation, if the planned timetable is achieved, will more or less co-incide with the introduction of the new EU Food Hygiene Regulations (from 1 January 2006) which will also place significant additional burdens on environmental staff.

**Lead in time**
19. Assuming the implementation date for the legislation will be 1 April 2006, work will be required prior to that and expenditure incurred in the current financial year. Ideally staff should be in post some months before the legislation goes live. Publicity and consultations with businesses should ideally be allowed a generous timeframe.

**Street Cleaning**
20. An increase in street cleaning – particularly in city centres – has been identified by elected members as a likely outcome of the ban. At the moment cigarette litter is a particular issue at the entrance to shopping centres and large office complexes and it is a problem that is expected to increase once the legislation is enacted.

21. There are differing views, however, as to the additional burden this will impose on councils and as with many of the issues relating to enforcement of the ban, advance quantification of their impact is not an exact science. Where streets are not swept in the evenings this might need to be reviewed. If cleaning is required in other than city centre areas, any noise caused by the sweepers will be a consideration. Cigarette related litter is difficult to deal with by mechanical sweeping and is labour intensive. What is clear is the view that responsibility for the immediate environs of premises such as pubs, clubs and restaurants should lie with proprietors allied to a licensing condition that licensees provide cigarette disposal facilities and/or local cleaning at licensed premises. Capital costs for the provision of additional litter bins are anticipated by many councils and to this must be added the cost of their installation and servicing.

**Training**
22. Training will be required not only for all staff involved, but also for elected members. A central training resource (perhaps a bespoke, module-based course) that can be delivered remotely has been suggested.

23. Training should include: enforcement; how to deal with confrontational situations/aggression/assertiveness; court room training; statement taking, record keeping; use of computers and relevant programmes

**Publicity materials**
24. These will be required on both a national and local basis and, as usual, in minority languages etc. Clarification is awaited as to how the £2M expenditure identified by the Scottish Executive for ‘communication ahead of implementation’ will be used. It is hoped that a proportion at least will be allocated to the central production of materials that can in turn be individually badged by councils.
**Income generated from fines**
25. It is not anticipated that income generated from fines will be high, but that income should be retained by councils for use, for example, to:- offset the cost of implementing the legislation, for smoking cessation services or for sports grants in keeping with the public health theme.

**Start up Costs**
26. These will include: advertising and employment of new staff; the development of enforcement strategies; preparation for training for enforcement and front-line staff, elected members and senior management; briefing of administrative and managerial staff and training of existing and new enforcement staff; promotion/publication of the new law and councils’ approach to enforcement, associated management of Freedom of Information and the provision of information to the public and businesses (recognised that the Scottish Executive could provide some materials centrally for badging by individual councils); use of existing EHO staff to provide advice on the ban in the run up to implementation.

27. Inspections will require to be at a higher level initially, but it is anticipated that the need for these will decline to a lower, constant rate over time.

**Exemptions**
28. Depending on any exemptions agreed later through Regulations, there could be financial implications for councils’ social work and housing services, eg to upgrade premises, the introduction of transitional arrangements as part of a move towards smoke-free status as well as a need for continuing support to protect workforce and client health in them. Private agencies used by councils as care providers could pass on costs to councils as service users.

**Practical Experience**
29. Councils’ experience of implementing similar legislation – eg dog fouling – is varied. In one council, 20-25% of fines are unpaid. The cost of pursuing these through Sheriff Officers is not cost effective.

**Conclusion**
30. The financial comment and estimates contained in this paper have been based on the information available to date, in some cases projected scenarios and best estimates. COSLA would welcome the opportunity to return to the Committee with more detailed financial information once its member councils have had the opportunity to consider the full implications of the new legislation in light of the detailed regulations.

February 2005
<table>
<thead>
<tr>
<th>Council</th>
<th>Estimated Costs (2006/07) + prep costs</th>
<th>Comments*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen City</td>
<td>114,000</td>
<td>Probably 75k in future years; 5000 premises; 2 FT officers; 24k start up</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>109,100</td>
<td>1 senior officer; 2 authorised officers; admin asst + 10k essential training</td>
</tr>
<tr>
<td>Angus</td>
<td>108,000</td>
<td>Includes start up costs in 05/06; for 05/06 - Senior EHO/EHO on out of hours conditions (33k); links with other enforcement teams – 5k; publicity + comms materials – 2k; for 06/07 – 08/09 – Senior EHO – 45k; 2 PT EOs – 20k; publicity, comms – 5k. 22.7k pa estimate after 06/07</td>
</tr>
<tr>
<td>Argyll &amp; Bute</td>
<td>145,000</td>
<td>Includes ICT set up costs of 10k + 4k for publicity materials, assuming central provision of some materials</td>
</tr>
<tr>
<td>Clackmannashire</td>
<td>52,000</td>
<td>25k staffing (AP3); 15k street cleaning; training 2k publicity etc 10k; admin – 15k</td>
</tr>
<tr>
<td>Comhairle nan Eilean Siar</td>
<td>55,000</td>
<td>Initial recruitment training + indirect costs + possible legal &amp; admin costs</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>159,800</td>
<td>5-6000 premises (includes food premises + other where H &amp; S enforced) 4FT officers (1 co-ordinator + 3 tech officers); for first 18-24 months reducing to 2 (co-ordinator + 1 tech officer) in next 18-24 months. + admin backup</td>
</tr>
<tr>
<td>Dundee City</td>
<td>95,500</td>
<td>includes 1 EHO (37,000); 1 Enforcement Officer – 25,000; Staff, training, overtime, travel, IT, local publicity + 5k initial set up</td>
</tr>
<tr>
<td>East Ayrshire</td>
<td>135,000</td>
<td>2 EHOs; Includes oncost; 10k for training + other operational costs + 10k street cleaning, litter bin provision</td>
</tr>
<tr>
<td>East Dunbartonshire</td>
<td>143,500</td>
<td>2 EHOs - 7k. accommodation – 13k; elected member training 1k – 2.5k; publicity; 5k additional street cleaning 50k</td>
</tr>
<tr>
<td>Edinburgh City</td>
<td>403,000</td>
<td>17,000 premises currently inspected – a further 3,000 expected to fall within the smoking legislation; 173k for staff (1 EHO; 1 EO; 2 Env Wardens; 2 EOs (night team); 230k - other costs (16k recurring overheads; 1k elected member training; 30k staff communication and signing; 10k publicity.</td>
</tr>
<tr>
<td>Fife</td>
<td>420,000</td>
<td>2 FT EHOs per area, reducing to 1 FTO per area as legislation beds in – 180kv for years 1 and 2, 90k thereafter; includes costs for mechanical sweepers (80k) + additional manpower; + additional litter bins</td>
</tr>
<tr>
<td>Glasgow</td>
<td>896,000</td>
<td>192k of this for first year only; 404k for initial 3 years. Covers additional EHOs – 1 team leaders + 5 enforcement assts + admin support – 250k for 3 years; legal support; technical &amp; admin support; monitoring; publicity &amp; info materials; additional street cleaning – 144k pa.</td>
</tr>
<tr>
<td>Highland</td>
<td>184,000</td>
<td>Staff only costs – 4 additional staff; 4,500 premises, but 1500 estimated to require active regulation. Other costs to be added later - admin, re signage,</td>
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<tr>
<td>Inverclyde</td>
<td>140,000</td>
<td>Includes 40k in 05/06 for preparatory work</td>
</tr>
<tr>
<td>Moray</td>
<td>126,500</td>
<td>Covers 4 officers (poss qualified technical officers) – 117k; training for new and existing staff and also Licensing Board members – 4k ; implementation in council premises – 1k; printing of fixed penalty notices + establishment of systems – 3.5k. NOT included, but expected to be substantial – additional street cleaning costs and also publicity materials which it is felt should be produced by the Executive.</td>
</tr>
<tr>
<td>North Ayrshire</td>
<td>40,000</td>
<td>1 EHO only costed + training</td>
</tr>
<tr>
<td>North Lanarkshire</td>
<td></td>
<td>Using Irish experience as model; 8,600 premises – risk assessment required in some form to determine priority for visits; specialist unit will be required, managed by an EHO and initially staffed by at least 6 technical officers on short term contracts; flexible working patterns and out of hours working.</td>
</tr>
<tr>
<td>Orkney</td>
<td>128,000</td>
<td>Based on 2 officers at 50k, including out of hours working, training, mileage and publicity. Pre-implementation costs included cover training, consultations with businesses, training for elected members. NOT included is cost of employing EHOs in lead in period pre-April 06.</td>
</tr>
<tr>
<td>Perth &amp; Kinross</td>
<td>312,500</td>
<td>5-6 staff at AP3-4; training; staff time + management costs; equipment – mobile phones, laptop PCs, printer etc; hire equipment (2 vans + running costs); publicity; admin (clerical support; job adverts; accommodation etc). Excludes training, street cleaning costs and miscellaneous additional costs</td>
</tr>
<tr>
<td>Scottish Borders</td>
<td>196,000</td>
<td>Includes 1 senior warden + 4 wardens + vehicles, training transport, recruitment – 155k; 1 AP111 officer – 35k; training 3/.5k; signage 1.5k publicity 1k</td>
</tr>
<tr>
<td>Shetland</td>
<td>75,100</td>
<td>2 EHOs at higher salary point (36,869) assumed; training £600; mileage costs</td>
</tr>
<tr>
<td>South Ayrshire</td>
<td>302,200</td>
<td>Covers additional staff + overtime, additional litter warden, training + publicity</td>
</tr>
<tr>
<td>Council</td>
<td>Cost</td>
<td>Details</td>
</tr>
<tr>
<td>-------------------------</td>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>470,000</td>
<td>Includes 170,000 for lead in work; costs for years 2 + 3 reducing to 230k; anticipated 6965 premises</td>
</tr>
<tr>
<td>Stirling</td>
<td>132,500</td>
<td>Senior EHO SCP 39-42); 3 EHOs SCP 31-38 Admin support (SCP 13-15); training; office accommodation</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>190,000</td>
<td>76k for start up + 114k in 05/06 covering recruitment, training of 2 EHO + 2 student EHOs, publicity + other misc costs; 113k and 114k in following 2 years; further 20% reduction anticipated in 09/10.</td>
</tr>
<tr>
<td>West Lothian</td>
<td>75,000</td>
<td>Includes staff (AP4), training, promotional work; 5000 premises</td>
</tr>
</tbody>
</table>

- comments are summaries only extrapolated from detailed submissions. Where councils have provided low and high estimates of staff costs, these have been averaged.

Notes:

‘Start up’ costs typically include: development of enforcement strategy; training of front-line staff, elected members and senior management; briefing admin and managerial staff; promotion/publication costs- eg staff time, postage, officer time for preparing and presenting seminars, press releases, briefings etc; advance advice provision by EHO staff; recruitment costs; accommodation and equipment costs
Enforcement costs typically include: initial high volume of inspections, decreasing over time; out of hours working; provision of advice; responding to complaints; monitoring; technical and admin support
SUBMISSION FROM OPTOMETRY SCOTLAND

Smoking, Health and Social Care (Scotland) Bill: Financial Memorandum

I am writing as Chairman of Optometry Scotland, the organization that represents the profession which will be charged with the implementation of the Partnership Commitment on “free eye checks”, as provided for in the Smoking, Health and Social Care (Scotland) Bill. We wish to take this early opportunity of advising the Committee that, in our view, the funding estimates contained in the Bill are likely to fall well short of that required to fulfil the Commitment.

We appreciate that the figures in the Bill were produced from the currently available GOS data and that the SEHD have informed the Health Committee that information on any additional costs for Dental and Optometry services will be made available as soon as practicable.

At the request of the Scottish Executive, The Review of Eyecare Services in Scotland is currently considering fundamental changes in the nature of care and responsibility optometrists will have for Eyecare in the community. The Centre for Change and Innovation is designing pathways for Eyecare that will make use of the services of Optometrists at a level far in advance of that for which the current very limited General Ophthalmic Services contract was designed almost 60 years ago. The introduction of Community Health Partnerships and integrated inter-disciplinary working arrangements will reinforce this updated provision of Optometric Eyecare.

Using Optometry, in the way under discussion with the SEHD, will reduce acute referrals to the hospital sector by approximately 40%. There will also be considerable direct patient, carer and social benefits that it is our intention to quantify within the interim Review of Eyecare Services Report.

OS believes that this Bill offers the opportunity to provide Scotland with a primary Eyecare service of which it can be truly proud and which will contribute significantly to a real health gain for the country. This must, however, be accompanied by realistic funding and we will continue to work with SEHD to develop the detail of that.

We would therefore commend the Smoking, Health and Social Care (Scotland) Bill to the Finance Committee and encourage its support bearing the caveats above in mind.

Hal Rollason
Chairman
SUBMISSION FROM SCOTTISH NHS CONFEDERATION

1. The Scottish NHS Confederation is the independent representative body for NHS Scotland boards and special health boards. We are grateful to the members of the Finance Committee for giving us the opportunity to present evidence on this important bill.

2. We have confined our comments to the sections of the bill where we believe that there are potential significant financial implications for NHS organisations. We have not commented on the implications for NHS National Services Scotland as, although they are one of our member organisations, they are giving their own evidence to the committee.

3. A key point that the committee should bear in mind when considering all new cost commitments for NHS boards is that, despite significant increases to their allocations in recent years, boards have only very limited financial scope available to develop new services or take on new commitments. This is because funding increases have been accompanied by new cost pressures which account for the greater part of boards’ annual allocation uplifts. Chief amongst these is the UK-wide pay modernisation agenda (the new GMS and consultant contracts and Agenda for Change), along with increases in prescribing costs and a revaluation of the NHS estate. Further pressures to come in the future will include the implementation of Modernising Medical Careers, the review of training for doctors. NHS boards increasingly find that their annual allocation uplifts are largely accounted for by the time they reach them, and that they have very little left over to redesign and develop services. Audit Scotland reported that of the additional £2.7 billion allocation uplift (£1.8 billion in real terms) for the whole of NHS Scotland 02/03, £1.4 billion was already accounted for, not including Agenda for Change.3 This picture was confirmed by the most recent Auditor General’s overview of NHS Scotland financial performance, which concluded: “Despite significant increases in funding …the NHS in Scotland is facing unprecedented challenges over the coming years…the fixed costs associated with staffing and property will make it difficult for NHS boards to free up money for redesigning services.”4

4. **Prohibition of smoking:**
The Confederation fully supports the proposals to prohibit smoking in public places and is confident that, in the long-term, it will result in a considerable reduction of the estimated £200m per annum that smoking-related ill-health currently costs NHS Scotland. It is extremely difficult to predict when these savings will be released and at what level they will be achieved, as the wide range of the Executive’s own estimate (£5.7m – £15.7m) in the Financial Memorandum indicates.

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3 Overview of the NHS 2002/03, Audit Scotland August 2004
4 Overview of the financial performance of the NHS in Scotland 2003/04, Audit Scotland December 2004
5. In order that the full health benefits of the prohibition of smoking in public places are realised, the policy should be supported by further investment in NHS smoking cessation services. The Executive has already confirmed, in A Breath of Fresh Air – Improving Scotland’s Health: The Challenge, that funding for smoking cessation will rise to £5m across Scotland for 2005/06. This figure is welcome but may need to be supplemented, not only in order to respond to increased demand as a result of prohibition of smoking coming into force, but also in order to allow NHS boards to actively promote their full range of smoking cessation services without fear of staff being overloaded, waiting times building up or prescription costs increasing significantly in the short-term. Several studies (such as Buck and Godfrey 19945 and Parrott and Godfrey 20046) have found smoking cessation services to be one of the most cost-effective forms of health intervention. It is difficult to say in advance of prohibition being implemented how much extra investment may be required, but the Executive should be prepared to respond if necessary to the evidence presented by NHS boards.

6. **Free eye and dental checks**
   The Confederation has always welcomed the proposal to introduce free eye and dental checks as an important contribution of preventive health care, but we have had some concerns about the impact that the costs of providing free checks would have on existing NHS services. We are pleased therefore that the Executive has committed to provide funding to National Services Scotland to cover the costs of free checks, but stress that this must be additional funding and not drawn from existing NHS allocations.

7. **Provision of General Dental Services**
   Section 13 of the bill provides for NHS boards to provide assistance and support, including financial assistance to general dental practitioners. This could be a useful method of encouraging dentists to contribute more of their time to treating to NHS patients or to move into areas which are currently lacking in dental provision. We believe however that it could also lead to an expectation on the part of practitioners that financial assistance will be provided, and that this burden will fall particularly on boards where there are particular shortages of NHS dentists and/or where issues with the quality and availability of premises have been identified, such as in remote and rural and urban deprived communities. The Executive should, in the interests of ensuring an adequate level of dentistry provision across Scotland, consider providing additional resources for those boards which are likely to find themselves in the position of having to make higher levels of financial assistance available.


8. The estimation in the financial memorandum of a £500,000 increase in administrative costs across NHS Scotland resulting from the new GDS provisions seems reasonable and, if the actual costs turn out to be in this region, they should be found fairly easily from existing allocations. However, it is difficult to predict exactly what administrative costs will be in advance of the new provisions coming into force, and once again it is likely that a larger burden will fall on those NHS boards that currently face particular problems with dental service delivery.

9. **Pharmaceutical care services**

The Confederation fully supports the Executive’s intentions, set out in *Modernising Community Pharmacy*, to further integrate community pharmacy into the NHS, to increase the clinical care offered by community pharmacies and to improve access to community pharmacy services across Scotland, as part of the overall strategy to deliver services closer to patients. An important element of this strategy is the new responsibility for NHS boards to secure the provision of adequate pharmaceutical services in their areas, and we support the plan to disburse the existing national ‘global sum’ to NHS boards so that they have more control over the use of that money in response to local needs.

10. We do not believe, however, that the current global sum of £97m for the whole of Scotland will be sufficient to allow boards make the investment that will be required to adequately rectify under-provision of pharmaceutical services over and above the maintenance of existing services. Until boards develop their individual Pharmaceutical Care Services (PCS) Plans, we cannot say exactly what the extent of under-provision is and what it will cost to address, however we do know that there are significant service gaps in many remote and rural and deprived urban areas. Expanding provision to fill these gaps and to ensure that there is equitable access to PCS across Scotland will have significant cost implications. The Financial Memorandum does give some indication of the specific costs that may be involved (£30,000 to £80,000 for fitting small to medium-sized premises), and it can be seen even from this broad estimation how costs could quickly accrue for boards which have significant service gaps to fill. These costs will be extremely difficult for boards to meet from their annual allocations at the present time, for the reasons that we outline in paragraph 3. The Confederation believes that the Executive should give serious consideration to finding additional resources for boards to fulfil their PCS Plans once they have been drawn up. The expansion of community pharmacy will be an important factor in the successful implementation the Executive’s health policy agenda and it should be funded properly.

11. Once again, the estimate of £500,000 across NHS Scotland for additional administrative costs associated with the new PCS provisions
does not seem unreasonable, but the true figure will not be quantified until implementation begins to take place.

12. **Joint Ventures**

The development of a Joint Ventures model would provide NHS boards with another vehicle, if they choose to use it, to invest in and expand community premises and services. Since there is so little flexibility within annual financial allocations for service development, the creation of new options for NHS boards in this respect is welcome. The new arrangements for securing and exploiting intellectual property developed within the NHS are also welcome, and are a source of potential income. Both of these are complex issues and we look forward to seeing the outcomes of the work of the Joint Premises Project Board for further detail on implementation.

13. Finally, we would reiterate that NHS boards currently have very limited capacity within their existing financial allocations for service expansion. One idea that has come from Confederation members is that the Executive should provide boards with financial memorandum-type costings for new health policies, before they reach legislative stage, where this is relevant. We would suggest that this would be extremely useful, not only to aid financial planning at the centre and at board level, but also to assist the Parliament’s committees in their scrutiny of health policy.

**SUBMISSION FROM SCOTTISH SOCIAL SERVICES COUNCIL**

**Smoking, Health and Social Care (Scotland) Bill – Financial Memorandum**

Thank you for the opportunity to comment upon the Bill. The Council was aware of the Bill and supports the amendments relating to its functions. (These can be found in the Explanatory Notes, page 19, paragraphs 131-135; page 38, paragraph 259 and in the Policy Memorandum, page 24, paragraph 140). The Council brought to the attention of the Scottish Executive the issues it wished to see addressed relating to its functions. We do not anticipate any additional costs arising out of the sections relevant to the Council’s function and responsibilities.

Carole Wilkinson
Chief Executive

**SUBMISSION FROM SCOTTISH HEALTH ENDOWMENT RESEARCH TRUST**

SHERT was involved in discussions with the Chief Scientist Office about the proposed wording for the section of the Bill dealing with the repeal of
SHERT’s public body status and was also asked for comments on the financial assumptions which are now included in the Financial Memorandum.

The Financial Memorandum accurately reflects the financial implications for SHERT connected with the repeal of public body status in the way proposed in terms of Section 32 of the Bill.

SHERT can meet the one-off financial cost associated with the Bill.

We would also comment that, in the long term, we do anticipate that the change of status will lead to cost savings for SHERT. These are impossible to quantify and have therefore correctly been reflected in the Financial Memorandum as being “at the most ……… neutral”. Perhaps the likelihood of cost savings could be emphasised to the Finance Committee.

Any comments or queries should be directed to Simon Mackintosh or Alexander Garden at Turcan Connell, SHERT’s Secretaries.

Turcan Connell
Secretaries to SHERT
10th January 2005

SUBMISSION FROM THE SCOTTISH LICENSED TRADE ASSOCIATION

On behalf of the SLTA I am writing to formally respond to your invitation to give a written submission to the Finance Committee on the Financial Memorandum of the Smoking, Health and Social Care (Scotland) Bill. As previously advised both Paul Waterson, Chief Executive, and I will be representing the SLTA at the oral hearing on Tuesday 8 February.

The SLTA represents 1,800 licensees in Scotland who are mainly independent self-employed publicans operating bars and small hotels throughout the length and breadth of the country.

There is a common misconception, perhaps derived from uninformed press reports, that the SLTA has opposed the Government’s plans to increase restrictions on smoking in public places. On the contrary, we have been working with the Scottish Executive for five years as partners in the Voluntary Charter and we proactively approached the Deputy Health Minister in May 2004, asking him to legislate for the introduction of significant restrictions on tobacco smoking in licensed premises with incremental restrictions being introduced on an annual basis.

We would like to present six principal points for your consideration and for further debate at the oral hearing:

(a) The Financial Impact Study carried out by the Scottish Executive (through Aberdeen University’s International Review) has been incomplete, irrelevant and rushed.
(b) Independent research, commissioned by the licensed trade, suggests that the financial impact will be far greater than stated in the Financial Memorandum.

(c) We feel it is extremely important that Scotland’s policy on tobacco restrictions should be aligned to the policies adopted in the rest of the UK. There should be exemptions for licensed premises which do not serve hot food.

(d) The knock on effects of the health and economic impact of a sudden, outright ban have, so far, not been fully considered by the Scottish Executive.

(e) The gradual or phased approach may well achieve improved health results, in comparison to the outright ban approach.

(f) The licensed trade wishes to continue to work with the Government to achieve the common aim of a healthier Scotland.

Can I now elaborate on these six points.

(a) **Lack of Relevant Research**

The licensed trade has commissioned the Moffat Centre for Travel and Tourism Business Development, Glasgow Caledonian University, to undertake a project to source, review and evaluate existing research which has been undertaken in analogous destinations and countries which have legislated for either an outright or a phased ban on smoking in workplaces. This included the aforementioned International Review undertaken by the University of Aberdeen.

Their report is herewith attached at appendix 1.

The Moffat Centre conclusions include:

- The weakness of the International Review is its lack of relevant evidence to:
  - (a) support the argument that an outright ban in all workplaces will reduce the number of smokers when increases in smoking may be displaced elsewhere eg in the home
  - and (b) make a claim that a no smoking policy will not harm the hospitality business, particularly bars.
  
  (page 50 refers)

- The authors of the International Review add weight to the above argument by freely admitting that “the estimates for Scotland of the
impact on the hospitality sector of a smoking ban are not considered to be as robust as the estimates for the health effects”. This was likely to be the case as the authors are from a health background. (page 50 refers)

- We would expect pubs and bars to feel the negative effects of a total ban much more keenly than in the restaurant and hotel sectors. (page 54 refers)

- Nearly all the governments in the countries and states reviewed for this work, with the exception of Ireland, have given significant notice of their intention to introduce a total ban on smoking in hospitality establishments. This is only fair given the apparent difference in perception of the public towards smoking in different categories of hospitality premises. The Scottish Executive could take a lead from the experiences of other nations’ legislature. (page 54 refers)

- It has been acknowledged as a weakness in the Executive’s commissioned research that the studies reviewed do not include analysis of a total ban situation. This is compounded by the lack of transferability of the cases used in their argument. (page 54 refers)

- A government-backed investigation into the effects of the ban in Ireland could be undertaken, using a cross sectoral group that encompasses health experts, industry practitioners and government policy makers. This would surely provide a consensus on the effects of and timescale for introducing a total ban, if that was the conclusion of the group. (page 55 refers)

(b) Likely Financial Impact

The licensed trade in Scotland has been alarmed by the lack of any in depth study of the potential financial impact of the smoking ban. As one of the key partners in the “Against an Outright Ban” Group we commissioned the Centre for Economics and Business Research (London) to independently review the economic impact on both the licensed trade and the beer industry in Scotland. The CEBR report is attached as appendix 2. Its findings include:

- The value of annual turnover in the licensed trade will decline by £105m (page 5).
- Annual profits in licensed premises may decline by £86m (page 5).
- Employment in the licensed trade can be expected to decline by 2,300 jobs initially (page 5).
- About 142 average sized licensed premises may close as a result of decreased trade (page 5).
The Chancellor of the Exchequer may lose out on a total of £59m in annual tax revenues from Scotland (page 5).

(c) **Alignment with the Rest of the UK**

The SLTA feels strongly that Scotland should align its general smoking policy with that of the rest of the UK. Tourism is a major contributor to the economic welfare of Scotland and we feel that there is a strong possibility of tourists preferring English destinations rather than Scottish ones as a result of the different tobacco policies. Eighty percent of visitors to Scotland are English based. There is support for this theory from American boundary States (see page 40 of Moffat Centre research) where border-hopping has become an issue.

We would like to make it clear that we do not agree with the exemptions proposed in England for registered clubs. Whatever smoking restrictions are introduced (in any country) it is not fair or reasonable to give preference to clubs (which don’t pay tax on their profits) over business premises (which do pay several different taxes on their income). If clubs are subject to different laws from licensed premises, health problems are not solved – they are merely shifted.

(d) **Knock on Effects**

Little recognition seems to have been afforded to the ramifications of a downturn in the Scottish leisure industry and the consequences of lower employment. The fear of unemployment affects the mental and physical welfare of all those who work in any industry which is subjected to such sudden cultural change as this.

Moreover, there has been no Scottish Executive research into the potential consequence of smokers ceasing to visit licensed premises and switching their disposable spend into take home drinking. Approximately six-sevenths of health problems encountered from ETS are derived from domestic situations and it is quite possible that the outright ban approach will result in greater health problems as a consequence. Obviously, this is a crucial point and we strongly contend that the Scottish Executive should conduct independent research into the likelihood of this before any legislation is approved.

(e) **The Benefits of the Gradual Approach**

The Scottish Executive’s own research, and many other opinion surveys show that the Scottish public favour tobacco restrictions but they also favour a gradual approach to the banning of smoking in licensed premises. It is our contention that the public will support a phased approach to an eventual ban but could well be hugely resistant and rebellious to the outright ban proposition. If the outright ban proposal simply fosters the “couch potato syndrome” the desired effect of moving towards a smoke free Scotland will not be achieved. The legislation will
not solve a health problem – it will simply shift the health problem from ETS experienced in public places to ETS experienced in domestic environments.

(f) **Working Together in the Future**

We would stress that the Scottish Licensed Trade Association wishes to continue to work with the Government to improve Scotland’s health and we understand fully the benefits of a reduction in tobacco consumption. What we are seeking at this stage is a reappraisal of the best means to achieve the desired outcome. It will be to the benefit of all parties if the Scottish Parliament adopts a phased approach to a smoking ban or the structure proposed by Dr John Reid for England (apart from the matter referred to earlier – there should be the same smoking rules for pubs and clubs).

These are our main points. However, we would further comment on the Financial Memorandum as follows:

1. No attempt seems to have been made to examine the loss of excise duty, VAT, etc to the Exchequer should smoking of tobacco reduce following the implementation of the ban. The most recent figures (2001/2002) calculate excise duty on tobacco to be £9.5bn. Scotland has about 9% of total UK population so it is fair to assume that the tobacco take from Scotland is circa £855m. Section 202 of the Financial Memorandum pontificates that 4% of smokers might quit following the introduction of a workplace ban. If that proves to be the case the tobacco take will decrease by over £34m. Against that, NHS savings due to 4% lower treatment costs would be £8m. Thus, the net cost would be in the region of £26m.

2. The Financial Memorandum makes reference to National Health Service Scotland savings should there be a reduction in the number of smokers over time and therefore a reduction in the treatment of smoking related diseases. However, the Memorandum fails to endeavour to capture the cost of expensive geriatric healthcare and attention if longevity is achieved through the smoking ban.

3. Further, no attempt has been made to calculate the cost to the country of providing pensions for smokers who live longer as a result of the smoking ban. This is a major issue for everyone at present – pensions are not being funded adequately as it is.

We would also make the following observations on the Financial Memorandum:

(a) If the smoking ban is to be enforced effectively by the authorities we estimate that each of Scotland’s 32 licensing boards will require around six additional environmental health officers to cover the geographic territory and the long working day within the licensed trade (including
sports and social clubs) which stretches to almost 24 hours. We believe that the cost of this policing could amount to as much as £6 million per annum.

(b) We are baffled by the “international research” which is suggesting that there will be an identified saving from smoking breaks which would no longer be permitted under the terms of the proposed legislation. This is patently a nonsense. If smoking breaks are permitted by employers at the moment then it is clear that the staff involved will require to leave the premises rather than stay within the premises, once the ban is imposed. So there would be no cost implication whatsoever. However, it is our experience that very few employers permit smoking breaks in Scottish industry at present. In most companies if staff want to smoke they must do so in their own time, not in the time of their employers. So it is a “cost neutral” issue.

Conclusions

The licensed trade has always been, and will always remain, supportive of the ultimate objective of a smoke free Scotland. However, we strongly believe that the Scottish Executive has not afforded the time and consideration necessary to identify the best move for public health. As we have stated, there is a significant body of evidence to suggest that an alternative strategy, with the same aim, may further increase the health benefits achievable from restricting the use of tobacco in licensed premises.

Surely what is effectively the most radical move in public health policy this government has seen deserves a greater attention to detail?

We urge the Finance Committee to request more time to conduct research into the financial and health benefits of alternative approaches. In addition, we would urge the government to consider new and innovative ways to tackle smoking. This debate seems to have been dominated by a ban / no-ban approach. At no point in the process would it seem that anyone has really sat down and looked for the best solution.

Should the Executive decide to give the decision just a bit more thought we would of course be delighted to help in anyway possible.

We look forward to further debating these issues with you at the oral evidence on 8 February.

Stuart Ross
Chairman of the Year 2004
The Scottish Licensed Trade Association
SUBMISSION FROM ASH SCOTLAND

Part of Bill: Part 1

Main Objective: Prohibiting Smoking in Enclosed Public Places

International Evidence: Economic Impacts of Smoke-Free Legislation
The Scottish Licensed Trade Association (SLTA) has recently claimed that there are few examples of extensive smoke-free legislation in place from which to draw conclusions regarding the possible economic impact of introducing smoke-free legislation in Scotland. However, there is a wealth of international evidence to demonstrate that smoke-free enclosed public places don’t have a negative impact on business.

a) Republic of Ireland
The Licensed Vintners Association (LVA) recently published research concluding that the economic impact of smoke-free legislation is unfavourable for the licensed trade in the Republic of Ireland. However, the LVA’s study was based on subjective interviews with over 270 publicans around Dublin. They were asked to describe how they viewed the impact of legislation, to estimate the effects the legislation has had, and to predict the economic future of their business. This material is entirely unreliable as a proper economic assessment as it is not based on hard financial or economic data.

It is interesting to note that the publicans’ estimates of their sales figures are significantly different to the hard data available, such as the drink sale figures produced by the Central Statistics Office (CSO) as well as the drinks manufacturers themselves. According to the latest figures from the CSO, bar sales are reported to have picked up sharply, with sales figures rising by 2.3% between September and November 2004. This rise marks a turnaround after two months of declining volumes. Whilst bar sales continued to be down on 2003, falling by around 5.1%, this is dramatically less than the 29% fall in volumes claimed by the LVA, whose figures do not take account of seasonal changes to drinking purchases.

Smoke-free legislation in the Republic of Ireland was introduced in what was already a shrinking bar sales market. Sales reportedly hit their peak in May 2001, and since then, the volume of drink sold in Irish bars has fallen by approximately 15%. Many factors have contributed to this climate, including changing demographics, the price of drink, increased price competition from supermarkets and off-licences, increased excise duty on alcohol, and changing working patterns and lifestyles. Yet the LVA report attributes all of the alleged downturn in the trade to smoke-free legislation. This is simply not credible, and claims to this effect don’t stand up to scrutiny.

The LVA has also claimed that the introduction of smoke-free legislation in the Republic of Ireland has led directly to the loss of 2,000 jobs in Dublin. However, these figures are dubious, as they too are based on subjective interviews with bar managers or owners and not on objective economic information. Mandate Trade Union, the third largest union in the Republic of
Ireland, represents almost two thousand bar workers, mainly based in Dublin. The union’s records indicate that job losses in the greater Dublin area have been in the order of a couple of hundred, not the thousands claimed. Levels of visits to pubs and restaurants are thought to have remained constant since legislation was introduced, with 1 in 5 smokers choosing not to smoke at all when out socialising. The rate of smokers visiting pubs has remained steady at 74%, and the frequency of non-smokers visiting pubs has increased from 67% to 70%.

b) United States of America

A recent report on the first 12 months since the smoke-free legislation in New York was introduced has documented clear financial benefits to comprehensive legislation; 10,000 new jobs have been created (2,800 seasonally adjusted jobs), air pollution levels have reduced six fold, and business tax receipts in restaurants and bars are up 8.7%.

Many hospitality groups have claimed that their business has been detrimentally affected by smoke-free legislation. For example, in Beverly Hills, California, the Restaurant Association said that their businesses had suffered a 30% decline in revenues during the five months after smoke-free regulations were in effect. As a direct result of such opposition, organised by the tobacco industry, Beverly Hills repealed their smoke-free restaurant ordinance. Studies have since shown that, contrary to tobacco industry claims, there was no detectable drop in restaurant sales during the time the ordinances were in effect, nor was the an increase in restaurant sales following reversal of the 100% smoke-free ordinances. In fact, sales increased slightly during the period the smoke-free regulations were first in place.

Whilst hospitality groups often claim that smokers will stop visiting pubs and restaurants, hence projected loss in trade, international data in fact shows that once-lost custom from nonsmokers starts to return. For example, it has been reported that, in the State of Massachusetts, there are more non-smokers who avoided smoky restaurants and bars pre-legislation than there were smokers in the State.

c) Australia

A recent study has assessed the economic impact of introducing smoke-free policies in Tasmania on sales in bars, licensed clubs, restaurants and cafes. Using seasonally adjusted monthly sales data from January 1990 to September 2002, and statistically controlling for underlying economic trends, unemployment, and population changes, the study concludes that smoke-free legislation has not had any negative impact on sales turnover in restaurants, cafes and pubs, when compared to total monthly retail turnover in Tasmania.

Estimated economic impact of smoke-free legislation in Scotland

A recently published international review models the likely impacts of moving from the current voluntary code to comprehensive legislation on smoking in enclosed public places in Scotland. Modelling procedures utilise existing evidence on the economic impacts that have been measured in other countries with comprehensive smoke-free legislation. The report concludes
that conservative estimates of savings in the workplace exceed the ‘worst case scenarios’ for losses in the hospitality industry. The effect on the hotel, restaurant and bar sectors in Scotland is centrally estimated at £110 million (range –£63 million to +£281 million). The study also suggests that the most sizeable economic impact is a net gain for society in resource terms, which are centrally estimated at £115 million five years post legislation.\textsuperscript{xii}

The SLTA have criticised this international review, claiming that there is not enough relevant research on which to base estimates of potential economic impact in Scotland.\textsuperscript{xiii} However, despite this claim, they have commissioned research that suggests “the capital cost of compliance with the Bill will be in the region of £85 million. The research also suggests that “costs may be well in excess of that, depending on the views of the local regulatory authorities on matters such as the provision of fire escapes and facilities for the disabled” \textsuperscript{xiv} These estimates were calculated on the basis of information that is available from Ireland, which the SLTA claims concludes that turnover in Ireland is down by more than 7\% in value and 10\% in volume, and that the number of jobs has reduced by 6\%.\textsuperscript{xv} However, as already outlined on page 1, the latest hard data available suggests an increase in sales figures of around 2.3\%.\textsuperscript{2} The shrinking bar sales market that was previously reported had been in decline since May 2001\textsuperscript{2}, and the alleged downturn in trade cannot be attributed solely to the introduction of smoke-free legislation.

The SLTA have reported that smoke-free legislation will force more than 140 pubs to close, and lead to the loss of 2,300 jobs, and £59 million in tax revenue in Scotland.\textsuperscript{xvi} The level of turnover in Scotland should be borne in mind when interpreting any future claims of economic loss; there are around 5,000 openings and closures of businesses over a 3-year period, without attributable effects to policy changes.\textsuperscript{11}

Predictions of a downturn in business are encountered in every country where legislation has been, or is currently being, introduced. However, smoke-free legislation has been passed in every conceivable type of community, from small towns and rural areas to a number of states, and economists have studied the impacts on communities across the spectrum. Anecdotal reports, polls or interviews with business owners concerning economic impacts of smoke-free legislation should be treated with great scepticism. No objective, peer reviewed study ever conducted has found a significant negative economic impact associated with smoke-free legislation.\textsuperscript{xvii} Recent research has compared the quality and funding sources of 97 studies concluding either a negative effect, no effect, or positive effect of smoke-free legislation on the hospitality industry. The best designed most rigorous studies consistently report no impact or a positive impact of smoke-free restaurant and bar laws on sales and employment. It is noteworthy that all the studies concluding a negative impact have been funded by the tobacco industry.\textsuperscript{xviii}

Recently discovered tobacco industry documents demonstrate that second-hand smoke may be even more harmful, volume for volume, than directly
inhaled cigarette smoke. Yet the tobacco industry continues to place the highest priority on preventing the introduction of restrictions on smoking in public places, and remain equally active in spreading misinformation about the effects of legislation that has already been introduced successfully in other countries.

The Scottish Licensed Trade - Proposed Legislation

The licensed trade umbrella group, Against an Outright Ban (AOB) represents the SLTA, the Scottish Beer and Pub Association, and other pub groups based in Scotland. In May 2004 they outlined proposals for implementation of a 5-point plan, across a 3-year period, as an alternative to the comprehensive legislation that the First Minister outlined in November 2004. The SLTA’s Chief Executive, Paul Waterson, believes that the 5-point plan would provide a “major contribution to improve health prospects in Scotland”. This alternative approach proposes that:

1. Smoking be banned at the bar counter in all licensed premises.
2. Smoking be banned in any area where and when hot food is served.
3. Smoking be banned in any area from which the public is excluded.
4. Licensed premises must allocate
   a. 30% of total floor space to a non-smoking area in year one
   b. 40% in year two, and
   c. 50% in year three. This would be followed by a further review
5. Licensed premises must display a smoking policy at the entrance in order that customers can see the facilities available before they enter.

The option of postponing introduction of new law provides the hospitality trade and tobacco industry with increased time to step up attempts to scupper the introduction of legislation. The tobacco industry and their allies use this in every battle they have fought to try and prevent the introduction of smoke-free legislation.

Adopting the proposed 5-point plan would ensure that Scotland’s legislation was aligned to the policies adopted in the rest of the UK, which the SLTA believes is of extreme importance. However, the 5-point plan, like the current Voluntary Charter, would fail to deliver significant protection to hospitality workers in Scotland. Even where designated smoking areas are provided under the current Charter, they often continue to expose people in the vicinity to second-hand smoke, and they increase the exposure to smoke by concentrating smokers in the one place. Neither the current Voluntary Charter, or the proposed five-point plan are based on evidence on how to protect health, either for staff in the leisure industry, or for the public who use these facilities. Voluntary agreements do not provide significantly increased protection from second-hand smoke.

The Impact of Smoke-free Legislation on Tourism

The SLTA suggest that there is a “strong possibility of tourists preferring English destinations rather than Scottish ones as a result of different tobacco policies”. Their concerns are contrary to the evidence available from the
Republic of Ireland, where 2004 saw a reported record numbers of visitors and double the growth rate of revenue compared to Northern Ireland, where smoking is still unrestricted.xxiv Surveys of tourists in Ireland demonstrate that availability of smoking areas is not a factor for most people when choosing holiday destinations. However, when smoking is an issue, it is because people want smoke-free holiday destinations.24 Glantz and Charlesworth (1999) identified 3 US states and 6 US cities in which opponents of smoke-free legislation specifically advanced claims that such laws would adversely affect tourism. Contrary to industry claims, the introduction of smoke-free legislation was not associated with significant drops in tourism in any of the locales outlined, and in several cases significant increases in tourism were observed as a result of smoke-free legislation being introduced.xxv

The Health Benefits of Comprehensive Smoke-Free Legislation
The SLTA believe that a phased approach to legislation may well achieve improved health results compared to the option of introducing the proposed Smoking, Health and Social Care Bill in Scotland.13 However, the health benefits of comprehensive smoke-free legislation are tangible and evident in a short space of time when introduced, as outlined below.

A recent review of smoke-free workplaces in the USA, Australia and Canada estimated that comprehensive smoke-free legislation reduces smoking prevalence by 4%, and overall tobacco consumption by 30%.xxvi In the six months after legislation was introduced in the Republic of Ireland, an estimated 7000 smokers had given up smoking.xxvii These figures have not been matched in the North, where smoking rates remain static.xxviii A modest reduction in active smoking rates would have major benefits in terms of reducing numbers of deaths among the Scottish population generally.

The hospitality and tobacco industry continue to voice concerns regarding a ‘dramatic escalation a possible rise in smoking in the home’ as an immediate consequence of the introduction of smoke-free enclosed public places.xxix The SLTA have recently suggested that approximately six-sevenths of health problems encountered by ETS are derived from domestic situations.13 However, evidence from countries such as the USA, Canada and Australia suggests that the introduction of legislation for smoke-free workplaces and enclosed public places may have the effect of enhancing protection from SHS in the home. For example, in Australia, the introduction of legislation for smoke-free workplaces during the 1990’s was accompanied by a steep increase in the proportion of adults who avoided exposing children to tobacco smoke at home. Among households with children, the proportion with smoking restrictions increased overall from 25% in 1989 to 59% in 1997. More specifically, in households where one adult smoked, the proportion with smoking restrictions increased from 17% to 53%, and in households where both adults smoked, the proportion with smoking restrictions increased from 2% to 32%.xxx Smoke-free legislation will clearly support current smokers attempting to quit, and denormalise smoking in society, so that future generations do not get addicted to smoking.
**Hospitality Industry Representatives and the Tobacco Industry**

The SLTA claim that the licensed trade has always been, and will always remain, supportive of the ultimate objective of a smoke-free Scotland. They stress that they are committed to working with the Government to improve Scotland’s health, and that they understand fully the benefits of a reduction in tobacco consumption.¹³

Whilst there are many reputable experts with years of experience working in the field of second-hand smoke, the SLTA chose to invite a scientist from Imperial Tobacco Limited to speak about the health hazards of second-hand smoke at their recent seminar on smoking in enclosed public places.³⁵ Imperial Tobacco still deny the link between cancer and cigarettes, and unsurprisingly, numerous attempts were made at this seminar to undermine the vast body of established research outlining the health risks associated with exposure to second-hand smoke.

The SLTA have also widely publicised and quoted results of a recent study that claims to investigate the real effectiveness of ventilation in pubs. The study concludes that simple, low-cost ventilation systems provide an adequate means of reducing the health risks associated with second-hand smoke by significantly improving air quality.³⁶ This study, although widely publicised and quoted by the Licensed Trade, has not yet been published, and is currently being peer reviewed. Funding for this research was coordinated by Atmosphere Improves Results (AIR) from the SLTA. It is common knowledge that AIR is a tobacco industry funded organisation.³⁷ There is a substantial body of published work on ventilation, carried out independently of the hospitality and tobacco industry, which shows how second-hand smoke cannot be effectively removed from the air.³⁸ It is also widely accepted that there are no known safe limits for second-hand smoke exposure.³⁹

The SLTA are one of the key partners in the Against an Outright Ban (AOB) Group, which represents a consortium of organisations and individuals in the Scottish licensed trade. Their choice of ‘experts’ when engaging in scientific debate, their attempts to criticise the science on second-hand smoke, cast doubt on whether second-hand smoke harms people, and prolong the controversy about the health effects of second-hand smoke, are tactics that are entirely consistent with those used by the tobacco industry to combat smoke-free laws around the world.⁴⁰ The SLTA stress that they are committed to working with the Government to improve Scotland’s health, and that they understand fully the benefits of a reduction in tobacco consumption. However, they continue to attempt to fight second-hand smoke issues, and obstruct the introduction of smoke-free legislation in Scotland.

It has been estimated that second-hand smoke (SHS) kills up to 1,000 people every year in the UK, with some studies suggesting the figure is even higher than this.⁴¹ Legislation on smoke-free enclosed public places will not harm the economy, and will improve Scotland’s appalling rates of cancer, heart and lung disease, by cutting smoking rates, helping workers and customers to quit and by reducing people’s exposure to unwanted smoke. **Introduction of the**
new legislation for smoke-free enclosed public places in Scotland is the next and most important measure that can be taken to improve the health of Scotland’s people.

Maureen Moore
Chief Executive
ASH Scotland

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13 SLTA submission to the Finance Committee of the Scottish Parliament, F1/S2/05/5/1, 08/02/2005.
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The Tobacco Manufacturer's Association funding of AIR and Dr Geen's consultancy are documented at http://www.airinitiative.com/press.asp?id=109


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SUBMISSION FROM HEALTH SCOTLAND

RESPONSE TO SLTA EVIDENCE ON SMOKING IN PUBLIC PLACES

Introduction

In April 2004 Health Scotland commissioned Anne Ludbrook (Health Economic Research Unit) and colleagues from the University of Aberdeen to conduct a study of the health and economic impact of the regulation of smoking in public places. The researchers were advised by a reference group that included experts in the field of epidemiology, respiratory medicine, health economics and tobacco control. The draft report was sent for peer review to four referees with international reputations in the fields of tobacco epidemiology, health economics and tobacco control. Reviewers commented on the high quality and robustness of the research and agreed with the overall conclusions. Indeed a consistent view was expressed that the overall estimates of the health and economic benefits were, if anything, rather conservative.

In their evidence the SLTA were critical of the research. The remainder of this submission is the response of the principal researcher Anne Ludbrook and the research commissioner from Health Scotland, Sally Haw to the issues raised by the SLTA.

Comments

These next comments relate to the first two points in the evidence submitted by the SLTA.

(a) Completeness, relevance and timescale of the ‘Financial Impact Study’.

The SLTA claim that the research was incomplete but fail to identify any studies that the evidence review missed.

All of the evidence reviewed related to the health and economic impacts of the regulation of smoking in public places and was entirely relevant. It is true that there was little evidence relating to impact on bars and this is made clear in the report. We excluded evidence from New York relating to the one year follow up of the comprehensive ban on smoking because it was not published in a peer reviewed source. However, it should be noted that this report showed a positive impact on bars and restaurants but did not show results for the sectors separately. As with all aspects of the research, the authors have been careful not to overstate the case for regulation.

Based on their own research report, the SLTA state that the International Review did not identify evidence that a ban would reduce the number of smokers because the smoking may be displaced elsewhere. However, the review cites specific evidence that both smoking prevalence (number of
smokers) and cigarette consumption by continuing smokers are reduced by restrictions and bans and that bans have greater effect than lesser restrictions (such as segregation). Again, this evidence was interpreted cautiously in terms of modelling the results for Scotland.

There is a difference between conducting research efficiently to a short timescale and rushing the research. No evidence is put forward to identify any aspects of the report that were not conducted properly.

(b) CEBR estimates of likely financial impact.

We have not as yet had the opportunity to attempt to replicate the CEBR analysis. However, our examination of the data indicates a number of concerns. The CEBR researchers do not justify the starting date of 1996 and there is no obvious reason to include 8 years data prior to the ban. This start date introduces problems of re-indexing the published data (not discussed by the CEBR researchers). It also takes in a period of growth in the value of the bar sector, relative to the whole retail sector, in the early part of the period, whereas the performance of the bar sector relative to the retail sector has been in decline in the more recent period. This pattern of increase and decline introduces structural problems in the analysis.

Furthermore, the CEBR model does not take into account the impacts of other relevant changes on the bar sector. In particular, restrictions on children being in bars after 9 pm were introduced from September 2003. It is reasonable to hypothesise that these restrictions would have most impact on holiday and tourist business (as this would be the main time at which families might wish to be out together in licensed premises). In this case, there might be an effect in the summer months of 2004, which would confound the analysis of the smoking ban.

The CEBR researchers indicate that the accuracy and reliability of their results are supported by observation of monthly trends. However, extrapolating the seasonally adjusted trend from 2000 (which we believe is a more reasonable starting point) and comparing this with observed monthly data gives a reduction in ratio of the sales value index for bars to the sales value index for all retail business (excluding the motor trade) of 4.4% (rather than 7.3%) and for the ratio of the volume indices of 2.4% (rather than 10.7%). This is without taking into account any possible effect of the restriction on children after 9pm.

Points (c) – (f) are not related to the evidence review.

Comments relating to the Moffat Research Centre Report

Chapter 9 – Review of Aberdeen University Study.

1. The first paragraph states that the Aberdeen study defines its geographic scope by selecting and reviewing studies from other countries.
This is incorrect. We reviewed all the studies that met the quality criteria and these happened to be from other countries. We have not excluded evidence from the UK, as this opening paragraph might imply, and the Moffat report does not offer any evidence that has been missed.

2. The Aberdeen study reviewed all of the evidence from all of the sectors. Only one study related to smoking restrictions affecting bars but this reflects the available evidence. We excluded the one-year report from New York City, which has introduced a comprehensive smoking ban, because the report was not a peer reviewed publication. The reported experience in New York of the Smoke Free Air Act was an increase in tax receipts from bars and restaurants but this was not broken down between the two sectors.

3. The Moffat report attempts to argue that because areas where restrictions have increased incrementally have reported no significant effect on business, an outright ban in bars where smoking restrictions have previously been very limited will necessarily have a more adverse effect. This is a logical fallacy and is not supported by any evidence. Most studies have found no significant effect when restrictions are first introduced. Also, the study cited relates to restaurant restrictions, and the author(s) of the Moffat report maintain a position that evidence relating to restaurants and hotels is not relevant to bars.

4. The comments under 9.3 relating to the study by Glantz and Smith 1997 are erroneous. Although this study was undertaken before a State wide ban on smoking in bars took effect in California, the data in this study were taken from 5 cities and 2 counties which had already enacted bans on smoking in bars.

5. The author(s) of the Moffat report then totally misinterpret the use of the term ‘subjective’ in the Aberdeen University report, despite a clear distinction having been made. Subjective is used to describe the type of information contained in certain reports and papers; i.e. opinion survey results. This is in comparison to objective data, such as sales tax receipts. At no time does the Aberdeen University report refer to self-interest or bias. An overview of the subjective research findings is provided in the Aberdeen University report.

6. The author(s) of the Moffat report assert that there are two weaknesses in the Aberdeen University report relating to a lack of evidence on:
   - reduction in smoking following a ban rather than a displacement of smoking from the workplace; and
   - the impact of a no smoking policy on the hospitality sector, particularly bars.

In relation to the first point, the author(s) have either not read, or not understood, the section of the Aberdeen University report relating to changes in smoking behaviour. This provides a clear overview of evidence of a reduction in smoking prevalence (number of smokers) and a reduction in total...
number of cigarettes smoked by continuing smokers. The only reservations expressed in the Aberdeen University report related to estimating the precise size of the effect, not its direction, and a cautious interpretation was employed in modelling the results for Scotland.

Regarding the second point, the main argument resorted to by the Moffat report is an attack on the background of the authors of two studies cited in the Aberdeen University report (one of which is referred to by the wrong date and was not included in the evidence review). The study that was used in the review, Glantz and Smith 1997, was published in a leading medical journal and subject to rigorous scientific review. These are appropriate considerations in a serious review of evidence; personal attacks on the authors are not. The Moffat report author(s) neglect to comment on the authors of nine other studies cited in the review, all reporting similar findings, one of which was published in a hospitality sector journal (Cornell Hotel and Restaurant Administration Quarterly). As no ‘economists familiar with the hospitality and tourism industry’ appear to have published any analysis of objective data in peer reviewed publications, it is unclear what additional evidence such individuals could bring to the study.

The remainder of this section of the Moffat report largely consists of repeating the caveats included in the Aberdeen University report. We had considered all the potential weaknesses of both the health and economic impact evidence and drew very careful conclusions taking these into account. The author(s) then indicate that the level of analysis of economic impacts has to be similar to that given to the health argument. However, it is almost impossible to replicate the kind of study designs available in medical research. We recommended that research should be undertaken at the level of individual businesses using objective data, such as tax information, although this could be difficult to achieve for reasons of confidentiality relating to such data.

Chapter 10 The counter argument

This chapter provides no new evidence and repeats the argument that there is no reliable evidence for reduction in active smoking despite the evidence put forward in the Aberdeen University report.

Anne Ludbrook
University of Aberdeen

Sally Haw
NHS Health Scotland

February 2005
FINANCE COMMITTEE

EXTRACT FROM THE MINUTES

5th Meeting, 2005 (Session 2)

Tuesday 8 February, 2005

Present:

Ms Wendy Alexander  Mr Andrew Arbuckle
Mr Ted Brocklebank  Jim Mather
Mr Frank McAveety  Des McNulty (Convener)
Alasdair Morgan (Deputy Convener)  Dr Elaine Murray
John Swinburne

Smoking, Health and Social Care (Scotland) Bill: The Committee took evidence on the Financial Memorandum from—

Panel 1

Paul Waterson, Chief Executive and Stuart Ross, Immediate Past Chairman, Scottish Licensed Trade Association;

Hilary Robertson, Director and Susan Aitken, Policy Officer, Scottish NHS Confederation;

and Councillor Eric Jackson, Social Work and Health Improvement Spokesperson, COSLA, Alan McKeown, Team Leader, Health and Social Care Team, COSLA and Gordon Greenhill, Society of Chief Officers of Environmental Health.

Panel 2

Hilary Robertson, Director and Susan Aitken, Policy Officer, Scottish NHS Confederation
Scottish Parliament
Finance Committee
Tuesday 8 February 2005

[THE CONVENER opened the meeting at 10:03]

Smoking, Health and Social Care (Scotland) Bill: Financial Memorandum

The Convener (Des McNulty): Good morning, everyone. I remind members and others that all pagers and mobile phones should be switched off. This is the Finance Committee’s fifth meeting of 2005. Our first agenda item is consideration of the financial memorandum to the Smoking, Health and Social Care (Scotland) Bill, which the Minister for Health and Community Care, Andy Kerr, introduced on 16 December 2004.

Members have a copy of the bill and accompanying documents. We also have a significant number of weighty submissions, which include submissions from our witnesses. I am pleased to welcome Paul Waterson, who is the SLTA’s chief executive, and Stuart Ross, who is the SLTA’s immediate past chairman. From COSLA, we expect Councillor Eric Jackson, who is the social work and health improvement spokesperson, and Alan McKeown, who is the team leader of the health and social care team, but they are not here yet. However, we have Gordon Greenhill, who is from the Society of Chief Officers of Environmental Health of Scotland. From the Scottish NHS Confederation, we have Hilary Robertson, who is the director, and Susan Aitken, who is the policy manager.

COSLA contacted us to say that the figure that is shown in its submission for the City of Edinburgh Council should be £230,000, not £403,000, but that does not affect the total implementation figure.

I propose to invite each group of witnesses to make a brief opening statement—our time is restricted—after which I will proceed to questions from members, who will seek elucidation of the evidence. At the end of the process, the committee will make a submission that is based on its analysis of the financial memorandum to the lead committee, which is the Health Committee, before that committee takes evidence from ministers. That is the Finance Committee’s standard practice.

I will give the SLTA the first opportunity to speak.

Paul Waterson (Scottish Licensed Trade Association): Good morning, everyone. I thank the committee for inviting the Scottish Licensed Trade Association to give evidence. We contend that the research that the Executive conducted into the health and financial impacts of the proposed smoking ban is inadequate, to an extent irrelevant and definitely incomplete. Our research clearly shows that few total smoking bans are in place worldwide from which to draw conclusions. The Irish ban, which is the closest to home, has not been in place long enough for full evaluation. Health and economic benefits could be maximised by adopting a controlled and structured approach to curbing smoking and many countries have taken that course of action.

With that in mind, in May 2004, we asked the Government to legislate on our proposals, which included a ban on smoking at the bar counter in all pubs and whenever and wherever hot food is served, and the suggestion that, within three years, 50 per cent of the total floor space of all pubs should be given over to a non-smoking area. Those are fair and enforceable proposals that our membership strongly backs. They would reflect public opinion, give our customers choice, protect our industry and contribute to improving health.

I will finish by quoting Dr John Reid, who said: "we believe that in a free society men and women ultimately have the right within the law to choose their own lifestyle."—[Official Report, House of Commons, 16 November 2004; Vol 426, c 1164.]

The Convener: Can Gordon Greenhill make COSLA’s opening statement?

Gordon Greenhill (Convention of Scottish Local Authorities): I am happy to do that, but I will not use Eric Jackson’s words.

I thank the committee for inviting us to give evidence today. COSLA has openly said that it supports the bill, which is groundbreaking, because it will effect by enforcement a public health improvement that will be felt for many years to come. Education has been tried for many years as a tool for changing people’s habits, but the bill will make a cultural change with enforcement.
Law is effective only if it is enforced. The thrust of COSLA’s submission is that enforcement must be properly funded. If the Parliament wants the law to be an effective public health tool, funding must be forthcoming for enforcement officers, training and education.

Hilary Robertson (Scottish NHS Confederation): I thank the committee for inviting the Scottish NHS Confederation. Our members fully support the bill’s aim of reducing smoking and firmly believe that the provisions will reduce smoking. The health benefits that will flow from that will be most welcome. The provisions will make a significant difference to Scotland’s health over time. Our evidence concentrates purely on those aspects of the bill that will have a direct financial impact on boards; we do not comment on the areas that will not.

The Convener: Thank you for your opening statements. I invite questions from members.

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): I begin by asking the witnesses from the Scottish Licensed Trade Association how they quantify the research that they did. We would expect you to disagree with the official figures, which we got from the research that was carried out by the University of Aberdeen, but why do you disagree with them so much? How do you justify your comment that its report is “incomplete, irrelevant and rushed”?

Stuart Ross (Scottish Licensed Trade Association): We say that the research is incomplete and, to a certain extent, irrelevant because there are few countries in the world in which outright smoking bans have been implemented. There are only three—Ireland, New Zealand and Norway—and the bans in those countries are all recent. No research has been conducted into whether a phased approach to a smoking ban—as opposed to an outright ban—has greater benefits for health and less financial impact.

Mr Brocklebank: You produce statistics from the Moffat centre for travel and tourism business development at Glasgow Caledonian University, which suggest that your turnover will decline by £105 million, that

“annual profits in licensed premises may decline by £86 million”,

that

“employment in the licensed trade can be expected to decline by 2,300 jobs”.

and that

“some 142 average-sized licensed premises may close down as a result of decreased trade.”

To an extent, the Moffat centre must be guessing in the same way that others are guessing, because we do not know that those things will happen. Why should we believe the projections of the Glasgow Caledonian University survey rather than the projections of the University of Aberdeen survey?

Stuart Ross: The research by the Centre for Economics and Business Research Ltd was conducted by examining the information that is available from the situation in Ireland. It concludes that turnover in Ireland is down by more than 7 per cent in value and 10 per cent in volume and that the number of jobs has reduced by 6 per cent. It took those figures, assigned them to the Scottish situation and worked out the numbers. The figures are quite scary and they are of considerable concern to our membership.

Paul Waterson: The Aberdeen research considered only one study and that was from California, where there is not a total ban. That study examined hotels and restaurants but not pubs, which is one of the reasons why we think that it is fundamentally flawed. There is a sectoral difference, but the study took only an aggregate look at the situation. We do not believe that one study from California should be the basis for such an important piece of legislation.

Mr Brocklebank: On the one hand, you say that the Irish example has not been in place long enough for us to make any real judgments, but on the other you outline facts and figures that appear to be produced from what we have seen already from the Irish legislation. You seem to want the best of both sides from the Irish experiment.

Paul Waterson: We have been put in that position by the timing of the bill. We are saying that we should wait for at least a year to see what the Irish experience throws up, because it is the closest experience to home on which we can work. We had to go with something because of the timing of the situation that we are in.

The Convener: I welcome Councillor Eric Jackson and Alan McKeown to the meeting; Gordon Greenhill was able to give an opening statement on behalf of COSLA.

I raise an issue on which we would like a view from both the SLTA and COSLA. If people are forced outside pubs to smoke, there will be consequences in the form of litter—not just cigarettes, but other things—on the pavements and streets. Do you have any thoughts on the impact of that? Secondly, where should the responsibility lie for clearing up litter on the public pavement outside licensed premises?

10:15

Paul Waterson: We can imagine that when people leave pubs and stand outside—especially
pubs in tenements—noise will emanate upwards, particularly late at night. From the publican’s point of view, it is difficult to control patrons and the level of noise when people go out into the street with alcohol. Also, there may be bans on drinking alcohol in the street. We can imagine that where there are a lot of nightclubs together in a street in the middle of a town, there could be more people out in the street than in the nightclubs.

In Ireland, apparently, a new society is growing up outside pubs and people like to go out to talk and so on. There are obvious problems with litter, with noise and with trying to control the number of people outside pubs. It is hard enough to control them inside pubs, let alone outside. We have a responsibility to try to do something about the problem, but it is difficult to put publicans and licence holders in that position.

Stuart Ross: One of the big differences between Scotland and Ireland is that we have so many more tenement properties. In such premises, there are no facilities to the rear of the pub because of the noise that would be caused to neighbours. In streets where there are rows of pubs, such as in the east end of Glasgow, there would be difficulties on busy soccer nights, with everybody spilling out of the pubs to smoke. We can imagine issues arising that do not apply in Ireland because of the different type of property structures there.

The Convener: Many pubs have people on the door—I will not call them bouncers—to control access and egress, and obviously bar staff have control inside the pub. Will the ban mean that pubs will have to have somebody standing at the door or in the vicinity to ensure that there is some regulation of noise and other nuisance?

Paul Waterson: Where does the responsibility end? Do we allow doormen to intervene in situations that arise outside public houses? Where does the police’s responsibility come in? Trying to control people outside premises is a major difficulty and it is obvious that that will be a major problem with the ban.

Stuart Ross: Recently, Belhaven Brewery Company, which I work for, sent a team of people to Ireland to look at the situation there. They found that drinks were being poured from glass containers into plastic containers and then taken outside to be consumed. In Scotland, we have a different situation; in certain cities it is against the byelaws to drink alcohol outside, but in other cities that is permitted. When the regulations come out, there needs to be some clarification of where responsibility starts and stops on the issue.

Councillor Eric Jackson (Convention of Scottish Local Authorities): The litter issue is addressed in our submission. At the moment, litter is a particular problem outside shopping centres and large office complexes and we expect similar problems to arise when the ban comes in. Local authorities have different views about the implications and the cost, and we are working through that. We assume that there will be a need for additional fixed litter appliances outside pubs.

Alan McKeown (Convention of Scottish Local Authorities): We have the estimated costs from a couple of councils. Glasgow City Council estimates that the cost will be about £144,000 for three years, which includes the purchase of fixed litter bins with ash-trays and the cost of additional street cleaning. If such cleaning is to be done outwith normal hours, there will be an additional cost. South Ayrshire Council estimates the cost at £81,000. We can aggregate those costs up throughout Scotland and we expect that they will be significant. It is fair to say that local government will be expected to be responsible, but we hope that people who use pubs will take some personal responsibility and that licensed and other premises will provide some signage to assist us.

The Convener: As well as litter issues, there are environmental health issues and possibly police issues. Would you like to say anything about those?

Alan McKeown: To consider the matter in the round, we need to examine the implications of the bill and the review of licensing. Gordon Greenhill can give us some more detail on that.

Gordon Greenhill: There are two elements. First, it is an offence to drop litter and the Scottish Executive has adequately funded local authorities under the quality of life and cleaner, safer funding streams to put in place environmental wardens and agencies to enforce the legislation on litter. We have embraced that approach in Edinburgh, but the funding for it is temporary. If we wish it to continue, the funding will have to be made permanent. If people who go outside offices and the like to smoke drop litter, they will be issued with a fixed penalty; it is as simple as that. After people have been fined, they do not drop litter again.

We have worked closely with the offices in which smoking is currently not permitted. They have agreed to clear up 20yd or 30yd on either side of their front door, so that they do not cause a nuisance to their neighbourhood. That is the law. The street litter control provision in the Environmental Protection Act 1990 can be implemented. There are street litter control notices on all the hot food shops in Edinburgh, which have to clean up after their patrons. The situation will be no different because of the Smoking, Health and Social Care (Scotland) Bill. At present, if someone smokes inside a shopping mall, pub or club, the ash-trays are not taken outside by the licensee.
and emptied on to the pavement—they are trade waste. If someone steps outside a pub to smoke, the licensee should be responsible for cleaning up outside the premises.

The issue of noise has been raised. Most tenement properties are on busy thoroughfares and general speaking is covered by the ambient noise level. Loud shouting in the street is already an offence. I do not believe that there will be a major problem of litter and noise if people step outside to smoke. That can be done in an orderly manner if, when they leave the premises to have a cigarette, people are provided with a facility in which to put their cigarette end. There is legislation to ensure that that happens.

Alasdair Morgan (South of Scotland) (SNP): You have offered a rose-tinted view of life in cities. The idea that people standing outside a pub at night drinking will have conversations that are not above the ambient noise level is bizarre. You said that if people drop litter they are issued with fixed-penalty notices. If that provision applied to every piece of litter in Edinburgh, the coffers of the City of Edinburgh Council would be rather large, which they are not.

The SLTA is arguing for a phased approach. We have heard about the costs—probably legitimate costs—that will arise from extra litter and the need for extra policing. How would a phased approach make any difference, except to ensure that we reached the same end point over a slightly longer period?

Stuart Ross: Are you referring to the cost to the licensed trade?

Alasdair Morgan: I am referring to the general costs—the cost of clearing up litter and perhaps needing extra police to deal with people outside pubs. Even if we take a phased approach, we will eventually reach the same end point. Are you suggesting that people’s behaviour will change if the policy is implemented over five years rather than one?

Stuart Ross: That is exactly the argument that we are making. We believe that if, over a period of years, we maintain choice for consumers but restrict tobacco in the way in which Paul Waterson suggested in his opening statement, consumers will continue to come to pubs. There will be choice for them, but gradually, through education and watching more floor space being given over to no-smoking areas, they will come to realise that smoking is an antisocial habit and get used to the idea of a smoking ban. The phased approach will bring the health benefits that the bill seeks.

Alasdair Morgan: You argue that there is a lack of evidence to support the Government’s approach. Do you have evidence for the success of a phased approach?

Stuart Ross: At the smoking conference in Edinburgh, which was organised by the Scottish Executive, there were presentations from around the world, notably from Australia and America, on phased approaches and how well they have worked. Norway has been working towards a total ban for 10 years. We heard speakers give different viewpoints, but the consensus view at the conference was that giving people choice works and that we must give people time to come to terms with a smoking ban. Smoking is an addiction and people cannot stop just because politicians change the rules.

Mr Frank McAveety (Glasgow Shettleston) (Lab): Do you share the view that enforcement costs could be reasonable and manageable? Who should meet those costs?

Paul Waterson: It would be totally unfair for licence holders simply to be told that they are responsible for everything that happens outside their pubs. We have put proposals on the table that do not include a ban and would allow us to retain control of our customers inside the premises. That is the way in which we should proceed. There may be noise problems even if five or six people are having a normal conversation outside a pub that is based in a tenement. It would be wrong for us to dismiss that issue—there will be significant problems. A large proportion of pubs are located in tenement properties.

Stuart Ross: We must take into account the fact that, at the moment, 60 per cent of the people who use pubs are smokers. That is not a small proportion.

Mr McAveety: Understandably, much of your evidence has focused on the economic disbenefits of an outright smoking ban. Have you undertaken any work to analyse the opportunities that may exist for the trade in respect of people who at the moment are not encouraged to enter pub environments because of the presence of smoke? Is there a significant imbalance between those kinds of pubs and clubs that could accommodate an outright ban and the many others in areas that you have identified where there is a tradition of what have been called working men’s pubs? What would be the impact of a ban on such pubs? Casual customers who would go into a city centre pub would not necessarily go into “The Wee Man” somewhere in the east end of Glasgow.

Paul Waterson: The health professionals keep telling us that this is a tremendous opportunity for us to attract a new range of customers. However, last week a non-smoking pub in Elgin, which had the whole market to itself, closed within a month or so of opening because there was no business there. There will be a major problem in rural areas, where I am sure the pubs will close. Such pubs are very concerned, because they do not have the
opportunity to reinvest in the environments that they offer. There is no doubt that the people who go to traditional working men's pubs will be forced out of the pub and will smoke at home. All our members are agreed on that point. Admittedly, the evidence is anecdotal, but many people say that they will not go to the pub if there is a smoking ban. That will lead to an increase in home drinking, with its associated problems. The pubs in some sectors are very vulnerable. We know that in Ireland the turnover of some pubs that are totally land-locked and have no facility for smokers is down by 50 or 60 per cent. Such pubs are especially hard hit.

**Councillor Jackson:** The issue of who should be responsible for paying for the extra work that the bill will create was raised. Our position is that, because this is a new burden on local authorities, it should be funded. It is for members to decide where the money should come from, but there is a cost to the extra work that is involved and we would expect to be reimbursed for it.

**Mr McAveety:** In its submission, COSLA notes that at the moment there is a difficulty in recruiting environmental health officers. The bill represents a substantial change in direction and there are passionate views on different sides of the argument. If the bill is implemented, whom will we recruit to enforce it, given that there are already difficulties with recruitment of EHOs?

**Councillor Jackson:** We have already raised that issue with the Executive. We mentioned the possibility of introducing a fast-track system, of the sort that has been developed for social workers. Clearly, we need to start the recruitment process now, so that we can build up the number of people whom we employ and expect to need. In part, that involves building up the profile of the job.

10:30

**Mr Andrew Arbuckle (Mid Scotland and Fife) (LD):** I am sorry to say that my identity card is still not recognised—I can get through doors in Parliament, but my card is not recognised in the Finance Committee.

Can we have more information on the enforcement or monitoring costs that will fall on local authorities? Do those costs take into account the fact that most of the work will take place during unsocial times outside normal working hours, such as at weekends?

**Councillor Jackson:** Yes—those costs are built into all the submissions that we received from our member councils. The work that EHOs do at the moment contains an element of that kind of work; they consider noise control and check establishments that sell food, so a lot of their work is done out of hours.

**Mr Arbuckle:** Will somebody expand on the view that it is the landlord’s responsibility to clean up litter and cigarette ends in the area outwith his property? Is that legally enforceable?

**The Convener:** I am not sure that that is a financial question. We need to be careful not to get into the policy.

**Mr Arbuckle:** I ask about the cost implications of cleaning up.

**The Convener:** Let us get COSLA’s view on the SLTA’s evidence that the cost of enforcing the ban could be £6 million per annum. Perhaps Alan McKeown will respond to that.

**Alan McKeown:** The £6 million is our estimated cost in view of the fact that the bill has been published before detailed regulations have been drafted. We have tried to direct our authorities through areas such as training and recruitment costs, which includes the cost of paying for staff and introducing new systems, associated legal costs, additional out-of-hours and street-cleaning costs, the security cost for staff; the cost of providing assertiveness training or training in dealing with aggressive customers for staff; and mobile phone and other communications costs.

We have been able to pull together a detailed picture of the costs. At this stage, we think that £6 million per annum is a reasonable cost for the next couple of years, given the intensive work that will need to be done. Who will be wholly responsible for that is still to be decided—the regulations that follow the legislation will dictate that. We will all have a route into the regulations. We will look at which areas we are responsible for and which will therefore build up a cost.

Once we have the regulations, we intend to review and firm up the £6 million cost. Perhaps we will develop a framework with key headings that will be cost drivers. Then, we can discuss how that picture will be built up, how resources will be distributed and, indeed, where the resources will come from.

There will be a number of direct routes and additional resources will be provided. If there is a cost saving to the national health service, we want to know whether resource will be transferred back to local government to facilitate implementation of the ban. We also want to know what income will be generated from fines. We need to look at that picture, which is still unclear. It is just one of the things that one works through in such a process.

**The Convener:** The general view of the Finance Committee in respect of much legislation is that we want—before bills are passed—to see precisely what will happen and how the proposals will be implemented so that cost calculations can be checked. You are flagging up clearly that there
are a number of areas of uncertainty because you do not know the enforcement mechanisms and you cannot make an exact guess.

Alan McKeown: That is fair—we have to deal with such conflicts in the process. However, we have been able to build up a detailed picture of costs. Almost all our authorities have replied to us in some detail. There is a bit of fog around the exact numbers that they have given us and we acknowledge that that represents a slight failing in our figures, but no one could be exact in their figures right now. The figures that we have produced in our evidence are fairly close to what will be required; I do not anticipate their being hugely different one way or the other. Some of the costs could be met centrally—we could do some training and recruitment and provide information centrally. We are trying to see what best value we can get for our money.

However, individual authorities will have additional costs. Let us consider rural authorities. The Highland Council, for example, will have to cover huge distances in enforcing the ban, so it will have significant transport costs. We need to be alive to those costs and we need to be able to present a detailed picture on behalf of our members so that they do not miss out.

John Swinburne (Central Scotland) (SSCUP): I read with great interest the submission from the Scottish Licensed Trade Association. The amount of income and profit that will be lost if a ban is imposed is staggering. You say in your evidence that if people stop smoking, it will impact on the reduction of costs in health treatment. Recent reports have shown that alcohol is as big a danger to health as tobacco. Therefore, would it not be good thing if sales of alcohol were vastly reduced in this country?

In your submission, you mention the cost to the country of people living longer. There is a bit of an ageist reference to “geriatric healthcare”, which I find totally unacceptable. However, I concur with one accurate point in your submission, which is that pensions are not funded adequately. Do you agree that it would help the nation’s health if alcohol consumption were vastly reduced?

Stuart Ross: I do not think that the question is relevant to the debate, but the argument about smoking in public places potentially shifts the consumption of alcohol from public places to domestic settings. The question of why people consume alcohol is different to the question of why they use tobacco.

John Swinburne: That argument is not borne out by the amount of profit that you will lose. There is nothing to suggest that people will go home to drink.

Stuart Ross: There is, in fact. The Centre for Economics and Business Research Ltd study touches on that and contains figures on switching of alcohol consumption from on-premise to off-premise. The statistics from Ireland show that there has so far been about a 10 per cent swing; those statistics are incorporated in the report.

Paul Waterson: Drinking at home introduces serious problems as far as alcohol abuse is concerned. As soon as drinking is forced into a domestic setting in a jurisdiction that has a big off-sales industry, there are real problems with alcohol abuse. If we force people to drink outside the controlled environment of the pub, we will simply add to alcohol abuse problems.

Jim Mather (Highlands and Islands) (SNP): I am keen to ask about the overall adequacy of the financial memorandum. I ask COSLA and the SLTA whether the full financial scenario has been properly modelled. Have we captured all the positive and negative impacts on the public purse? When they answer, I ask the witnesses to consider evidence that we heard last year from the Allander series of lectures: Nicholas Crafts of the London School of Economics told us that if Scotland could bring its life expectancy up to the UK level, that would increase our gross domestic product by 21.3 per cent. He quoted W D Nordhaus of Yale University in coming to that conclusion. That 21.3 per cent represents £16 billion. If we moved towards that, what impact would that have on your business and the public purse vis-à-vis the public sector and local government in particular?

Stuart Ross: At the national conference on smoking that was held in September, speakers from around the world gave us an account of how the provision of choice and a phased or ratcheted approach to tobacco restrictions have worked adequately. In answering John Swinburne’s question about longevity, I do not think that any research has been conducted into whether the Scottish Executive proposals would be more effective than the proposals that we make today.

As I said, there are only three outright bans in over 200 countries throughout the world—in Norway, Ireland and New Zealand—and they are all very recent. It is impossible to conduct research that would answer Jim Mather’s question because enough evidence is just not available.

Jim Mather: Okay, I understand that. Equally, is there any worldwide example of another jurisdiction’s being involved in the gradualist approach that you advocate?

Stuart Ross: Yes. Australia is a good example. Although there have been significant tobacco restrictions there, there has been no impact on the economy. People who do not want to smoke can go to a non-smoking bar and people who want to
smoke can go to a smoking bar. Our argument is based on allowing people the right to make lifestyle choices, which we believe is a fundamental right of anyone in this country.

Jim Mather: I understand that people have that right. Are you saying that the Australian migration has been public-purse neutral?

Stuart Ross: That is what came over at the conference.

Councillor Jackson: I agree with that. I will let Alan McKeown speak to the financial memorandum but, on the general point, there will be costs and there will be savings. Our experience is that, given that people are living longer, we are involved actively in looking after them when they become frail and need our support later in their lives. The fact that people are living longer means that they are living more healthily until they need our help. My view is that the proposals could be cost neutral.

Jim Mather: What actions could you take at local authority level to load the dice in favour of more savings being made, rather than more costs being incurred?

Alan McKeown: It is difficult to estimate the broader impact of a ban on the use of tobacco in wholly enclosed public spaces on life expectancy and the national health service, although that would be an interesting exercise and we should perhaps consider doing it. The cost of meeting the policy objective of maintaining the position whereby people are living longer and more healthily in the community falls invariably on local authorities. People’s needs become more complex as they get older; therefore some of the care packages become more expensive. However, that debate is for another day. Research on the broader impact would be fascinating, if someone were to commission it.

On the adequacy of the financial memorandum and the stage of development that we had reached when it was produced, it is clear from the financial memorandum that there was more work to be done on the figures. Our evidence is that, in terms of costs, the financial memorandum is by no means as accurate as we would like, although it is as good as it can be right now and we are willing to work with the Executive to refine it. The message from us is that if we ain’t funded 100 per cent, 100 per cent implementation of the bill will be difficult, unless costs are shifted from somewhere else, which is about making political choices.

Mr Brocklebank: I want to follow up that point, which relates to some of my concerns about the methodology and costings of policing the ban. As I understand it, the Association of Chief Police Officers in Scotland has said that the police do not wish to be involved in policing the ban, therefore the burden will fall on local authorities. You say in your submission that there is a shortage of environmental health officers and that their age profile is increasing. Trying to police the ban will be a massive job for you, especially if the police are not involved. Clubs and private places will also be covered by the bill. Can you tackle the scale of work that will be involved?

Gordon Greenhill: All those questions are valid. The majority of the enforcement will be carried out by enforcement officers. People do not need an honours degree in environmental health to issue a fixed penalty notice, but training and management elements have to be put in place. The environmental wardens, whom many councils employ, enforce the litter legislation adequately at present. We are not criminalising smoking—if people pay their fixed penalty, the criminal offence will be discharged. Matters will become slightly complicated if cases progress to the next stage and a report is presented to the procurator fiscal, which is where training will be needed. The evidence is that the majority of people pay fixed penalties and cases do not proceed to the next stage. I am confident that throughout Scotland more than enough people can be trained up to the level that will be necessary to enforce the eventual legislation.

Mr Brocklebank: What is the reaction of the Scottish Licensed Trade Association witnesses?

10:45

Paul Waterson: The fixed penalty might be the end of the matter for the person who is smoking, but the licensed trader involved in running the premises could lose his licence. Andy Kerr stated in our journal last week that we would not be responsible for enforcement, so there seems to be confusion. Will it be worth our while to have legislation that will be so difficult to enforce? Will that be good law, given that it will be difficult to enforce at 1 o’clock in the morning, 12 o’clock at night or throughout the afternoon? There will be a massive cost to having inspectors police a business that runs 24 hours a day. We do not think that it is worth while; our proposals are far more practical, workable and enforceable.

The Convener: I want to wind up this discussion with a couple of questions. Stuart Ross came before the committee to give evidence on Stewart Maxwell’s bill, which was the Prohibition of Smoking in Regulated Areas (Scotland) Bill. One of the debates that we got into was about the relative advantages of a partial ban, which involved structural issues for many licensed premises, compared with a total ban. I know that you would prefer a phased-in ban. Will you give a sense of the relative advantages and disadvantages of the two options from your perspective?
Stuart Ross: Yes. When Stewart Maxwell lodged his bill we said that we would have been happy to support the proposals if they had related to where and when food was served. There were technical issues in respect of segregation of properties, which caused us considerable concern. Obviously segregation could take place and a total ban could follow. We debated the issues that were specific to the Maxwell bill at the time. As Paul Waterson said in his opening remarks, we have not changed our position. We met the then Deputy Minister for Health and Community Care as far back as May last year, when we proposed the phased approach. Throughout the four-month consultation period we have heard nothing from any other country to make us change our minds and say that we are not on the right tack. I believe that there are health and financial benefits in going down the route that we suggest and we have done our best to put those benefits down on paper. Some of the issues are complex, but we have made a full written submission that we have lodged with research which, although we were not on the right tack. I believe that there are health and financial benefits in going down the route that we suggest and we have done our best to put those benefits down on paper. Some of the issues are complex, but we have made a full written submission that we have lodged with research which, although we did not consult our members specifically on a phased approach, but I say without doubt that they support a one-step move.

It is recognised that the majority of smokers would like to give up. Our contention is that the bill would help to provide them with the impetus to do that. However, in order to give up successfully they need access to services to support them. We are not necessarily asking for additional funding because, until we begin to see implementation of the bill's provisions, we will not know for sure what its cost implications will be. We would certainly like to hear an undertaking that there will be flexibility so that if the £7 million per annum that will be available from 2005-06 onwards proves to be inadequate, additional central funding will be available for support services. It is well documented that smoking cessation services are a very effective health intervention. As a cost-benefit exercise, smoking cessation services are very effective, so we want to ensure that boards are in a position to support smokers who want to give up, and that they do not have to divert resources from other services to do so.

I will pick up on a couple of points that were made earlier about people going home to smoke. I cannot cite any evidence, but our members' contention is that implementation of the bill would help to change the smoking culture in Scotland. We expect people to want to give up—the bill will act as a trigger to push them into wanting to give up and taking action to do it.

If the choice were between a phased ban and no ban I am sure that our members would support a phased ban, but our preference is certainly for a one-step arrangement.

Susan Aitken (Scottish NHS Confederation): The Executive confirmed an investment of £7 million in the breath of fresh air for Scotland strategy. Although the strategy is welcome and important, it came out before we started talking seriously about a ban, so it does not take into account the impact that the ban might have. Obviously, our hope is that the ban will have a considerable impact and that people will actively seek out the NHS's support to give up smoking. In some ways we want smoking cessation services to be flooded by people looking for support and help, but we must ensure that there are sufficient resources to back that up. The ban must not be seen as an end in itself but as a lead in the wider strategy to reduce smoking considerably throughout Scotland.

Hilary Robertson: It is worth remembering that many of the public places to which the ban will apply are also workplaces, so people who work there and who are not smokers will be protected from smoke to which they would otherwise be exposed. That will have significant health benefits for them.

The Convener: I thank all the witnesses. As I said at the beginning, the substantive policy issues
that are involved are not really for the committee; we are specifically interested in the financial matters. It has been agreed across the board that there has been a lack of definition of some issues on enforcement and other matters. We may wish to continue correspondence with the witnesses to establish the facts. I thank the witnesses for giving oral evidence today.

That concludes the evidence from the first panel. The representatives from the Scottish Licensed Trade Association and COSLA will leave us at this point, but the representatives from the Scottish NHS Confederation will stay to discuss other matters.

I remind committee members that on 1 March we will take evidence on the bill from Executive officials. The second panel is witnesses from the Scottish NHS Confederation. We will talk about the other elements of the bill. We move straight to questions.

Dr Elaine Murray (Dumfries) (Lab): I come from an area where there is an extreme shortage of dentists. In fact, no dentist in Dumfries and Galloway—private or NHS—has a list open. I am concerned about the costs that you identify in your submission and the burdens that will fall on boards where there are shortages of NHS dentists. The expectation might be that additional incentives may have to be given to dentists to do checks. What might happen in areas where there are no dentists to do them in the first place?

Hilary Robertson: There are varying estimates of the total shortfall of dentists around Scotland. One of the most recent figures is in a report by NHS Education for Scotland, which estimates—in its workforce planning for dentistry—that Scotland is lacking approximately 215 dentists in total throughout the country. We contacted our members in areas where we know there is a particular issue and we managed to get an estimate for the Grampian area based on work that was conducted there about 18 months ago. It was estimated that NHS Grampian is about 40 dentists short; that situation is likely to be replicated in other parts of the country. The picture is changing. More dentists are leaving NHS dentistry, but not necessarily all the NHS patients are going with them.

The provision in the bill that allows boards to contract with groups of dentists and co-operatives is welcome and the additional support is welcome. We think that that may be an incentive. However, we are concerned that the fact that there is under-provision, which is well recognised throughout the country, may mean that the requirement to provide the incentives falls unduly heavily on board areas where there is currently greater under-provision of NHS dentistry than in other parts of the country. When we asked our members about the issue, they found it extremely difficult to put any figures on the cost, because until they map current provision accurately and identify where gaps exist it will be impossible for them to say what they expect the costs to be.

Dr Murray: Are you able to say how many Scots are not registered with a dentist?

Hilary Robertson: I do not have that figure.

Susan Aitken: I do not have the figure here, but I know that the Health Committee published a report last week that contains such figures. The figure is quite high; I think that it is slightly more than half of Scots, but the figures are slightly different when they are broken down into adults and children. That information is in the research report that the Health Committee published last week. We could certainly find the figures and provide them to the Finance Committee.

The ability of boards to offer incentives to dentists, to dental practices or to groups of dentists to set up in their area is a useful tool; it would be helpful for boards to be able to do that. However, we anticipate that although boards would not have to do it, the fact that the tool exists will lead to an expectation that financial support will be available. In many ways that is good because it is, perhaps, too much to expect dentists to come into areas where there is no provision, to set up premises and to purchase equipment on their own without any support. However, we must bear it in mind that in areas such as Dumfries and Galloway—the Health Committee’s report found consistently that Dumfries and Galloway, Grampian, Ayrshire and Arran and the Western Isles are, under the various ways of measuring the situation, the ones with the biggest under-provision problems—provision of incentives could lead to significant costs.

Our argument is that boards do not currently have flexibility within their arrangements and the money is not there. Peter Collings, the director of finance in the Health Department, gave evidence to the Audit Committee a couple of weeks ago and the new NHS allocations were announced on Friday. Peter Collings estimates that £400 million to £450 million of the £550 million allocation uplift across Scotland will be accounted for by the time it reaches boards, mainly through pay modernisation, although there are other factors such as pay uplift and the annual increase in prescribing costs.

Therefore there is not a lot of money to play with for service development, although we are talking about a major service development in relation to which all boards will bear a burden and some boards will bear a particular burden. Boards will have a useful tool, which I hope will contribute to setting up dentists in areas that are not currently
served and encourage dentists to take on more NHS patients and give more time to the NHS. However, the quid pro quo is that the policy will be expensive and the funds are not really there to implement it. There is not a great deal of flexibility in the allocations.

11:00

Dr Murray: There is also a capacity issue. There are not enough dentists and we cannot create dentists out of nowhere. A free check-up might be desirable, but there is not much point in the patient having one and being told, “You’ve got a mouth full of caries”, if nobody can do anything about it and the patient cannot get treatment.

Susan Aitken: NHS Education for Scotland calculated that as a result of the entry into the system of newly qualified dentists and better workforce planning, which will make more appropriate use of the entire dental workforce, including dental assistants and hygienists, it should be possible to make up the shortfall by 2008, which is not terribly far away. However we must ask how many of the new dentists who enter the system will be NHS dentists. There is a shortfall in the numbers of qualified professionals, but it is not so drastic that it cannot be addressed, according to NHS Education for Scotland. The key issue is how we persuade dentists to remain in the NHS and carry on treating NHS patients. That is the crux of the matter.

Alasdair Morgan: Do you have any idea how many extra dentist hours per year will be needed to fulfil the requirements of the bill?

Susan Aitken: The short answer is no, and I do not think that the boards know the answer to that yet, either.

Alasdair Morgan: How can we estimate the costs of the policy, if we do not know how many additional dentist hours will be required?

Susan Aitken: We cannot.

Hilary Robertson: That is the point. When we consulted our members about the implications of the bill and the accuracy of the financial memorandum, they simply could not give us an answer, because they have not yet mapped out the areas in which there is overprovision or underprovision. In most cases there is underprovision, but until there is a clear picture of the situation our members will find it very difficult to calculate the number of hours of NHS dentistry that they will need to provide to make up the shortfall.

Alasdair Morgan: Is there a suggestion that somewhere in the country dentists are sitting around doing nothing?

Susan Aitken: No.

Alasdair Morgan: A substantial number of extra dentist hours will be required, but we do not know how many. How can we be sure that the bill’s requirements will be met by the new dentists who will come into the system?

Susan Aitken: Dentists are not sitting around doing nothing, but some dentists do not treat NHS patients—that is the context of the shortfall and underprovision and the reason why people have to go private. The issue is how we encourage those dentists to treat NHS patients.

Alasdair Morgan: Let us leave aside the suspension of credibility that is needed if we are to believe that dentists who have discovered that they can make a lot of money from treating private patients will suddenly come back to the public sector. Even if such dentists were to come back to the public sector, all the patients who were being treated privately and presumably quite liked that system would try to find another private dentist. The pressure and the demand on the system would be exactly the same. If we simply move people from one sector to the other without increasing the total number of dentists, we will not solve the problem. Somebody will still not get treatment.

Susan Aitken: According to NHS Education for Scotland, total capacity will increase over the next four years, not only because of an increase in the total number of dentists in practice but as a result of better planning for the entire dental workforce. Such planning is going on in other parts of the NHS workforce, in which people are working differently and not doing certain jobs when they would be better employed doing something else. For example, dentists might be undertaking jobs that a dental assistant could do. We hope that the workforce planning that is being undertaken will eliminate such situations over the next four years. That is another element of what is happening.

Boards find it difficult to put a figure on the costs because no proper mapping has been undertaken to show precisely where the gaps are and how many dentists are needed to fill the gaps. Only boards can address that matter. Grampian NHS Board told us that about 18 months ago it estimated that it needed about 40 extra dentists. The board calculated the figure using a fairly simple dentist-to-population ratio, but the situation is more complex because since then some dentists have left the NHS without taking all their patients with them, which has increased the number of patients who do not have NHS provision. A big mapping job needs to be done to identify the gaps and to consider how they can be filled, who can fill them and the number of hours that will be needed from dentists and dental teams.
Alasdair Morgan: The other corollary of the issue that Elaine Murray raised is that, in the short and medium term, dentists who perform free dental examinations will detect a lot of work that needs to be done on people’s teeth. Has an estimate been made of the amount of work that the examinations will identify?

Susan Aitken: Not to my knowledge.

Alasdair Morgan: I presume that a dental examination takes 10 or 15 minutes, but if someone needs treatment after their examination they will need a significantly longer course of treatment. We do not know how much work the free examinations will generate, because we do not know how many examinations will take place.

Susan Aitken: NHS National Services Scotland might have a clearer idea of the number of examinations that will be needed. Eye and dental examinations are a slightly different issue from the one that you raise, although there are obvious connections. The issues are financially slightly separate, in that there is a centrally held general dental services budget from which boards draw down costs, whereas increases in the number of dentists and in dental provision must be funded by the boards themselves.

Free eye and dental examinations will have an impact on provision. I am not sure that anyone will be able to predict the extent of that impact until implementation begins and we start to get an idea of the number of people who currently do not go for checks because they have to pay for them but who will take advantage of the free examinations.

Alasdair Morgan: Would it be too cynical to suggest that the cost could be estimated quite well? We know how many dentists there will be and we know that they can work only so many hours per week, so we know what the cost would be. The more problematic issue might be whether the hours that are worked will deliver the number of dental checks and the amount of treatment that will be required. The costs will be fixed, anyway.

Susan Aitken: The costs will be to the NHS and will depend on the number of hours that dentists give to the NHS. We cannot predict the costs, because we do not know the number of hours.

We should remember that we are considering the matter in advance of the Executive’s response to last summer’s consultation, “Modernising NHS dental services in Scotland”. We are in a wee bit of a vacuum, because we do not yet know how the modernisation will be effected. Also, the new dental contract is not yet with us. Elements of the bill anticipate measures that will have to be put in place to modernise the service and the contract, but we do not yet know the full details of the modernisation plans.

The Convener: The Finance Committee’s problem is that it must consider a financial memorandum that is based on a number of imponderables.

Jim Mather: I apologise for returning to the provisions on the prohibition of smoking in public places, but I have a significant number of questions that I did not ask earlier because I thought that we would get a second pass.

The Scottish NHS Confederation says in its submission that the proposals will result in “a considerable reduction of the estimated £200m per annum that smoking-related ill-health currently costs NHS Scotland.”

That figure is equivalent to about 2.5 per cent of the NHS budget. Given that smoking is linked to cancer, strokes, lung disease and other illnesses, is the estimate a little low?

Susan Aitken: I am sure that the estimate is low. A number of academic researchers have used that figure in relation to direct links between smoking and ill health. Of course, smoking is a contributory factor in many conditions but is not the primary cause. The ultimate cost of smoking to the NHS is probably unquantifiable. Equally, the ultimate saving to the NHS of reducing smoking is probably unquantifiable. It is impossible to say how many people will not start smoking because they are not in a pub in which smoking is allowed and will therefore not contract a smoking-related illness later in life. We hope that that will be the case with many people, but we cannot put a figure on it.

Jim Mather: I accept all that you say. However, I am contrasting the suggested saving of £200 million, which could be higher, with the £5.7 million to £15.7 million estimated gross savings in the financial memorandum.

My question is quite simple: could the prohibition of smoking be a trigger for a higher level of personal responsibility for health, which would bring about a sea change in people’s health and in the way in which the health budget is spent?

Hilary Robertson: We expect the legislation to act as such a trigger, because we know that a majority of smokers would like to give up. Our concern about the financial memorandum relates to the support for them to do that. When we consulted our members on the previous bill, one of the major points that was made related to the cultural aspects of smoking. If a piece of legislation can change some of those cultural aspects and ensure that the cultural norm is that people do not smoke when they are out for a drink, that will have a beneficial effect. However, quantifying all that is difficult.
Jim Mather: I want to try to consolidate that and get some hard numbers and hard methodology around it. Do you have any plans to talk to the health services in Ireland and other countries in which a smoking ban has been implemented to find out whether there are lessons to be learned that might result in better and more cost-effective provision of health services?

Susan Aitken: Do you mean health services specifically related to smoking or health services generally?

Jim Mather: I wondered whether you had tried to find out what other health services had done to take advantage of smoking bans, whether their efforts had worked and what they would do differently if they had a second chance, which is, in effect, what we have got. Do you have any plans to do that?

Susan Aitken: We have no such specific plans at the moment. However, we would be happy to support the Executive in any work that it wants to do in that regard. The lessons that might be learned are hugely important.

I am not sure that the legislation will make a huge difference to the way in which health services are funded in the short term. The bill is designed to deal with the long-term problems and is part of a wider programme of ensuring that people take responsibility for their health, which you talked about. The Wanless report on public health, which the Treasury commissioned last year, spoke about the ideal scenario being one in which people were fully engaged in thinking about and making choices about their own health. We should aspire to such a situation. The bill is an important step towards it, but it does not go all the way.

There has always been—and probably will be for some time—an issue about the balance of health spending in terms of how much goes into prevention and health improvement and how much goes into health care and health services. That is a very involved debate, which deals with questions of how much money goes into primary care and services in the community as opposed to acute services, for example. The bill will not change that balance in the short term, but we hope that it will help us to move towards a fully engaged scenario in which we are able to think about the health service differently and to move away from the current focus on acute services.

11:15

Jim Mather: It can be useful to consider other people's experiences. Listening to your answer, I was thinking that it might be more helpful to talk to the New York police department than to the New York health department, as its policy of zero tolerance for fare dodging and littering on the subway had a disproportionate impact on the murder rate. The causal link between certain initiatives and their results can be somewhat oblique, but the signal can, nevertheless, be powerful. That shows that it is possible to make step changes over time, if we learn from other jurisdictions.

The Convener: Given the work that has been done by people such as Michael Marmot, who has clearly defined issues relating to health causation, I am surprised that it is not possible to make rather better estimates of impacts on health. For example, it should be possible to work out statistically the issues relating to smoking-connected illnesses that affect people's capacity to work for what should be the normal period of their working life. We do not know what the ban would deliver in reducing the number of people who are inclined to smoke, but it should be possible to produce a range of estimates of, for example, the impact that a 5 per cent, 10 per cent or 15 per cent reduction in the number of people who smoke would have on working hours over a period. That is the kind of figure that Jim Mather and others are looking for.

Mr Arbuckle: The only firm figure that we have in relation to free dental checks is the figure of £500,000 for establishing administrative back-up. I am concerned about that, because we should not go down that road until we know the financial consequences. The move is progressive, but it is quite a big one to make without our knowing what the cost will be. I am sure that it is within the committee's remit to ask for more information on what the cost will be and on whether the human resources are available for delivery.

The Convener: I am not sure that that is a financial question in relation to the memorandum. I think that you are quite clearly straying into policy areas. I will let our witnesses talk about the financial issues that arise from that question, but I think that we need to be a bit cautious with regard to the policy aspects.

Susan Aitken: The figure of £500,000 relates to the predicted increase in administrative costs as a result of the new provisions, such as the cost of administering the new list. According to our members, it is difficult to say whether that estimate is accurate but it is probably not unreasonable. If the costs fall within that scope, they could probably be fairly easily found within existing allocations. The service development element could stretch what is available within allocations at the moment.

The Convener: I think that we have concluded our questions. I thank Hilary Robertson and Susan Aitken for attending.
On 1 March, we will take evidence from Executive officials. The bill is quite complex and wide ranging and it might be helpful if members could identify the bits that they want to ask questions about. From what members have said so far, it is clear that we are interested in the smoking and dentistry issues. Are there any other strands that members want to pull out?

Alasdair Morgan: Pharmacy.

The Convener: Okay.

John Swinburne: Compensation for hepatitis C sufferers.

The Convener: I am not sure that that relates to finance in this particular—

John Swinburne: Is it not money that they are going to get?

The Convener: I am sure that our suggestions will be helpful to the clerks.

Alasdair Morgan: Basically, we are interested in a bit of everything.

The Convener: It is basically pharmacy, dentistry and smoking. In relation to smoking in particular, are members interested in the enforcement issues or the broader health issues?

Mr Brocklebank: Others may be interested in the health aspects, but I am interested in enforcement.

The Convener: The key financial issues are about enforcement, so perhaps we can focus on that.
FINANCE COMMITTEE

EXTRACT FROM THE MINUTES

7th Meeting, 2005 (Session 2)

Tuesday 1 March, 2005

Present:

Ms Wendy Alexander  Mr Ted Brocklebank
Jim Mather  Mr Frank McAveety
Des McNulty (Convener)  Alasdair Morgan (Deputy Convener)
John Swinburne

Apologies were received from Mr Andrew Arbuckle and Dr Elaine Murray.

Smoking, Health and Social Care (Scotland) Bill: The Committee took evidence on the Financial Memorandum from —

Panel 1
Sarah Davidson, Head of Tobacco Control Division, David Palmer, Team Leader, Legislation Implementation Team and Calum Scott, Economic Adviser, Analytical Services, Scottish Executive Health Department

Panel 2
Roderick Duncan, Bill Team Leader, Tobacco Control Division, Dr Hamish Wilson, Head of Primary Care Division, Eric Gray, Primary Care Division, Team Leader, Dental and Ophthalmic Services and Chris Naldrett, Primary Care Division, Team Leader, Pharmacy Issues Team, Scottish Executive Health Department.

Members asked the Clerks to produce a paper on rules and guidance governing the content of Financial Memoranda.
Smoking, Health and Social Care (Scotland) Bill: Financial Memorandum

The Convener: The second agenda item is to take further evidence on the Smoking, Health and Social Care (Scotland) Bill. On 8 February we took evidence from the Scottish Licensed Trade Association, the Convention of Scottish Local Authorities and the Scottish NHS Confederation. We also agreed that we would take further evidence on three parts of the bill only: part 1, on the prohibition of smoking—we will concentrate on the cost of enforcement; part 2, on general dental services, general ophthalmic services and personal dental services; and part 3, on pharmaceutical care services.

We have two panels of witnesses from the Executive. The first panel is here to answer questions on the prohibition of smoking. I am sure that Sarah Davidson is pleased to be answering questions on that, rather than on the Holyrood building. I am pleased to see her before the committee again. She is now the head of the Executive’s tobacco control division. Another person who has appeared frequently before the Finance Committee is David Palmer, who is now the team leader of the legislation implementation team. Calum Scott is the economic adviser of the analytical services division of the Scottish Executive’s Health Department. I thank you all for coming along and I invite Sarah Davidson to make a brief opening statement, after which we will proceed to questions.

Sarah Davidson (Scottish Executive Health Department): As the convener said, the committee is considering the Smoking, Health and Social Care (Scotland) Bill and the accompanying financial memorandum. Since those documents were published in December, the new team that I am heading up has focused on developing the detailed regulations and the associated regulatory impact assessment. The second of those documents looks at the full range of the financial and economic implications of sections 1 to 8 of the bill. Both documents are currently with ministers and should be published shortly. The committee will appreciate the fact that, in advance of publication, we cannot go into the detail of either the regulations or the RIA. However, we will be happy to return to the committee as soon as the documents are published to give the committee an informal and detailed briefing on them.

For the purposes of today’s meeting, it is worth saying a couple of things about the approach that we have taken to framing the RIA. As required, in that document we have considered three options: a do-nothing option, a completely smoke-free option and a middle option. In attaching suggested costs and benefits to those, we have continued to adopt a central estimate from the range of possible outcomes that have been suggested by the available evidence. The central estimate represents our most realistic view of what would happen under each option, which continues the approach that was taken by the health economic research unit—HERU—at the University of Aberdeen in its initial review of the international evidence, which is summarised in the financial memorandum.

There are one or two exceptions to that, where we have been more prudent or conservative in our estimates. First, in our estimate of the impact on productivity of a total ban, we have erred on the cautious side; secondly, in our estimate of the impact on the bar sector of a total ban, we have continued to assume a central estimate of zero impact. We have also taken a cautious approach to the morbidity gains that may be achieved in the active smoking population and have assumed a central estimate of zero. All of that will no doubt become clearer when you have the RIA before you, and it might be helpful for us to spend some time with you after its publication so that we can go into some of that.

You will have noted that paragraph 210 of the financial memorandum refers to research that will establish the net present value of the health benefits and the potential costs of the legislation over a long period. You should be aware of the fact that the outcome of that work will be contained in the RIA and will be estimated over a 30-year period.

The one other area of assessment to which I want to refer is the estimates of costs to local authorities. The committee has received a submission from the Convention of Scottish Local Authorities on that, which contains some initial returns from individual councils. As COSLA said in its evidence to you, those estimates will require to be refined in the coming weeks in the light of the published regulations. We have now established a working group with COSLA, involving both officials and elected members, within which we will discuss the resources that are required to enforce the legislation. The outcome of those discussions will be reported to you in due course and will be incorporated into the final version of the RIA later in the year.

My colleagues Calum Scott, from the analytical services division, and David Palmer have been closely involved in the economic appraisal of the
policy. The three of us will do our best to answer any questions that you have on the financial memorandum.

The Convener: Thanks very much. One of COSLA’s suggestions was that savings to the NHS resulting from the smoking ban should be transferred to local government to help meet the costs of implementing the ban. Is that feasible? What is the Executive’s view of that?

Sarah Davidson: We have not discussed that in detail with COSLA, although it is on the agenda for exploration. If anything comes out of our discussions, we will inform you about that in due course; however, it is not something that we have considered in detail yet.

The Convener: It strikes me that the proposed smoking ban might trigger a change in alcohol consumption habits and have myriad effects on where people drink, how much they drink, the circumstances, and so on. Has any broader research been conducted on the impact of smoking bans on patterns of alcohol consumption, as opposed to the more restrictive research that has taken place at the University of Aberdeen?

Sarah Davidson: We are not aware of any specific research on that, although there has been anecdotal reporting in recent press coverage and so on. Some research has been done on the extent to which smoking moves from public to domestic settings and we seek to build on that research, which suggests that that move has not happened in places where smoking bans have been imposed. However, that is not the same issue as whether alcohol consumption moves. We know that changes in the cost of alcohol in Ireland have led to off-licence sales being slightly higher than on-licence sales in recent years, but there has not been a full appraisal of that to tease out all the implications.

Alasdair Morgan: On the costs to local authorities, you say in the financial memorandum that

“it is anticipated that costs of enforcement will diminish over time as the smoking prohibition becomes established and self-enforcing.”

This morning, I listened to a news story about the wearing of seatbelts. Many of us might have thought that that was well established but we find that a substantial number of people do not wear seatbelts. In view of that, it might be a bit optimistic to think that the costs will diminish as much as we think.

Local authority bodies such as environmental health and trading standards, which have comparative regulatory functions, are always complaining that they do not have enough resources to get anywhere near enforcing the current legislation. Are we not in danger of being in the same position in relation to the proposed ban on smoking? Central Government says that there will be some costs to local authorities but that those costs “will diminish over time” so it will not give them much more money. That will be yet another problem for local authorities, who already say that they cannot fund the burdens that we place on them.

Sarah Davidson: There are two points to make in relation to that. First, one of the things that we have learned from the Irish experience is that we should not assume that high compliance rates are not directly linked to adequate and visible enforcement in the early months of the implementation of a ban. Adequate resourcing and staffing go hand in hand with the achievement of compliance and there is not much likelihood of our matching Ireland’s compliance rates unless there is adequate enforcement. I think that ministers recognise that.

Secondly, as I think you know, ministers have established a smoke-free areas implementation group to consider the issues. That group brings together people from the enforcement side, COSLA, the bar and pub sector and the nightclub sector. There are all sorts of places where the ban will have to be implemented. For the group, the ideal is to reach a point where the enforcement authorities have a good understanding of the challenges that they face in policing the ban and where the difficult areas will be. That will allow them to map out the resources that will be required. Certain ministers have indicated that they will take the outcome of that work seriously in considering the resources that need to be available to police the measure.

We are watching closely what is happening in Ireland. We recognise that we can learn only so much from one year, and although the indications are that the requirement for enforcement might drop off, our minds are not closed on the matter.

Alasdair Morgan: I turn to address not resources, but the people who will enforce the ban. If they are new people, is it not rather unlikely that they will somehow drop off after a while? Is there not a pattern when a regulatory regime is established with people to man it, whereby it carries on growing unless something happens to stop it? Like most empires, such bodies tend to build themselves up. If the people who are to enforce the ban are not new people, what existing functions will not be carried out while the smoking ban is enforced? Do you have any ideas about that at the moment?

Sarah Davidson: The short answer is no, but we are opening up that agenda with COSLA. We have had only preliminary discussions so far. We will want to discuss with COSLA the positive opportunities for joint working, particularly in
relation to the new licensing regime, which will come in a bit later than the smoking ban. There are definitely opportunities, but we recognise that there is a lot still to be understood, both on COSLA's side and on ours, about the implications of the legislation.

Mr Frank McAvety (Glasgow Shettleston) (Lab): I presume that we are a year away from potential implementation of the ban. The strong evidence that we received from environmental health officers in a previous evidence session was that their age profile is increasing substantially. What do we do about the level of experience that we will lose between now and next year?

What do we do about enforcement? The police—on this and on many other issues linked to legislation that has been introduced by the United Kingdom Parliament—say that this is not a priority for them. I cannot imagine that they will be keen to police the ban and it strikes me that enforcement will rest with local authorities.

How quickly will the implementation group look at that staffing issue? Are we serious about looking at levels of recruitment? We are talking about trying to upskill some folk, but it is already difficult to recruit enforcement officers in other areas of local government. Where will we get the individuals to play the enforcement role? If we are losing that level of expertise among environmental health officers at one end, we might not have the input of new recruits at the other end.

Sarah Davidson: COSLA raised the subject of recruitment with us around Christmas time. Gordon Greenhill, who has given evidence to the committee, is giving some creative thought to ways of encouraging people into the profession, and we are waiting for advice from him about that.

There is an issue about how to get people in at the right level but, as COSLA noted, one does not have to have a fully qualified environmental health officer to provide corroboration or to serve a fixed penalty notice. COSLA and the Executive have to think about whether there is room for being creative—in the best possible sense of the word—in that area.

However, there is no doubt that there are pressures on the environmental health profession. The implementation working groups will look at those issues in the next couple of weeks. We are clear that by the time the bill has cleared its parliamentary stages by the end of the summer, we need to have a good idea about how everything will work.

Mr McAvety: Will smokers be recruited?

Sarah Davidson: Local authorities will not have much choice about that—as long as recruits do not smoke in enclosed public places, they will be okay.

The Convener: I understand that in Ireland a number of licensed premises have set up external buildings to accommodate smokers. That might or might not be possible in some licensed premises, particularly in the west of Scotland, where many licensed premises are part of tenements. For neighbours of such premises, noise from people going in and out of pubs would be even more of a concern than at present. Is there any evidence from Ireland that might assist us to assess the extent of that potential problem? I can see how enforcement will be carried out inside licensed premises, but I am not sure how you will deal with enforcement around the licensed premises. Noise and litter are the two issues that are most likely to be important.

David Palmer (Scottish Executive Health Department): I am not aware of any research in Ireland that deals with enforcement outside licensed premises. However, we will pursue that with our Irish colleagues in the longer term to get a feeling for changes on the ground.

I think that Gordon Greenhill said in his evidence to the committee that there was already legislation in place to allow local authorities to police areas outside pubs. The issue of litter and litter bins ran through the estimated costings that COSLA presented to the committee on that date, although I do not think that it was separately identified. We are thinking about those matters and we need to pull them together in the implementation group and have a hard think about what we need to do to ensure that enforcement is at as high a level as possible on day one.

The Convener: Being thought about is different from being acted upon. One of my concerns is that I could have constituents—as could other members here—who live in the same block as licensed premises and whose lives might be adversely affected by what we propose. We need to be clear about how the ban will work and, if additional costs are associated with it, we need to be clear about how they can be met.

David Palmer: I rely on Gordon Greenhill’s opinion that there is legislation in place for litter and noise nuisance and that we must ensure that that legislation is enforced where there is a problem. I do not know enough about litter and noise in that context and so I cannot give the committee a knowledgeable answer. That said, the framework is in place and we must ensure that it is properly resourced so that litter and noise are not a problem.

10:45

The Convener: I could give you anecdotal evidence that people feel that legislation against noise and litter is not adequately enforced at
present. Instead of taking away from the problem, a smoking ban has the potential to add to it. It needs to be addressed in that context.

John Swinburne: Do you not agree that you are attacking the problem from the wrong end? The big tobacco companies are making enormous profits of the order of millions of pounds per annum. If you have irrefutable proof that smoking damages health and costs the national health service in Scotland millions of pounds per annum, surely the tobacco companies should have to make some reparation for that? Surely you should be able to seek reparation from them? You should sue them until they are put out of business. I have been a smoker for 61 years, so it is not as though I do not know what I am talking about. Although I have managed to control it to a degree, smoking is a vile, filthy habit that kills people. If the evidence that you have is proof positive, surely you should go for the jugular? Instead of putting little impositions on people who are just following a particular hobby, you should get right at the tobacco companies.

The Convener: That question is probably one for ministers and not for officials.

John Swinburne: Surely they could pass it on to ministers and get them to move in the correct direction?

The Convener: I think that they could, but you should also raise the question with ministers. I will let Sarah Davidson respond if she wishes to do so.

Sarah Davidson: I think that David Palmer is eager to respond.

David Palmer: The point to make is that the issue is not one of taking away the individual’s right to smoke, but of protecting other people from smoke. If we were to take away an individual’s right to smoke that could be seen as a fundamental infringement of someone’s civil liberties. That said, someone’s right to smoke should not be allowed to impact on other people. In terms of the damage that smoking does to people, the relationship is one between the individual and the tobacco company. As has been shown in the United States, it is the individual who has to take the tobacco company to court.

Mr McAveety: Do you accept the evidence that the Scottish Licensed Trade Association provided for an earlier meeting about the substantial disbenefits in terms of jobs and the wider economic impact of the bill?

David Palmer: That evidence certainly took a different slant from what we had seen before. I have seen the Irish figures and the SLTA’s view of life and the figures produced by the Central Statistics Office Ireland do not necessarily square up. Anne Ladbrook has written to the committee about some of the evidence that the SLTA produced. Nonetheless, we must take account of that evidence. Clearly, we have to look carefully at the likely economic impact on the licensed trade and the hospitality sector in general. As Sarah Davidson said in her opening statement, the financial memorandum shows that we took a prudent view of the likely impact on the hospitality sector.

Although the research in Aberdeen suggested that pubs and bars would benefit to the tune of £100 million, we took the benefit back down to zero because we thought that that was the prudent thing to do. We want to ensure that we are prudent and cautious about the estimates that we make.

Mr Broicklebank: I still have some difficulties getting my head around the role of the environmental health officers and the whole business of enforcement. From an earlier response, I picked up the feeling that it might be appropriate in some circumstances to have fewer fully trained environmental health officers. However, given some of the complexities of enforcing a total ban, particularly in private clubs, it seems that a lot of expertise will be required of environmental health officers in terms of legally gaining access to private clubs. I can see that it might be possible to gain access to public houses and so forth but, as far as I am aware, there are smoking clubs in Edinburgh—clubs that are set up for their members to do nothing else but smoke. How would environmental health officers have either the legal ability or technical knowledge to gain the evidence required in such clubs? I would have thought that that would be a fairly complex job.

Sarah Davidson: I agree that a framework must be established to examine how each of the inclusions in the bill will be policed, for want of a better word. The bill gives environmental health officers the right of entry to private clubs. However, as you rightly say, there are many other issues around how they gain information. Officers would not just walk into a private club in the speculative way in which they would walk into an open licensed premises on the high street. Part of the discussion in the implementation group and in COSLA is about working through that and developing a training package for environmental health officers, so that by the time the legislation goes live all those issues have been resolved and people know what their rights and responsibilities are.

I want to counter any impression that we are suggesting that partially trained people should be doing things for which they have not been trained—that is not the case. The environmental health officers group has made the point that, particularly in outlying areas, there will have to be
joint working to deal with a lot of the work. We would look to COSLA and its chief officers for advice on the various grades at which that work could be done and where a fully trained senior environmental health officer might be backed up in his duties by either another appointed officer of the council or someone else who was deemed appropriate. We need to explore those issues with COSLA so that we can understand fully what the costs will be.

Mr Brocklebank: You have not turned your back on the Executive funding the training costs; that will not be left entirely to COSLA. Is that right?

Sarah Davidson: We have said that we will discuss that with COSLA.

The Convener: We have finished our questions on part 1 of the bill. I thank the witnesses for coming along. We will take a couple of minutes to swap over witnesses.

10:52
Meeting suspended.

10:53

On resuming—

The Convener: We will now take evidence on parts 2 and 3 of the bill from Roddy Duncan of the tobacco control division who is also the bill team leader; Dr Hamish Wilson, head of the primary care division; Eric Gray, team leader of dental and ophthalmic services in the primary care division; and Chris Naldrett, team leader of the pharmacy issues team in the primary care division, all of the Scottish Executive Health Department. The titles of some of those divisions should be shortened. I invite Roddy Duncan to make a brief opening statement before we proceed to questions.

Roderick Duncan (Scottish Executive Health Department): The Smoking, Health and Social Care (Scotland) Bill is wide in scope and, in addition to the provisions on smoking in public places, comprises a range of measures aimed at improving the delivery of health and social care and continuing the modernisation of the NHS in Scotland. The financial memorandum has outlined the costs associated with the provisions of the bill, the largest of which are those associated with the introduction of free eye and dental examinations for all. Most of the other provisions incur relatively small costs or are cost-neutral in respect of implementation of the bill. My colleagues will be happy to address your questions on parts 2 and 3 of the bill.

The Convener: I want to ask a basic factual question at the outset. How many extra dentist hours per year will be required to fulfil the measures in the bill?

Dr Hamish Wilson (Scottish Executive Health Department): I cannot give you a straightforward or precise answer to that question. The bill seeks to introduce a new form of oral health assessment. However, as that assessment will be more extensive than the current dental examination, there will be consequences for the man-hours needed to deliver it. We are still working through with the dental profession the details of that oral health assessment and any possible manpower consequences.

At the moment, approximately 70 per cent of adults pay for their examinations and 30 per cent are exempt. Simply making those examinations free to the existing registered population would place no additional requirements on dentists. However, we appreciate existing difficulties with access and if we are trying to encourage more people to attend dental practitioners we will certainly need more dentists. As far as providing current NHS services is concerned, we have estimated that, across Scotland, we are approximately 200 to 250 dentists short. Oral health assessments and dental examinations are part of that overall gap in service that we are trying to fill.

The Convener: You will appreciate that the committee is faced with some difficulty. As you have rightly pointed out, the bill is trying to introduce an improved form of oral health assessment for people. We know that a significant group of people do not attend the dentist and that a number of people in some areas of Scotland are unable to do so. I presume that, even without the introduction of this oral health assessment, you have a calculation for the current shortfall. To some extent, it could be argued that this new measure will compound rather than alleviate the problem. However, in any case, you are unable to quantify either element, because you have not yet completed your deliberations with the dental profession.

Dr Wilson: As I have said, an external quantification of the current gap in the number of NHS dentists has come up with a figure of 215. We are already making inroads into that matter. This year, more dentists are coming into the NHS in Scotland.

I should point out that the introduction of the oral health assessment is not the only issue that has to be considered. The modernisation of NHS dental services, which ministers have been considering and to which they will shortly announce their response, is intended to include a package of measures that will attract new dentists into the NHS and encourage some dentists, who might in recent years have moved in a different direction, to return some of their hours to the NHS.
In addition, we are training a larger number of professions that are complementary to dentistry. For example, dental therapists and hygienists can undertake certain treatments that have traditionally been carried out by dentists. Moreover, south of the border, the National Institute of Clinical Excellence has recommended a different way of approaching dental examinations. Instead of the traditional dental examination every six months, NICE has said that the matter should be considered on an individual basis, which means that the interval between examinations could vary between three months and two years. That might in turn release some time in the dental profession that could be devoted to oral health assessments.

You are right to say that the situation is complex. However, our starting point for addressing it is NHS Education for Scotland’s well evidenced figure that we are 215 dentists short.

11:00
The Convener: Forgive me, but I want to pursue the issue. You said that we are short 215 dentists, but you could not say how many extra dentist hours per year will be needed to implement the bill. I am concerned about that. I bumped into a colleague from the Scottish Commission for the Regulation of Care this morning; I am concerned that the route down which we are going is similar to that which we went down with provision of free personal care; somebody thinks the measure is a good idea, but nobody has modelled the consequences of, or piloted, the proposed legislative provisions. Can you give me a better idea of how many dentist hours might be required, where the dentists will come from, what the costs would be of putting them in place and how the mechanisms that you say would release dentist capacity will work? The financial memorandum contains no hard evidence to support the claims that you make on that.

Dr Wilson: To clarify, the financial memorandum was constructed on the basis of the existing service because that was the only relevant information that we had. To look ahead to the different set of arrangements that we have discussed, it has been roughly calculated that about 1 million examinations might be substituted by new oral health assessments. At present, approximately 2 million examinations are done under the NHS. Given the change in the frequency of examinations that the measures might produce, given that not everyone will wish to or be able to attend in any one year and given that it will take an average of, say, 20 minutes for an oral health assessment, we might be talking about 300,000 hours of dentist time, which might come down to about 150 dentists. That is a rough approximation of the time that would be required if we were to introduce only oral health assessments.

However, as I said, other factors come into play, such as the opportunity for professions that are allied to dentistry to take over part of the dentist’s role—not in carrying out oral health assessments, but in follow-up treatment—which would relieve existing dentists in respect of the time that they currently spend with patients. Also, dentists undertake examinations at present, which is offset against that figure. We need to work back from the gross figure.

The Convener: You said that you have not completed your discussions with the dental profession about the implications of the introduction of oral health assessments. Have you completed discussions about the work that is to be done by professions that are associated with dentistry? Are people in training and in the pipeline so that they are ready to take up that responsibility?

Dr Wilson: Yes. We are increasing the number of dental therapists who are trained in Scotland to 45 per annum. Traditionally, no dental therapists were trained in Scotland; it is only recently that we have started such a programme in Scotland. Also, there are several hundred dental hygienists throughout Scotland who could be used more effectively.

Alasdair Morgan: Many members struggle with the fact that, when we talk to our constituents, we hear that more and more of them cannot get any dental treatment at all. You talk about more dentists coming into the NHS, which may be true, but all we hear about is dentists who leave the NHS to go to private practice. At the end of the day, the measures might be a publicity own goal. The quid pro quo for offering free dental checks is that people will get them at a frequency that is four times lower than was the case previously—every two years instead of every six months—which may well be medically justified, but I suspect that it will be difficult to convince a sceptical public about that. That is just a comment.

We are 200 to 250 dentists short at the moment and we are going to introduce examinations that may take longer, certainly to start with. I hope that the new system will bring in lots of people who do not have examinations at present, otherwise there would not be much point in the exercise. Presumably—otherwise the exercise would be futile—some of the examinations will result in treatment, which will take up more dental hours. Again, I point out that those dental hours are not available. It does not seem that the costs in the document go any way towards recognising the reality of the situation on the ground.

Dr Wilson: We totally accept that what is in the financial memorandum is a cost that is based on dental examinations for the existing number of registered patients. We indicated what the cost
might be under current circumstances if that number increased by 25 per cent, so we have given some such costs in the financial memorandum. The difficulty that we had at the time was that we had not entered into detailed discussions with the profession about the new form of oral health examination and what that might entail.

In parallel with that, ministers have said that they will shortly respond to the consultation on modernisation of NHS dental services. That response is likely to be to target an increase in the number of dentists and allied dental professionals who we can bring into the service in order to deal with the problem that you described, which relates to the new form of assessment and the consequent treatment.

There is strong evidence from elsewhere that a more extensive oral health examination is a potent prevention measure and that, although it might reveal the need for additional treatment in the short term, it will turn the system around over time and will put in place a more prevention-focused outlook.

Alasdair Morgan: There will be a considerable hump before we reach that longer term goal. It strikes me that it would be fair to assume that a large proportion of people who do not get dental examinations at the moment need treatment, but currently seek it only when faced with an emergency. We will strike a big hump if we are successful in encouraging those people to come in for examinations. Having created that expectation and demand, how on earth are we going to meet it?

Dr Wilson: We will do so by using the increased number of dentists and allied dental professionals.

The Convener: There are two problems. One is the unidentified cost and the second is the feasibility of delivering the increased number of dentists and dental support staff. I am not sure that you have convinced us on that.

Ms Wendy Alexander (Paisley North) (Lab): I start by saying that I appreciate Dr Wilson's candour. I hesitate to suggest that it is because you come from a professional background, but you have been candid about the difficulties that might be experienced in fulfilling the bill's legislative obligations. However, in your candour, you have given us something of a constitutional difficulty. What is the purpose of a financial memorandum in a unicameral system? A financial memorandum should fully scope the financial costs that are associated with fulfilling the legislative provisions of any bill. However, your testimony this morning has convinced Parliament's Finance Committee that this financial memorandum does not fulfil the legislative purpose that is laid down for it constitutionally. As we all know, there have previously been examples of inadequate financial memorandums—the one that springs to mind is the one for the Education (Additional Support for Learning) (Scotland) Bill, which made wonderful promises about integrated learning without ensuring that the resources existed to support it. In that case, the financial memorandum did not fully scope the associated financial costs.

We are keen to avoid a future Auditor General for Scotland saying that this financial memorandum was inadequate and that the Finance Committee, whose job it is to scrutinise the adequacy of the financial memorandum, was remiss in its duties.

In fairness, I do not expect you to provide an answer now. However, the committee is inviting you to go back to consider whether the financial memorandum fulfils its constitutional purpose of itemising fully the financial resources that will be required to implement the provisions in the bill. Perhaps you will then write to the committee to say whether the Executive considers that the financial memorandum is adequate, or whether it wants to take advantage of the recently created provision that allows the Executive to submit an alternative financial memorandum that would more accurately meet the constitutional obligation to scope the resources that are required to fulfil the bill’s provisions. It would be prudent for all of us, given the committee's scrutiny function and the officials' responsibilities in relation to the purpose of the financial memorandum, if you were to reflect on the document's adequacy and perhaps to take advantage of the opportunity to resubmit it.

Dr Wilson: We can certainly consider that.

The Convener: There might be a bigger issue than has so far been raised, because the British Dental Association suggests that there needs to be a “threefold increase”—to £520 million—in the funding of NHS general dental services. The profession's view is that very large sums of money are required. We might respond, "They would say that, wouldn't they?" However, such a huge gulf between the costings of the professional body and those of the Executive does not give the Finance Committee great comfort that what is suggested can be managed within the envelope of resources that has been set out.

Dr Wilson: An issue that we face is that ministers have not yet announced their overall response to the consultation on modernising NHS dental services in Scotland and the resources that will be attached to that response, which might in part address the points that members have made.

It is fair to point out that the BDA based its estimate of additional costs on consideration of the situation in a particular area in Scotland. The BDA
considered the differential between the arrangements for the salaried service and those for the independent contractor service and then extrapolated figures for the whole of Scotland. We do not necessarily accept that that was a reasonable basis on which to determine the resources that are needed for NHS dentistry throughout Scotland. However, as I said, ministers will very shortly announce their response to the consultation and the resources that will be attached to that—we might ally that point with Ms Alexander’s comments.

**The Convener:** You say that the BDA based its argument on what is happening in one area of Scotland. An equivalent piloting or mapping process from the Executive might have given us a greater evidence base on which to make a judgment. However, the Executive does not provide either basis for analysis.

**Dr Wilson:** We are moving beyond the issue of free dental checks to the broader issue of dental services. The resources that will potentially be attached to the ministerial announcement will be targeted at specific areas in the way that you suggest. I should add that the intention has been to introduce oral health assessments initially for older people, which might offer the kind of piloting experience that you describe. However, the system has not yet been introduced.

**Jim Mather (Highlands and Islands) (SNP):** I am keen to build on the dialogue about planning the resources. I would derive a lot more comfort from the situation if I had a clearer idea of the current demand in relation to the various roles in dentistry and, beyond that, a clear understanding of the future additional demand that is envisaged so that we could consider the total resource that will be required in the context of what is available, the current shortfall and the additional resources that would be provided. If we had a clear picture of the situation, particularly if figures were given for each NHS board area, I would be enormously comforted.

As a representative of the Highlands and Islands, I have grave concerns about the implications of the bill, especially when we start to scratch the surface of latent demand and, once that demand has come through, of the additional remedial work that may need to be done for many people.

11:15

**Dr Wilson:** Again, the issue that you raise will be addressed partly by the ministerial response to the consultation. I am sorry that I am not able to give more information at present.

**Jim Mather:** I understand that. However, the implication that we are launching measures in the dark without concrete figures is a material worry. I am keen to put that on the record.

**Dr Wilson:** We will seek to address the issue in the response that you have invited us to make.

**The Convener:** Is legislation necessary to do any of the things that you are suggesting in part 2 of the bill? Could those measures have been wrapped up in a more general modernisation programme for dentistry? I am not sure whether the bill is a convenient peg on which to hang the measures. Technically, do any of the provisions in part 2 require to be legislated for in this context?

**Dr Wilson:** The clear advice that we have received from solicitors is that we should take powers to implement the partnership agreement commitment to free dental and eye checks for all. That provision requires to be made in legislation.

**The Convener:** Surely the introduction of free dental and eye checks for all is a matter of money; legislation is not required to make it possible.

**Eric Gray (Scottish Executive Health Department):** The advice that we have received is that primary legislation is needed if we want to introduce free checks for everyone.

**Ms Alexander:** If the advice from solicitors is that legislative provision is required, concomitant with that the financial memorandum must cost fully the financial implications of the provision. It is not possible to say, “We will separate it out and deal with it in our programme for modernising dentistry.” Our job is to ensure that the financial memorandum covers fully the costs that are associated with any proposed legislative changes. I accept that the argument could go either way. However, because advice has been received from solicitors, we are unable to pick and choose the coverage of the financial memorandum. No doubt it will be easier to reflect the costs of the provision in the financial memorandum after the statement on dentistry has been made.

**Dr Wilson:** We believe that the measures in the rest of part 2 are required under primary legislation to deliver some of the changes that ministers are considering under the modernising agenda. Much that can be done in dental services does not require primary legislation. Many of the responses to the consultation on modernising NHS dental services made proposals that we can implement through changes either to secondary legislation or to the way in which dental practitioners are paid. Those changes can be made through directions, rather than primary legislation.

**Alasdair Morgan:** The information on provision of general dental services refers to new arrangements that have still to be agreed with the profession. Our experience of new arrangements in the health service, such as the consultant
contract and the arrangements for out-of-hours working by GPs, is that none of them has been implemented at no cost; all have been implemented at vast cost. However, we are assuming that the new arrangements that the bill will introduce will be entirely cost neutral. Can you put your hand on your heart and say that that will be the case?

Dr Wilson: The specific costs that are allied to changes under the heading of "provision of General Dental Services" can be regarded as neutral. They do not in themselves require additional expenditure. I am sorry to keep coming back to the impending ministerial announcement on modernising NHS dental services, but the measures that ministers are considering in relation to improving NHS dental services throughout Scotland will have a cost, although those measures will be much broader than the specific measures that have been included in the bill. As I have already said, a number of measures can be introduced in NHS dentistry in Scotland that do not require primary legislation but will have a cost.

Alasdair Morgan: Perhaps I am picking this up wrongly, but the financial memorandum states: "the new arrangements would be nationally agreed". Agreed with whom?

Dr Wilson: They would be agreed with the British Dental Association on behalf of the profession.

Alasdair Morgan: We are talking about changes in the system of "fees, capitation and allowances".

Dr Wilson: That is correct.

Alasdair Morgan: Is there any other trade organisation that, when asked to consider a change in its arrangements, will not wish to come out of that change with more money in its pockets? That has not been the case in other sections of the medical profession.

Dr Wilson: That has been made quite clear in the evidence that the British Dental Association has given to the committee. There is a process of negotiation, which is continuing.

Alasdair Morgan: Higher expenditure will, I presume, be a result.

Dr Wilson: Potentially, yes. If the proposals are agreed by the Scottish ministers, they will provide the funding for them.

Alasdair Morgan: Is not that a consequence of the bill?

Dr Wilson: No, it is not a direct consequence of the bill.

Alasdair Morgan: So, is it an indirect consequence of the bill?

The Convener: That is probably not a question for the officials. Having listened to this evidence, it strikes me that it might have been better if the ministerial announcement had been made by now, so that we could be clear about the overall framework. We would then have been able to consider the legislation in that context. There seems to be a cart-before-the-horse element to the way in which the process has developed. Perhaps the issues that we have raised need to be conveyed back to the minister.

A further question arises from the experience of the general medical services contract and the process for hospital consultants. In those cases, negotiation took place at United Kingdom level. By the minister's own admission, that did not necessarily lead to the best outcome as far as the Scottish context was concerned. Are we to have a repetition of that with the negotiations involving the British Dental Association that you mentioned?

Dr Wilson: The negotiations on the position in Scotland are being conducted purely for Scotland. The desired changes to dental services in England have already been announced, and those changes will be implemented south of the border with effect from April 2006.

The Convener: Can we quantify what the English changes would mean in a Scottish context and then identify the potential implications of having separate Scottish arrangements?

Dr Wilson: There are no direct implications for Scotland from the English changes.

Alasdair Morgan: I will switch briefly to pharmaceutical care services, referring to paragraphs 234 and 235 of the financial memorandum. Paragraph 234 contains additional costs of £500,000 for health boards as a result of the new arrangements. However, I am not clear about the costs under paragraph 235. As far as I understand it, it refers to health boards filling gaps in the current provision under the current pharmacy arrangements. Would such costs also be funded by the health boards from their existing budgets, or would Government funding be available?

Chris Naldrett (Scottish Executive Health Department): The expectation is that those costs would come out of health boards' existing allocations or their uplifted allocations. It is a bit of a chicken-and-egg situation for us: until the boards take up the duty to identify need and plan the required resources, we cannot quantify the figure.

Alasdair Morgan: The £500,000 that is mentioned in paragraph 234 is not a huge sum in the context of the health service budget, but we are talking about individual health boards, some of which are struggling to stay solvent. Most break even only with difficulty. Is it really sensible to tell...
boards, “Here’s some extra responsibilities. Fund them out of your existing budgets”?

Chris Naldrett: You need to consider the arrangements in the round. In modernising pharmacies, we are trying to introduce a different way of working.

That is not to say that all services will add cost, because there are different ways to do the same job—I think the expression is “doing it smarter”. Economies of scale could arise from the new set-up. I will echo a comment by Dr Wilson. We are about a year away from the contract’s implementation—it is still being negotiated—but if resource implications are identified when that happens, we will take them to ministers and address them.

Alasdair Morgan: I return to Ms Alexander’s comments about the financial memorandum’s purpose. Will the bill force health boards to spend money or will expenditure be optional?

Chris Naldrett: Health boards will have a duty to identify and provide the necessary services.

Alasdair Morgan: In that case, we need to be clear about the costs.

Dr Wilson: The £500,000 is for support staffing in health boards. As for additional service costs, the planning process that health boards will be required to follow will identify gaps. We cannot quantify those gaps at present because that planning process has not taken place. That is the chicken-and-egg situation again.

In general, it is recognised that we have a good network of community pharmacies throughout Scotland. That was reflected in the debates in Parliament when the Office of Fair Trading pharmacy services report was produced. I think that members want that network to be protected. We consider the planning arrangements against that background. We have a network that is generally regarded as being good, so we do not expect to find huge service gaps.

The Convener: I thank the witnesses for giving evidence. The committee expects to consider a draft report on 15 March.

Ms Alexander: Could the clerks examine the scope of financial memorandums before that meeting? The information could by all means be shared with the Executive. Increasingly, the question whether a financial memorandum covers all of a bill’s provisions comes into play. It would be helpful to have circulated to the committee information on the purpose of financial memorandums, but it would also be helpful if clerks and subsequently conveners were to discuss the matter.

I worry that we will create a future backlog for the Audit Committee if our consideration is anything less than rigorous. By signing off a financial memorandum, we collude in it or signal our satisfaction that it is comprehensive. This is not the first time that we have not felt wholly comfortable about that signing off.

It is fair to say that the matter is further complicated by the opportunity for the Executive to provide revised financial memoranda. We welcome revised financial memoranda, because without them, how would we have an accurate picture? However, we want to ensure that the parliamentary process does not simply allow for a variety of financial memoranda as they suit the Executive when, for example, it might be better to have heard the dentistry statement first, as has been said. We do not want to fall into a pattern of events in which the true financial memorandum does not materialise until later in proceedings, which would undermine our scrutiny function.

Those generic considerations are rising up the agenda. Perhaps the clerks and the convener could examine them and report on their observations in due course, later in the spring. As I said, we are on the boundary of not fulfilling an obligation to the Audit Committee, albeit through no fault of our own.

11:30

The Convener: I agree. One of the problems is that in a sense we have made stipulations to the Executive about what we expect in financial memoranda. As we have seen today, the Executive does not always live up to what is required either by our stipulations or by standing orders. We will have to deal with the issue in the context of our report on the bill. The matter is further complicated by the fact that we are waiting for a regulatory impact assessment on the smoking side of the bill.

I take the general point, which is an important one. Over the past two years the committee has done a considerable volume of work on the financial memoranda and it has flagged up the issues that have arisen. We must ensure that when bills come in, and in particular when they have substantial financial implications, those implications are properly mapped out. We may have to call a halt at some point and say that a bill can go no further until the financial issues are put in place. We perhaps need to have that dialogue with the Executive.

Ms Alexander: I agree whole-heartedly, but I think that prior to that we need to do a bit of work with the parliamentary authorities. You raised a fascinating point when you suggested that there might be no need for a legislative provision and that it could be argued that the matter falls outside legislation. However, the Executive officials said
that the Executive solicitor told them that the provision has to be in the bill and the financial consequences follow from that.

It seems to me that to ensure that we fulfil our scrutiny function we are required to be clear about what a financial memorandum should do and also to have a protocol with the Executive and its solicitors about the scoping and coverage of financial memoranda. This is an interesting one-off case, but I am anxious that the parliamentary authorities examine the implications of allowing a revised financial memorandum to be submitted. The parliamentary authorities must consider at what stage in the process such financial memoranda are submitted and, if they are subsequently published, whether there is any guarantee that they come to the committee for due process to ensure that they are comprehensive. I am not sure that there are as yet any rules that govern when and how a revised financial memorandum is published and scrutinised.

The Convener: Susan Duffy can perhaps answer the point about a revised financial memorandum.

Susan Duffy (Clerk): Changes that were made to standing orders at the start of the year allow for a revised financial memorandum to be brought forward if an amendment is agreed at stage 2 that alters significantly the financial implications of a bill. That provision has now been placed in standing orders. The committee has agreed that where that occurs it will endeavour to take evidence, as we did on the Water Services etc (Scotland) Bill. In standing orders, that is the only point at which the Executive is obliged to bring forward a revised financial memorandum.

Ms Alexander: Clearly, the issue that we have on this bill is nothing to do with an amendment at stage 2. We just think that there is a risk that the financial memorandum is inadequate to cover the provisions in the bill. Am I right in saying that in these circumstances the only thing that we can do is reject it? It appears that we may not have an appropriate mechanism for dealing with a situation that we see with increasing regularity, which is that the financial memorandum is not adequate. I do not want to be in the position that the only club that is available to us is to halt the whole process. It seems to me that there is a desperate need for a set of protocols and procedures when we feel that the scoping coverage of the financial memorandum is inadequate for the legislative provisions.

The Convener: We have had the discussion before, but perhaps we can have it again in stronger terms in order to achieve a better resolution than we have had up until now.
Dear Des

I have given very careful consideration to the request from your Committee, in the light of the discussion at its meeting on 1 March, to reconsider the information contained in the financial memorandum to the Smoking, Health and Social Care Bill as it relates to the introduction of free dental checks.

I would want to stress at the outset that I fully appreciate the concerns of the Committee about the current difficulties which many patients face in accessing NHS dental services, and the implications which this may have for ensuring that free dental checks are available for patients. As you know, we have carried out an extensive review of dental services in Scotland and we will be making a statement about the Executive’s response to the consultation and the action we intend to take on 17th March 2005. It is within that context that I believe we also need to view the provisions in the Bill.

Turning to the specific aspect of the financial memorandum, I believe that the approach taken in the memorandum to the cost implications of free dental checks is appropriate. The requirement for the Financial Memorandum is to provide details of the costs associated with the introduction of the provisions of the Bill. The provisions in the Bill relating to free dental checks are quite limited,
amending existing primary legislation to remove the requirement to pay from those who currently do so. The costs provided in the Financial Memorandum accurately reflect the costs that will accrue from this legislation.

Dental practitioners currently receive a fee for providing a dental check to adult patients. Some patients, mainly those in specific income categories, are already exempt from payment. Others pay 80% of the sum which the dentist receives for the dental checks. The intent of the Bill provisions is to exempt all adults from payment for a dental check. Thus, in costing the proposals for change, it is appropriate that we use the sums of money which non-exempt patients would otherwise have to pay. We recognise that not all patients who wish to have a dental check are able currently to access that, and we built that into the memorandum.

I would ask you to note that exempting patients from paying for dental checks that they currently pay for does not, itself, result in any additional dentist-hours of work.

However, these provisions are only one strand of a far more wide ranging modernising dental health agenda which we will announce shortly.

The announcement will include measures to expand the dental workforce including the increased use of professions complementary to dentistry, in particular hygienists and therapists who can provide a range of treatment as part of the dental team. There will also be measures to improve the recruitment and retention of dentists within Scotland. These measures should address the Finance Committee’s concerns that free dental checks will be made available more widely.

In addition, consideration is now being given to the implementation of a more extensive Oral Health Assessment as part of the modernisation package. An extended oral health assessment, including an assessment of the soft tissues of the mouth, will allow for improved prevention of oral diseases and for treatment to be more tailored to the needs of individual patients. Such an assessment should be more effective in alerting dental professionals to the possible presence of oral cancer or pre-cancer and should encourage earlier specialist referral and improved patient survival. This is particularly important for older patients where diseases such as oral cancer and gum disease are more prevalent. We are currently considering the cost implications of this and will be discussing these further with the profession. However, the costs will be part of the overall financial package underpinning the modernisation of dental services.
I understand the concerns that the Finance Committee has regarding the need to ensure that the Financial Memorandum accurately reflects the costs associated with implementation of the provisions of the Bill. I trust that the above explanation provides reassurance to your Committee and also sets that within the broader context of future changes to dental services.

Dear wish,

Rhona

RHONA BRANKIN
Dear Roseanna

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

I wrote to you on 18 March about the additional items to be introduced by the Executive as amendments at Stage 2 of the Smoking, Health and Social Care (Scotland) Bill. My letter confirmed that there were possible further items, but they were not sufficiently advanced to enable me to provide descriptions.

One of these items has now become clearer.

A minor amendment to the National Health Service (Scotland) Act 1978, relating to the statutory functions that may be given to Health Boards and Special Health Boards, may be proposed for inclusion in the Smoking, Health and Social Care (Scotland) Bill. The purpose of the amendment would be to clarify that Ministers may provide by order for any of their functions relating to the health service to be exercised by these bodies. We are still considering the detail of such an amendment and aim to have the precise drafting finalised by the end of the month. I thought the Committee would appreciate early notice of the likelihood of this further minor amendment.

I trust that you find this information helpful.

All the Best

Andy

ANDY KERR
I read your report with great interest, having provided evidence to the committee on 15th March 2005 on behalf of Imperial Tobacco Ltd.

Despite the Committee’s conclusions, it remains Imperial Tobacco’s view that when taking all the evidence into account, the science regarding other people's smoke and human disease remains inconclusive. Whilst the Executive can adopt a precautionary approach to smoking in public places, we strongly believe that any legislation should be proportionate and designed in such a way as to accommodate both smokers and non-smokers; avoiding involuntary exposure to smoke on the one hand, but still upholding the smoker's right to enjoy a legitimate product in public on the other.

It is necessary to clear up one matter, which is not a matter of opinion but one of fact. At point 44 the Committee took the view that '... ventilation would not provide an adequate alternative, because it does not remove carcinogens.' Acknowledging that one member of the Committee dissented from this position, I must re-state something that I submitted in my oral evidence, which was that this view of ventilation is fundamentally and scientifically incorrect. I want to be absolutely clear on this point. All components of ETS mix with air and are diluted to the same extent by ventilation. This is a fundamental property of gases, which is a tenet of basic physics as espoused in Dalton's law of partial pressures.

It might be possible that the Committee is confusing filtration (which can only remove particulate matter) with ventilation. I also note that in presenting their oral evidence to the Committee, ASH Scotland referred to research by 'Professor' James Repace MSc, attributing him with the comment '...that ventilation simply does not work because it does not remove the carcinogenic aspects from the air...'. This crucially misquotes what Repace actually sets out in his 2000 report. In fact, Repace accepts that ventilation may be effective in removing levels of ETS by 90% (a more recent joint study by the Dutch National Institute for Public Health and the Environment (RIVM) and the Netherlands Organisation for Applied Scientific Research (TNO) study confirms this).

Repace's argument was rather that the carcinogens in ETS are inherently dangerous to health at any level. That is a different debate. Cancer causing substances (carcinogens) exist everywhere -in the food we eat, in the water we drink, the very air we breathe -they are ubiquitous and unavoidable. They are -as a matter of scientific fact -diluted and removed from the atmosphere by ventilation.

While the Committee may wish to express an opinion on the efficacy of ventilation -or even filtration -it cannot arrive at a position which is fundamentally at odds with ! the laws of physics. To do so undermines the credibility of the Committee's Report.
I would be happy to discuss this issue with you further so that the matter can be resolved.

Yours sincerely
Dr Steve Stotesbury
Industry Affairs Manager European Union Imperial Tobacco Limited
LETTER TO MINISTER FOR HEALTH AND COMMUNITY CARE, 26 APRIL 2005

Smoking, Health and Social Care (Scotland) Bill: Delegated Powers
Section 4(2) and 4(7): Meaning of “smoke” and “no-smoking premises”

During its consideration of the Smoking, Health and Care (Scotland) Bill on 22 March and 12 April 2005, the Subordinate Legislation Committee noted that the bill creates offences of smoking or permitting smoking in “no-smoking premises” and that what constitutes “no-smoking premises” is left entirely to regulations made under section 4(2) and 4(7).

The Committee recognised the need for the definition of “no-smoking premises” and exemptions to be contained in regulations rather than on the face of the bill, in order to provide the necessary flexibility. The Committee also acknowledged the high level of consultation undertaken in relation to the first draft regulations proposed to be made under the bill. The Committee, however, was concerned that there should be sufficient consultation on future regulations to make further amendment to the bill. It is in this connection I am writing to you to seek your views in advance of stage 2 of the bill.

The Committee was concerned that consultation on future substantive regulations should be as wide as that conducted on the first regulations. The Committee would therefore appreciate your views in relation to enhancing the power at section 34(4), where the Executive is required to consult persons as it considers appropriate before laying a draft of the instrument, to include a provision that the relevant draft regulations be circulated. The Committee accepts the potential problem of developing procedures that would be applied in every circumstance, even for minor technical changes, and therefore requests your views on amending the bill to require that a draft instrument be circulated only where substantive changes are proposed.

I would be grateful if you could respond with your views to the Subordinate Legislation Committee in advance of the stage 2 consideration of the bill. I am copying this letter to the Roseanna Cunningham MSP, Convener of the Health Committee for information.

Yours sincerely,

Sylvia Jackson MSP
Convener
Subordinate Legislation Committee
Smoking, Health and Social Care (Scotland) Bill: The Minister for Health and Community Care (Mr Andy Kerr) moved S2M-2667—That the Parliament agrees to the general principles of the Smoking, Health and Social Care (Scotland) Bill.

Carolyn Leckie moved amendment S2M-2667.1 to motion S2M-2667—

Insert at end—

“but, in doing so, believes that the Scottish Executive’s pursuit of further privatisation in the form of joint ventures in section 31 of the Bill compromises the general benefits to health from the Bill and potentially undermines cross-party support for the passage of the Bill.”

After debate, the amendment was disagreed to ((DT) by division: For 9, Against 75, Abstentions 17).

The motion was then agreed to ((DT) by division: For 83, Against 15, Abstentions 3).

Smoking, Health and Social Care (Scotland) Bill: Financial Resolution: The Deputy Minister for Health and Community Care (Rhona Brankin) moved S2M-2284—That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Smoking, Health and Social Care (Scotland) Bill, agrees to any expenditure or increase in expenditure of a kind referred to in Rule 9.12.3(b)(ii) or (iii) of the Parliament’s Standing Orders arising in consequence of the Act.

The motion was agreed to ((DT) by division: For 83, Against 0, Abstentions 18).
Scottish Parliament

Thursday 28 April 2005

[THE PRESIDING OFFICER opened the meeting at 09:15]

Smoking, Health and Social Care (Scotland) Bill: Stage 1

The Presiding Officer (Mr George Reid): Good morning. The first item of business is a debate on motion S2M-2667, in the name of Andy Kerr, that the general principles of the Smoking, Health and Social Care (Scotland) Bill be agreed to.

Mr Andy Kerr (Minister for Health and Community Care): Each year environmental tobacco smoke in Scotland is associated with the deaths of more than 800 people who have never smoked. That is why we must take this historic, bold and right step to improve the health of the people of Scotland.

The Executive and I are proud that we in Scotland are leading the rest of the United Kingdom in the smoking debate, which is a tribute to devolution.

Lives have been destroyed, families have been devastated and careers have been shattered—those are the tragic consequences of illness and disease caused by tobacco smoke. In response to its consultation on a prohibition on smoking, the Scottish Executive received letters from many, many people whose lives have been blighted by the consequences of exposure to second-hand tobacco smoke. They include wives whose non-smoking husbands have died of lung cancer, asthmatics who cannot socialise in pubs and mothers who are concerned for their sons who work in bars. Those are examples of just some of the real-life stories that people have to tell about the devastating effect that tobacco smoke can have on people’s lives.

Each year environmental tobacco smoke in Scotland is associated with the deaths of more than 800 people who have never smoked. That is why we must take this historic, bold and right step to improve the health of the people of Scotland. The Executive and I are proud that we in Scotland are leading the rest of the United Kingdom in the smoking debate, which is a tribute to devolution.

I thank the Health Committee for its careful and considered conclusions in its stage 1 report and I am pleased to note that it is broadly supportive of the measures that we propose. I thank the many witnesses who provided evidence to the Health Committee and I thank the Finance Committee and Subordinate Legislation Committee for their considerations.

The bill has three main purposes. The first is to introduce a prohibition on smoking in certain enclosed public spaces. The second is to continue the modernisation of the national health service, including removing charges for eye and dental checks; improving the provision of dental and pharmaceutical care; improving NHS disciplinary processes; and allowing the NHS to participate in joint ventures for the delivery of facilities and services. Thirdly, the bill seeks to make social care provisions in relation to the Regulation of Care (Scotland) Act 2001. Clearly, this is a health bill and it is within the competence of the Parliament.

I turn to the specifics of the smoking provisions. Smoking kills and debilitates and is a major factor in health inequalities. On average, smokers can expect to live 16 years less than non-smokers, and 35 people a day die before their time because of smoking-related illnesses—a 35-a-day habit that we have to kick. There is also overwhelming evidence of harm associated with exposure to environmental tobacco smoke. That evidence is clear and irrefutable.

Elaine Smith (Coatbridge and Chryston) (Lab): As someone who has recently, finally, stopped smoking, I wish that I had never started.

Members: Well done.

Elaine Smith: Thank you. Is there any evidence that a smoking ban will help to prevent young people from starting to smoke, which is crucial?

Mr Kerr: There is strong evidence of that worldwide and in the work that we are doing in the Executive. We seek through the bill to denormalise smoking—to make it abnormal and unacceptable. I believe strongly that the bill will send that message.

Mr Brian Monteith (Mid Scotland and Fife) (Con): The minister talked about smokers. Does he differentiate between cigarette smokers and those who choose to smoke pipes or cigars, given that 90 per cent of those who smoke cigars and 80 per cent of those who smoke pipes do not inhale, but practically 100 per cent of those who smoke cigarettes do?

Mr Kerr: I do not make a distinction, because we are talking about the protection of public health—the health of everyone in Scotland, including the 70 per cent of people who do not smoke. I am yet again disappointed by the Conservatives’ response to the bill.

Stewart Stevenson (Banff and Buchan) (SNP): Will the minister join me in welcoming the coverage of all tobacco that is smoked? Will he highlight the oral health problems, such as cancers, that are associated with both pipes and cigars and the crucial role that dentists play in detecting them?

Mr Kerr: We are seeking to address those matters in the strategy that Rhona Brankin announced recently in relation to oral health checks, particularly for the over-60s. The points that the member makes are accepted, understood and uncontested by most people, with the exception of the Conservatives. I hope that the
Conservatives take the opportunity in this debate to comment on the fact that their spokesperson, Mrs Milne, said that environmental tobacco smoke is “unpleasant”. It is not unpleasant; it is a killer. We know that and we will act accordingly to ensure that the bill goes through.

Mrs Nanette Milne (North East Scotland) (Con): Will the minister give way?

Mr Kerr: I will give way in a minute. I need to make progress.

As Professor Sir Richard Doll has observed, an hour a day in a room with a smoker is nearly 100 times more likely to cause lung cancer in a non-smoker than are 20 years spent in a building containing asbestos.

As Minister for Health and Community Care I have a duty to act now to protect and improve radically the health of the people of Scotland. Banning smoking in public places sends out the clearest possible signal that we are determined to do just that. There are three good reasons why the creation of smoke-free places is good for health. First, it will make it easier for smokers to give up, because they are less likely to be tempted to light up if they do not see other people smoking, especially in pubs and restaurants where the association between drinking and smoking is so strong. Secondly, it will save the lives of people who are exposed to second-hand smoke. Thirdly, and most important of all, it will reduce the acceptability of smoking—it will denormalise smoking in our society and discourage young people from starting to smoke.

As I have said, smoke-free environments will encourage more people to quit. However, giving up smoking is hard and not everyone can do it on their own—I respect my colleague Elaine Smith for managing to do so. That is why the Executive is committed to supporting and enhancing smoking-cessation services and to bringing them into the community. We will deliver those services in the communities, in places where people live and work, making it easier for them to take the first step towards quitting and increasing their chances of success. In the next few years, our funding for smoking-cessation services will increase significantly from £3 million per annum in 2004-05 to £11 million per annum by 2007-08. Those services are being enhanced and rolled out across the country as I speak. The important thing is that provision is being made to help more people in more places—both smokers and non-smokers—to live healthier, longer lives. That is why creating smoke-free environments is one of the most important things that we can do to improve Scotland’s health.

Mr Stewart Maxwell (West of Scotland) (SNP): The minister is aware of my unswerving support for the banning of smoking in public places, but is he also aware of my concern about the definition of smoking in section 4(1) of the bill? For the benefit of those who will have to enforce the measure, can the minister tell from where he is sitting which of the two cigarettes that I am holding it will be legal to smoke and which it will be illegal to smoke after the ban comes into effect?

Mr Kerr: First, I place on record again an acknowledgement of the work that Mr Maxwell has done in relation to the bill and our efforts to create a smoke-free Scotland. As we progress with the bill I am more than happy to discuss the issue of how herbal cigarettes are defined and what effect that will have on the overall competence of the bill. I cannot identify from here which cigarette is herbal and which is tobacco based. I understand and appreciate the point that Mr Maxwell is making, which is why I will seek to ensure that we deal with it as the bill develops. I am happy to sit down with him to work through the issue with our lawyers and advisers—I look forward to doing so.

In response to Stewart Maxwell’s point, that is why we want the ban to be as comprehensive as it can be, to ensure that it is not just a legal measure but is easy to introduce and enforce. The smoking provisions are pro-clean air and pro-choice. The measures are inclusive—70 per cent of Scots do not smoke. There is currently no choice for non-smokers who have to socialise and work in smoke-filled rooms. Some of the asthmatics to whom I spoke recently told me that they are forced to avoid pubs. We have therefore proposed a comprehensive ban that is clear and simple to understand and enforce, and I am content that the provisions are consistent with the European convention on human rights. Therefore, there will be only limited exemptions on humanitarian grounds in the regulations. As exemptions will be dealt with in the regulations, those will not be finalised until the current public consultation is complete.

In the meantime, we are working hard with the business community to minimise the impact of the proposed ban and maximise the opportunities that the bill presents. To that end, I have established a smoke-free areas implementation group, which includes hospitality sector and public sector representation. That group, which I chair, will consider the key issues around the smoking measures. We are looking at the best ways to publicise the ban and advise businesses on the steps that they need to take; we are considering requirements for the training of enforcement officers; and we are seeking to exploit opportunities to market Scotland abroad and change its image to that of a healthy country. We are also considering how we can help businesses to exploit the opportunities that the ban on smoking in public places presents.
For the ban to be successful we must consider enforcement, and the Executive will work closely with the Convention of Scottish Local Authorities and local authorities to develop guidance that will ensure a consistent approach throughout Scotland. We recognise the importance of enforcement, and the Executive will provide additional funding to local authorities for that duty.

Mr Ted Brocklebank (Mid Scotland and Fife) (Con): As a non-smoker, I have sympathy with many of the aspirations behind the bill. Nevertheless, the fact of the matter is that smoking per se is not illegal. I understand that there are clubs and other places where people who enjoy smoking come together socially to smoke. Why should those people be denied the right to do what is their choice simply because the Executive has decided that it wants clubs to be included in the bill?

Mr Kerr: The bill rests on the Executive's aim of improving public health. The public health of those in a private club, a social club, a pub and a workplace is equally important and valid for me, as the Minister for Health and Community Care, to consider. The point of the bill is the protection of public health and the denormalisation of smoking, and it is my view that Ted Brocklebank's view of the matter is erroneous.

There is good evidence that the measures in the bill will have real-life effects on the public and their families. The success of the bans in Ireland and New York demonstrates that smoking bans work, and compliance rates are high—93 per cent in the Irish hospitality sector and 97 per cent in New York.

Mr Monteith: The minister talks about the success of the ban in New York. Why, then, will he not consider some of the exemptions that are allowed in New York, such as cigar bars?

Mr Kerr: I refer the member to my previous answer. I am pleased, however, that he has brought up the subject of the ban in New York. Back in 2002, few people were more fiercely opposed to the ban than the outspoken James McBratney, the president of the Staten Island Restaurant and Tavern Association. He accused Mayor Bloomberg of being a billionaire dictator and a prohibitionist who would undo small businesses such as his bar and restaurant. However, in early February, Mr McBratney said sheepishly:

“I have to admit, I’ve seen no falloff in business in either establishment.”

He went on to describe what he once considered unimaginable—the fact that customers seem to like the ban. I suggest that the Conservatives, who are making spurious arguments, should reflect on that point, see the future and join in our efforts to improve Scotland’s public health.

In Ireland, sales of tobacco have dropped by 15 per cent and an estimated 7,000 smokers have quit since the ban was introduced. In New York, two years after the ban was introduced, employment in the hospitality industry had increased by 5.7 per cent, the number of liquor licenses had also increased. Therefore, as the Executive's financial impact studies show, we expect a nil or positive economic impact in Scotland, although the proposed ban is, primarily, a health measure. Our focus is on providing healthy choices, promoting a clean air environment and protecting everyone from tobacco smoke. We believe that everyone has the right to breathe clean air.

The bill also contains a range of other important health and social care measures. We will lead the way in the United Kingdom by removing existing statutory charges for eye and dental checks. That will bring significant benefits in the early detection of eye and oral disease—to which I referred earlier—and will secure an important role for community pharmacists. Patient protection will be strengthened through the extension of the range of primary care health professionals that is covered by the national health service disciplinary system and the extension of the disqualification criteria in relation to professional conduct.

Mr John Swinney (North Tayside) (SNP): Will the minister give way?

The Presiding Officer: The minister is getting tight for time.

Mr Kerr: I am sorry. Perhaps Mr Swinney can address the matter later, in his speech.

On the other aspects of the bill, I am sure that the Executive will reflect on the report of the Health Committee, especially in relation to adults with incapacity and other such matters that it raises. I note the concerns regarding patient care and health care facilities, in response to which the bill will give Scottish ministers the power to enable health boards to enter into joint ventures that will ensure the renewal of our infrastructure at a local level for local health care. Other such matters are addressed elsewhere in the bill.

The bill will bring direct, measurable improvements to the health of the people of Scotland and provides an opportunity for Scotland to lead the way in the UK. I am delighted that so many MSPs from different political perspectives have united around the bill, which is the most important piece of public health legislation in a generation. Let us embrace this opportunity together. I hope that the Conservatives can, at last, recognise the benefits of the bill so that we can speak with the voice of the whole Parliament.
to ensure that we improve Scotland’s public health.

I move,

That the Parliament agrees to the general principles of the Smoking, Health and Social Care (Scotland) Bill.

09:31

**Carolyn Leckie (Central Scotland) (SSP):** I congratulate the Health Committee, the clerks and everyone in the Parliament who has worked hard on this extensive bill and produced excellent reports. There is potential for cross-party support—except from the Tories, but I will come back to them—for a progressive, pro-health agenda, in particular on the headline intention of the bill. I do not need researchers’ statistics to persuade me that second-hand smoke has a detrimental effect on health; I have only to see the immediate impact that smoke has on my daughter, who suffers from asthma, when she walks into a smoky room. I am persuaded by the health arguments of the bill, although I have some reservations. I will not dwell on those today but, as the bill progresses, I might come back to them. I am glad that the Executive is prepared to implement a policy that will, I hope, improve Scotland’s health; however, I would be more impressed if that policy was presented in tandem with health policies that were even more proactive, such as the provision of free school meals.

It is unfortunate that I am unable to concentrate on the positive aspects of the bill today. The debate has been dominated by the proposed smoking ban—probably predictably and rightly—and I note that the minister spent only one minute of his speech in talking about the section of the bill that makes reference to joint ventures and LIFT—local improvement finance trust—schemes. However, contained in the bill is a section that, if not removed, is so fundamental that the Scottish Socialist Party—and perhaps others whose policies are pro-public finance—will end up having to oppose the bill. That is why I hope that all parties—although perhaps not the Tories, who I imagine think that that is the only good section of the bill—will support our amendment to take out the section of the bill that relates to joint ventures.

It is important to differentiate between what the Executive, civil servants and public bodies say about the policy intentions around LIFT schemes, intellectual property and so on, and what the bill allows. In answer to my written question on the subject, Andy Kerr stated:

“There is no policy intention for joint venture companies established to provide clinical services.”—*[Official Report, Written Answers, 21 March 2005; S2W-15136.]*

Nevertheless, the bill facilitates that. It is obvious from the evidence that was given to the Health Committee that there is no support for the claimed benefits of LIFT schemes. The Executive and the bodies that are expected to implement the bill have been, at best, vague about how LIFT schemes would be implemented and what the impact would be on service provision, accountability, staffing levels and the terms and conditions of any future staff. The Executive has not ruled out staff transfer, and the Scottish Trades Union Congress/Executive staff protocol exists only as long as the Executive enforces it. The SSP believes that that is not enough protection for workers.

There are already more health centres in joint premises in Scotland than there are in England, and there is much greater potential in Scotland than in England for adverse outcomes for staff. None of the witnesses who were in favour of LIFT schemes was able to give us details of their impact on public services, but it is safe to assume that the high costs of private finance initiatives, in financial and clinical terms, will be replicated in LIFT schemes.

The returns for the private sector, which is 60 per cent dominant in the schemes, are at least double what they would be under public procurement. As we have seen with PFI, the public purse, services, patients, clients and staff pay handsomely for the private sector’s bumper returns. I recommend that members read in detail the evidence presented by Dave Watson of Unison, of which I am a member, and contrast its erudition, precision and confidence with the woolly, vague, ill-informed and sometimes pathetic case submitted by the advocates of LIFT schemes.

**Mr Kerr:** Will the member accept on record the fact that 50 per cent of general practitioner premises are privately owned and that capital support in the public sector, particularly in health, has increased radically over the past few years? All we seek to do with these proposals is to provide another option. However, it must be the best-value option, and that will clearly form part of the assessment of such projects. We want to attract additional investment at a local level in order to proceed with good examples of partnership working such as the Dalmellington area centre, Strathbrock partnership centre and Leith community treatment centre. The measures will allow more of that activity to happen.

**Carolyn Leckie:** That case has indeed been made for PFI; however, it has been blown out of the water by Allyson Pollock and others. I do not need to repeat their points again this morning.

The proceedings of the so-called joint conference that was sponsored by E C Harris and 75 per cent dominated by the private sector were summarised and submitted as evidence to the
Health Committee. One could almost see the slavering lips jumping off the page. I will give the chamber an example of how ill-informed that conference was. It was asserted that there was less deprivation in Scotland than in England—and Scotland, by the way, was thought to hold more exciting opportunities for the private sector as far as LIFT schemes were concerned. Those are the kind of people from whom the Executive prefers to take advice.

One crucial matter is critical mass. The participants in the E C Harris conference certainly identified that as a vital issue for them. The banks like to finance big deals, which means that health boards’ capital spending priorities become determined not by clinical priorities or health needs but by the demands of the banks. They determine the conditions of the finance and therefore dictate the size of projects.

It is clear from the evidence—and from the Executive itself—that there is no detail on these proposals and no rush to flush it out.

Stewart Stevenson: Will the member give way?

Carolyn Leckie: I am sorry—I am in my last minute.

As a result, it is not necessary to tie up this highly controversial measure in a generally positive piece of legislation. Although the measure is worthy of public debate on its own, it has not been able to attract that because of the high-profile nature of the smoking ban.

The Tories could, and should, be isolated today. I ask the Parliament to support my amendment to ensure that at stage 1 of the bill its passage can have cross-party support—with the exclusion of the Tories.

I move amendment S2M-2667.1, to insert at end:

“but, in doing so, believes that the Scottish Executive’s pursuit of further privatisation in the form of joint ventures in section 31 of the Bill compromises the general benefits to health from the Bill and potentially undermines cross-party support for the passage of the Bill.”

09:38

Shona Robison (Dundee East) (SNP): I welcome this stage 1 debate; I thank all those who gave evidence to the committee; I also thank the clerks for all their hard work in helping us with what has been at times a rather difficult bill.

The bill is perhaps a lesson in why bills with miscellaneous provisions are generally not a good idea and should, if possible, be avoided. The bill is dominated by the proposals to ban smoking in enclosed public spaces; however, it also contains very important provisions that relate to the regulation of the workforce, the introduction of free eye and dental checks, compensation payments to hepatitis C sufferers and the introduction of new powers to allow the formation of joint ventures for the provision of facilities or services in the NHS in Scotland. The minister did not have an awful lot of time to address all those issues in his speech. Similarly, the Health Committee found effective scrutiny of the bill’s component parts to be an extremely difficult challenge, although I must say that it made a valiant effort to do so.

I want to start with the part of the bill that focuses on smoking. It was fortunate that the committee had heard a great deal of relevant evidence during our consideration of Stewart Maxwell’s Prohibition of Smoking in Regulated Areas (Scotland) Bill, because otherwise we would have been faced with a very tight timescale in which to take that evidence.

The committee took evidence from both sides of the argument and went to Ireland to see how its ban was working out. Throughout this debate, claims and counterclaims have been made about, for example, the dangers of passive smoking and the impact of a smoking ban on health and on the economy. For me, the question is very simple: on the balance of probabilities, will this measure improve public health? Having listened to all the evidence and having seen for myself the impact of a ban in Ireland, I feel that it will.

Phil Gallie (South of Scotland) (Con): I am well aware that the Health Committee has recently expressed concerns about obesity. Has the member seen any research that links cessation of smoking with weight gain? If so, does that offer an added health risk?

Shona Robison: To be perfectly honest, that is a silly analogy. The member and his colleagues must assess whether, on the balance of probabilities, the measure will improve public health. I have to say that, at the start of the process, I had to be converted to support the measure. However, if we really listen to the evidence, we can conclude only that the measure will improve public health.

Mr Monteith: Will the member give way?

Shona Robison: I will give way in a moment.

One important aspect of the measure is the denormalisation of smoking. So many children in so many communities see smoking as a normal activity, because people all around them do it. If we denormalise such activity, particularly in enclosed public spaces, we will give the next generation a fighting chance of not taking up smoking at the levels that we have seen in the past. That can be only a good thing, and I hope that Brian Monteith will at least acknowledge that.
Mr Monteith: The member said that we can draw only one conclusion from the evidence. If so, will she explain to me how it is possible for a minister from the Labour Party in the Scottish Parliament to conclude that there should be a total ban on smoking in public places, while a Labour minister at Westminster can conclude from the same evidence that only a partial ban is required in a different part of the UK?

Shona Robison: Could it be that John Reid is wrong? I will be very interested to see the absolute mess that the Westminster Government gets itself into when it tries to implement a partial ban and to decide, for example, whether a premises that serves microwaved food should be included in a smoking ban. It will be a dog’s breakfast. The courts will be full of rulings to determine matters one way or the other. Because that approach will be such a nightmare, I was persuaded that an all-out ban was the way forward. I think that John Reid’s assessment is simply wrong.

However, we need to consider a number of important issues. For example, people have argued that smoking will be displaced into people’s homes. I do not agree that that will happen—indeed, the evidence from Ireland does not support such an assertion—but I think that the situation should be monitored effectively. In addition, because the number of people who want to give up smoking will increase as a result of the legislation, smoking cessation opportunities must be available when and where those people want them.

We must also think about enforcement. I listened to the minister’s comments about the concerns that must be addressed, but the matter is crucial. After all, the ban’s success in Ireland was in no small measure due to the way in which it was enforced. Enforcement was handled in a non-confrontational manner after the event. For example, if an instance of smoking in a public house was reported, that was dealt with later rather than at the time, so there was no upfront confrontation between enforcement officers and members of the public. We must avoid such situations. The Health Committee was concerned about the fact that it appears that individual local authorities will be able to determine local enforcement strategies. The minister and the Health Department must give clear guidance on what is expected in that regard.

Another ace card that the Irish have had is the Office of Tobacco Control, which was the driving force behind the package of measures that the Irish Government introduced. I believe that we need an equivalent body in Scotland to oversee the proposed changes. I look forward to hearing what the Deputy Minister for Health and Community Care has to say on that.

I realise that time is pressing, so I turn quickly to the other elements of the bill. Free eye and dental checks are welcome and have long been supported by members of the Scottish National Party. However, the committee received strong evidence—especially from the British Dental Association—that the workforce would struggle to deliver free dental checks. The minister has been questioned about that in other debates. We must acknowledge the BDA’s concerns that there will not be sufficient numbers of staff to deliver the free checks.

I want to highlight the Finance Committee’s strong concerns about the bill’s process. It said:

“the Committee is deeply concerned that it is being asked to scrutinise the financial implications of a Bill where the staffing and service implications which crucially determine the cost do not appear to have costed in a manner that gives the Committee confidence in the figures.”

We are talking about a classic case of putting the cart before the horse. When we considered the bill, we had not seen the minister’s action plan or a statement of his intentions. That is not a good way in which to proceed with legislation or financial memorandums. The Finance Committee expressed very strong views on that.

I will deal quickly with hepatitis C payments.

The Presiding Officer: Briefly, please.

Shona Robison: I have a number of concerns, of which the minister will be aware. I would like him to reconsider the exclusion from the compensation scheme of those sufferers who died before 29 August 2003. The committee has expressed sympathy with the view that that matter should be re-examined and I hope that Andy Kerr will do that. I also ask that the issue of residence be looked at. If someone was affected by hepatitis C as a result of receiving contaminated blood or blood products through the national health service, it should not matter where they live now; if that is how they became infected, they should get the compensation payments as of right.

I am being asked to wind up, so I will just make a brief comment on joint ventures. I am pleased that Helen Eadie welcomes the public investment trust model, on which we will seek to lodge an amendment at stage 2.

Although I have expressed reservations in certain areas, I support the bill’s general principles and look forward to the amendment process at stage 2.

09:48

Mrs Nanette Milne (North East Scotland) (Con): The Smoking, Health and Social Care (Scotland) Bill is complex and diverse. The fact that it contains highly varied subject matter has
made it quite difficult to deal with. As Shona Robison said, had the Health Committee not decided to use the evidence that it took on the Prohibition of Smoking in Regulated Areas (Scotland) Bill—which was introduced by Stewart Maxwell—in examining the Executive’s bill, it would have been even more difficult for us to be ready for today’s stage 1 debate.

It is clear that the Executive wants to rush through its smoking policy and I am not sure that that is wise, especially if one stops to consider how short the lead-in time to implementation will have been in comparison with the lead-in time to the introduction of the Irish legislation. In Ireland, years were spent preparing and educating the public so that they were ready for an all-out ban on smoking in enclosed public places by the time that the legislation was enacted. I do not think that the public in Scotland have reached that stage yet.

The Conservative group is generally content in principle with the proposals in parts 3, 4 and 5 of the bill, which deal with pharmaceutical care services, discipline and miscellaneous matters such as joint ventures and amendments to the Regulation of Care (Scotland) Act 2001. We agree with the recommendations of the Health Committee’s report on those matters.

We have no serious difficulties with part 2, in so far as it deals with general dental services in sections 11 to 14 and with practitioner lists in sections 15 to 17, although we do not think that the Executive’s recent announcements on its proposed changes to the dental service in Scotland will solve the crisis in NHS dentistry. We do not support sections 9 and 10 in part 2, which relate to free dental checks and eye examinations, nor do we agree with part 1, which deals with the prohibition of smoking in enclosed public places. Therefore, we are unable to support the general principles of what is a complex bill and we will be opposing the motion.

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): So far, the Conservatives have given us spurious reasons for not supporting the bill, such as those to do with pipe and cigar smoking and obesity. My father died of lung cancer and I think that the sooner the bill is in place, the sooner we will save lives. I ask the member to please give us some firm reasons for not supporting the bill.

Mrs Milne: I am aware of that.

We feel that the proposal for free dental and eye checks for all by 2007 would not be the best use of scarce resources. The most vulnerable people are already eligible for free checks; the difficulty lies in persuading them to attend for those checks and, in the case of dental checks, their being able to find a dentist to carry them out. Every effort must be made to ensure that those people access the services that are already freely available to them.

As we heard in last week’s debate on dentistry, there are not enough dentists in the NHS to carry out the checks. Once the checks have been done, who will carry out the treatment, given that there is such a lack of NHS dentists? I agree with the concern that Eleanor Scott voiced during last week’s debate, which is that it is unethical to diagnose a patient and then not treat them.

Dr Sylvia Jackson (Stirling) (Lab): Will the member give way?

Mrs Milne: Not at the moment.

We support the committee’s recommendation on the introduction of a comprehensive dental and sight-screening programme for children at the start of their primary and secondary school education.

With regard to the proposed ban on smoking in enclosed public places, let the Parliament be in no doubt that the Conservative group wants people to have the choice of a smoke-free atmosphere in enclosed public places, such as restaurants, pubs and public transport. Great strides forward have been made in recent years without legislation. Buses, trains, aircraft and public buildings, as well as many workplaces and restaurants, are now smoke free and the licensed trade, too, is coming on board. J D Wetherspoon has led the way by introducing a smoking ban in most of its pubs.

Increasingly, choice is developing for non-smokers and those smokers who prefer smoke-free atmospheres indoors. As public demand increases, there will be more and more smoke-free premises. The licensed trade is keen to cooperate and it has indicated its willingness to make concessions and to alter premises. We want to work with the industry to enhance choice for non-smokers.

Dr Jackson: In light of what the member has told us, how does she respond to the British Medical Association? The BMA briefing says:

“The BMA fully supports the principles outlined in the Bill which seeks to provide comprehensive legislation to create smoke-free enclosed public places”.

The Presiding Officer: Mrs Milne, you have three minutes left.

Mrs Milne: I have had a discussion with the BMA and it knows my position on that.
As a lifelong non-smoker and someone who accepts that the mass of her profession is in favour of the Executive’s proposals, I have thought long and hard about them in the past few months, but I remain unconvinced that legislation is the right way forward—especially at this point in time, when the licensed trade is eager to become involved in improving the atmosphere for its customers and its workforce. I fear that the bill will result in displacement of smoking to the home and an increase in home consumption of alcohol, which is itself a public health problem.

Mr Maxwell: Will the member give way?

Mrs Milne: I am taking no more interventions.

I feel for smokers—especially women smokers—who will be forced outside into inferior facilities, when their habit is legitimate. Several women whom I met in Ireland forcefully made the point that, since the ban had come in, they felt that were being treated like second-class citizens and they were unhappy about that. I am concerned for pensioners, particularly in small villages, who will miss the conviviality of a pint and a cigarette at their local in the company of their pals.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Smoking kills people.

Mrs Milne: Mike Rumbles’s constituency contains small villages where there is no choice of licensed premises. I worry for the future of establishments that are unable to provide outdoor facilities for their customers. There was not a level playing field in Ireland—that was obvious.

I am forced to the conclusion that choice is better than coercion. The increasing willingness of publicans to respond to the wishes of their customers will soon result in greatly increased choice for non-smokers, while leaving some choice for those who continue to smoke. People must take responsibility for their own health and lifestyles. I have little doubt that business will respond accordingly.

My colleagues and I feel that there is an undoubted public health case for encouraging people to stop smoking and deterring them from starting in the first case. We support the Executive’s plans for a sustained and vigorous campaign against the taking-up of smoking and we would give practical help, support and encouragement to those who wish to kick the habit. Believe it or not, like the Executive, we too would give practical help, support and encouragement to those who wish to kick the habit. Believe it or not, like the Executive, we too have the ultimate goal of achieving a smoke-free environment for everyone.

09:56

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): The Liberal Democrats believe that the bill will dramatically improve the health of the nation. I will first focus on the measures to introduce free eye and dental checks for all, which were a central part of the Liberal Democrats’ election manifesto in 2003. Those free checks for all underpin our commitment to health promotion and early intervention. On the proposal for free eye checks, it is remarkable that, as the committee report points out,

“All those who gave oral evidence to the committee, namely, Optometry Scotland, the Scottish Consumer Council, Fife Local Health Council and the health boards (Glasgow and Highland) and all those submitting written evidence were in favour of the proposal.”

There was a similar unity of view on the free dental checks—all those giving oral evidence to the committee were in favour of the proposal. Every member of the Health Committee, with one exception, believes that, if fully implemented, those measures have the potential to improve standards of oral health and reduce the number of long-term sight problems in Scotland.

I say “with one exception”, because it was clear that the one Conservative member of the committee would oppose the measures come what may. It is interesting that, even when there is unanimity among those giving evidence to the committee, the Conservatives cannot bring themselves to listen to that evidence and draw the correct conclusions from it.

Mrs Milne: Will the member take an intervention?

Mike Rumbles: Not yet.

The dogmatic approach taken by the Conservative party to the measures in the bill is flagged throughout the report and does not go with the spirit of the committee system. Surely the Conservatives could have asked for evidence from witnesses who were opposed to the measures. Why did they not ask for such witnesses to come forward? Was it that they simply could not find anyone willing to come to the committee to support their views?

The major issue in the bill is the proposal to prohibit smoking in wholly enclosed public places. In June 2004, the Liberal Democrats became the first major party in Scotland to adopt that proposal as party policy. I am pleased that the Health Committee accepts that

“evidence exists of adverse health effects from passive smoking”.

The committee’s report states:

“The majority of members, therefore, support the proposal contained in this part of the bill, believing that it will help save lives.”

The report refers to the “majority of members” because, once again, the one Conservative member of the committee refused to accept that
passive smoking kills. That is typical of the Conservative party’s approach to almost all the measures in the bill that are aimed at improving the health of Scots across the nation.

Mr Monteith: Can the member cite any medical evidence received by the committee that suggests that passive smoking kills?

Mike Rumbles: I will come to that shortly. When members of the Health Committee visited Ireland to see how similar measures were being implemented there, we consistently heard the view expressed that it was important that every political party behaved responsibly by backing the health measures.

There is no dispute about the fact that passive smoking kills. In Scotland, only the Conservative party steadfastly refuses to accept the medical evidence. The attitude of the Conservative party on the issue is nothing less than neanderthal and nothing less than a scandal. The Conservative party seeks to undermine the medical evidence that passive smoking kills. It sides with the tobacco manufacturers rather than with patients and it sides with FOREST—the Freedom Organisation for the Right to Enjoy Smoking Tobacco—rather than with the World Health Organisation. Shame on the Conservative party.

Brian Adam (Aberdeen North) (SNP): Does the member agree that the arguments advanced by the Tobacco Manufacturers Association and, indeed, by the Conservative party echo those that the industry advanced when it did not accept that smoking kills? It is the same argument, recycled.

Mike Rumbles: I could not agree more. That is why it is absolutely shameful for the Conservative party to take the attitude that it has taken.

As for the medical evidence, Professor David Hole estimates that there are between 850 and 950 deaths from passive smoking every year among lifelong non-smokers in Scotland. His recent report states:

“Passive smoking represents the greatest risk to public health when compared to other forms of ‘involuntary’ environmental exposure.”

It is because of the attitude of the Conservative party in challenging the medical evidence on passive smoking that so much time has to be devoted to the issue. In other countries, such as Ireland, where there is a responsible Opposition, no such debate is needed. All the time and effort can be focused on making sure that people are aware of the dangers of passive smoking and on getting behind the measures to tackle the problem.

In Ireland, the people are behind the measures that the Irish Government is taking. Tobacco sales have fallen by some 17 per cent, as we were informed by Ireland’s deputy health minister. Fewer people are smoking in Ireland—estimates suggest that as few as 25 per cent of the adult population are still engaged in smoking. The measures are working. The Irish public are benefiting from them and all the national political parties back them. Is it too late to ask the Conservative party to embrace the medical evidence that passive smoking kills and then to join everyone else in tackling the problem? If we are serious as a nation about tackling passive smoking, we cannot take half-measures, as they will not solve the problem.

The Scottish Licensed Trade Association argues that economics should outweigh health; it argues that we should have a partial ban. The Tobacco Manufacturers Association argues that proper ventilation of premises is the answer. Of course, neither of those approaches is acceptable for those who want to see an end to the situation in which some people cause the deaths of others through passive smoking. As the committee stated, “ventilation would not provide an adequate alternative, because it does not remove carcinogens.”

In other words, people might feel better, but they would still take in carcinogens. The same argument applies to so-called smoke-free areas.

Mrs Milne: Will the member take an intervention?

Mike Rumbles: I have already taken interventions from the Conservatives.

Unfortunately, we do not have time adequately to examine many of the issues that the bill raises—that is one of the problems with this type of bill. I had hoped to refer to enforcement. One issue that the committee flagged up was the hepatitis C cut-off date, to which Shona Robison referred. I hope that the minister will look again at that matter.

In conclusion, we believe that the bill contains measures that will dramatically change Scotland for the better. We will tackle the problem of passive smoking and, by doing so, we will save lives. With free eye and dental checks, we will make a difference to the nation’s health through a comprehensive health promotion and preventive medicine initiative. Taken together, the measures should see us progress to a better Scotland in the 21st century. I urge everyone to give the bill their full support.
great deal of work is ahead of us at stage 2. The support of the clerks and others will be crucial in ensuring effective scrutiny of such a diverse bill.

As a member of the Labour Party and of the Health Committee, I am delighted to support the bill, which has the potential to become one of the most important pieces of legislation that the Parliament will ever pass. However, as we have heard from other members, it is not perfect yet. In its stage 1 report, the committee expressed concerns that the bill is too diverse, as Shona Robison and Mike Rumbles said. The committee believes that the Executive should try to avoid that approach in future. My speech will focus on three of the bill’s provisions: the prohibition of smoking in public places, which is the headline grabber; optometry services; and the authorisation of medical treatment.

None of us is comforted to be reminded that Scotland continues to be the sick man of Europe, but we must stop saying that and start taking action. When the committee first took evidence on a smoking ban in the context of Stewart Maxwell’s member’s bill, I had an open mind on the matter and was yet to be convinced that initiating such a move would bring real long-term health benefits to the people of Scotland. However, as our committee analysed the Prohibition of Smoking in Regulated Areas (Scotland) Bill and the Smoking, Health and Social Care (Scotland) Bill and as we considered the evidence, which we have heard much about this morning, from other places—most notably Ireland and New York, where the compliance rates, as the minister said, remain high—I have become ever more certain that a total ban will have a positive impact on the nation’s health.

We all know the statistics, which we have heard much about this morning, and we all know the scale of the problem. In my mind, there is absolutely no doubt that the introduction of a ban on smoking in enclosed public spaces will protect the 70 per cent of non-smoking Scots from the harmful effects of environmental tobacco smoke. As other members have said, a ban will also encourage smokers to give up smoking. That is borne out by the experiences elsewhere, including in Ireland, where tobacco sales are down significantly since the introduction of the ban.

Marilyn Livingstone (Kirkcaldy) (Lab): Despite Nanette Milne’s claim about the ban’s impact on women in Ireland, does the member agree that the increased numbers of young women who smoke represent the real impact on women? Does she agree that the task ahead of us is to bring about a sea change to try to stop young women smoking, given the impact that smoking has on their health and on that of their families both now and in later life?

Janis Hughes: I totally agree that the high and increasing rates of smoking among young women are a cause for concern and an issue that needs to be addressed. The one issue on which I agree with Nanette Milne is that we need to ensure that the bill will not simply ban smoking in public places, but ensure that people—and, in particular, young people—do not take up smoking in the first place. I know that the Executive has agreed to move forward in that regard.

Any debate that is inspired by the bill must inform people of the real and serious dangers to human health that are associated with passive smoking. In the parliamentary debate that followed the First Minister’s statement in November, I highlighted concerns over the implications for children if parents were to choose to smoke in the home instead. Bearing in mind the similar concerns—no specific evidence was available—that were raised with us in the Republic of Ireland, the committee has recommended that the issue be monitored following the ban’s implementation.

I support what Shona Robison said about the Office of Tobacco Control. In Ireland, our committee saw at first hand how that body plays a vital role in co-ordinating inspections in cooperation with environmental health departments. It was also proactive in delivering a communications strategy.

The bill will introduce significantly more than just a smoking ban, as it will also introduce many important benefits and offer us an opportunity to redefine how we deliver certain services. In particular, I welcome the bill’s provisions on optometry services and I strongly support the introduction of a comprehensive sight-screening programme at the start of primary and secondary school education so that problems can be identified and treated at an early age. I speak from personal experience, as one whose mother thought that my complaints of short-sightedness in primary school were made only because I was after a pair of attractive glasses. However, I was diagnosed as being extremely short-sighted when I was screened in secondary 1 and have worn glasses or contact lenses ever since. I benefited from that screening, so I think that it is important that we screen children at an early age so that they can avoid some of the problems that can affect them in later life.

Optometry Scotland proposes that primary access to eye care should be moved away from general practice and ophthalmology clinics into community optometry practices. The organisation argues that such a move would not only allow hospital clinics more time and resources to deal with more complicated conditions, but offer patients quicker diagnosis of problems. Many optometrists feel that they could contribute more in
a community setting than they contribute at the moment. The bill will allow us the opportunity to redefine how we deliver those services.

On incapacity certification, I share the committee’s concerns about the bill’s amendments to the Adults with Incapacity (Scotland) Act 2000. I fully support the Executive’s desire to extend the range of health professionals who can issue an incapacity certificate, but I am more dubious about the proposal to extend the duration of such certificates to three years. Although the professional bodies from which we took evidence supported such an extension, a number of patient representatives expressed their reservations. We need to consider the issue carefully, but I support the committee’s view that we should not change the current legislation on the duration of certificates.

I believe that the bill will have a significant and long-lasting effect on the lives of the people of Scotland. The Scottish Executive has taken the lead in the fight against ill health and it deserves to be commended for its bravery. I am delighted to support the bill and I urge members to follow suit.

10:10

Stewart Stevenson (Banff and Buchan) (SNP): It has been said that life provides five kinds of people: those who make things happen; those who watch things happen; those who wonder what happened; those who did not know that anything happened; and those to whom things happened. As with so many subjects, we in the Parliament need to be those who make things happen for the benefit of those to whom things happened. Nowhere is that more true than in the case of the primary issue with which the bill deals. I come to today’s debate as an unashamed extremist. Bertrand Russell said that only extremists create change; those who sit in the middle and agree with the herd create no change. That is why I have no tolerance for those who wish to maintain the status quo.

Let me deal with just a few of the claims that are made by the smoking lobby in one form or another. Nanette Milne claimed that the industry is made by the smoking lobby in one form or another. Philip Morris International created the slogan: “Today’s teenager is tomorrow’s potential regular customer.”

We can see where that company is coming from. However, in 1999, it commissioned the Arthur D Little consultancy to study the economic impact of smoking deaths in the Czech Republic. The resulting report proudly informed the Czech Government that each smoking death provided an annual public benefit of $1,277, which would amount to $147 million each year.

How did such homicides—that is the only appropriate word—make their social contribution? Using what Arthur D Little described as “the results of the exercise of our best professional judgement”—

that is, the judgment of the hangman—the report identified that deaths from smoking produced savings on health care expenses, housing for the elderly, social security and pensions. Even more surprising, the report’s findings on the effect of smoking on employment were that “replacing those who die early … leads to savings in social benefits paid to the unemployed and in the costs of re-training”.

Perhaps we should hand medals—posthumous medals, of course—to those selfless souls who smoke themselves to death for society’s benefit. Would their families value such a medal more than the presence of the loved one who was killed by these evil peddlers of death? After all, those who make such a sacrifice are hardly volunteers for the task, when they are simply the collateral damage that is inflicted on friends in the cause of smoking company profits.

As James VI wrote in 1604—this debate ain’t new—the point is that “habitum, alteram naturam”. That is, habit changes nature. Four hundred years ago, James VI identified the pernicious effects of nicotine addiction, but we are fortunate to have other views that are of more social value, such as those that are expressed in the recent NHS document. The document suggests that, in 30 years’ time, the smoking ban will save 406 lives a year. I believe that to be a fairly modest estimate, but I am reminded of Napoleon’s demand for poplar trees along Europe’s military routes to provide shade for his soldiers from the sun as they marched to war. His generals said, “But, Napoleon, it will take 30 years before the trees are high enough to deliver a benefit.” He said, “Then there’s no time to waste.” So it is in this case. We must plan for financial impacts, positive or negative, but what must drive us is releasing our people and their families, friends and colleagues from the scourge of the addiction inflicted by the
The NHS report identifies possible negative impacts on the viability of smaller bars. I recently visited a bar in Burghhead and had some of the issues put to me forcefully. I have a few thoughts for the secondary legislation that will follow the bill, because we must protect the small village pub, which plays an important role in local societies. First, we must hold the line on exemptions—there must be none—because that would create unfair competition. However, I might have one exemption to propose later. Secondly, we must seek proactive assistance for such enterprises before implementation, to allow them to broaden their appeal, develop new markets and directly support their customers in their efforts to reduce or eliminate their dependency on tobacco. Finally, I make the entirely personal suggestion that we should consider whether transitional business rates relief could be given for a couple of years, so that bars that can demonstrate a link between reduced trading and the smoking ban can have limited compensation.

James VI said:

“Tobacco ... hath a certaine venemous facultie ... which makes it have an Antipathie against nature”.

That is true.

I close with my one suggested exemption. I believe that we should consider exempting Tory social clubs from the provisions of the bill. That would make a decisive contribution to eliminating the scourge of Tories from Scotland and Scottish society, although perhaps we should protect even the Tories from themselves.

10:17

Irene Oldfather (Cunninghame South) (Lab): I did not think that I would be able to agree so whole-heartedly with Stewart Stevenson, but we may have found an area of consensus on his final suggestion for an exemption.

Today's debate represents a milestone in the short history of our Parliament. Since 1999, we have passed 83 pieces of legislation, many directly improving the lives of ordinary people, on free personal care, the abolition of tuition fees and a raft of other measures. However, none has impacted on saving lives in the way that the Smoking, Health and Social Care (Scotland) Bill will do. To my mind, it is the most important piece of legislation to impact on the health of our people in a generation.

Other members will speak about the wider provisions of the bill, but I hope that members will understand my desire, as convener of the cross-party group on tobacco control, to speak to the principles in part 1. In doing so, I want to reflect on what I believe has been a sea change in attitudes in Scotland over the six years that the Parliament has been in place.

In the early years of the Health and Community Care Committee, of which I was a member, a poll was taken of committee members’ attitudes to a smoking ban. The fact that a number of us, including Hugh Henry and me, supported a full ban on smoking in public places made the evening news. Indeed, I have to say that I was not a popular person in the Market Bar in Kilwinning that weekend—sometimes we have to stand up for what we believe in. Attitudes have definitely changed in the past six years, and I hope that the work of the cross-party group, set up in 1999, has contributed to raising awareness of the debate on passive smoking and to changing those attitudes.

I acknowledge the work of individual back benchers, such as Stewart Maxwell and Hugh Henry—before he reached the dizzy heights of ministerial office—and of organisations such as the British Medical Association, Action on Smoking and Health and the trade union movement, who have assisted us in reaching the dynamic point that we have reached today. I have no doubt that, without the commitment of the Scottish Executive, the Minister for Health and Community Care and the First Minister, we would not have such a comprehensive piece of legislation. I hope that in the coming months we will maintain that position and that we do not dilute the bill under the pressure that will inevitably come upon us all.

There is a moral imperative to act. We know that smoking kills 19,300 Scots every year and that one death in five in Scotland is smoking related. We know that smoking is responsible for 33,500 hospital admissions every year. Second-hand smoke is a class A carcinogen, and that costs the NHS in Scotland an estimated £200 million every year.

Those figures represent the financial costs, but there are also human costs. No one who attended the reception at Edinburgh Castle last night could fail to be moved by the stories of how smoking had robbed loved ones of time with their relatives. They would know that this is the right thing to do. Anyone who has watched someone die of lung cancer, as I have, will know that this is the right thing to do. Anyone who has lost a mum or a dad, or a gran or a grandpa, through smoking-related illness will know that this is the right thing to do. That is why we must stand firm in the weeks and months ahead and why we must not water down the bill. I am pleased that we have the degree of cross-party support that we have for the measures.

I would like to mention a few things that I want to draw to the Executive’s attention. I call them the
three Es: exemptions, enforcement and enclosed areas. I hope that I have time to deal with them all; I shall certainly do my best.

Starting with exemptions, I welcome the approach that the minister has taken in stating to the Health Committee and to the Parliament that the overall principle of the bill is to move towards smoke-free environments with minimum exemptions. The approach to exemptions so far has been humanitarian—with the exception, perhaps, of Stewart Stevenson’s final suggestion. I understand that if people live in a residential home, that is their home, and that residents should be able to smoke in their own room if they want to do so. The same is true of hospices and psychiatric units. However, I am concerned that there should be clearly defined and limited smoking areas in such premises, in the best interests of other patients, staff and visitors. I know that the Executive is keen to work with the Scottish Commission for the Regulation of Care to ensure that all care homes are clear that their duty of care is to vulnerable, elderly people who would be at risk.

The Deputy Presiding Officer (Trish Godman): You have one minute left.

Irene Oldfather: I will not be able to cover all the issues that I wanted to cover, but I would like to say a quick word about day centres. I am aware that the Health Committee’s stage 1 report highlights concern about the omission of day centres from the list of exemptions. Although I appreciate that view, I remain unconvinced that day centres should be exempt from the ban. Although day centres provide a vital service, they do not qualify as places of residence. People use them on a day-to-day basis in a similar manner to attending school, college or work, and I do not think that there are sufficient grounds to grant a residency exemption. I would be particularly concerned about the precedent that that could set for other areas. I am not persuaded of that argument.

My time is running out and I do not have time to address enforcement and enclosure, but I shall write to the minister about those issues on behalf of the cross-party group.

Today we begin a journey to change the lives of young Scots. They are the generation that wholeheartedly supports the change. I have not visited one school in my area where one person has said that it is not a change that they want. We must not let them down. I urge members of all parties to support the principles of the bill.

10:24

Eleanor Scott (Highlands and Islands) (Green): The various proposals in the bill are generally ones that my party and I support. I agree with other members that it is an awfully motley collection of disparate bits of legislation, and I echo the remarks of other members and of the Health Committee that those matters would have been better dealt with separately. I strongly endorse the committee’s comments on that point. Smoking is clearly the most important and innovative issue addressed in the bill and will naturally take precedence in the debate, but the other issues merit a bit more time than we have been able to give them because they have all been lumped together.

The prohibition of smoking in enclosed public spaces is something that is easily supportable, and my party has supported it from the beginning. I will talk about some of the arguments that have been used against it. One is the idea that people will smoke more at home. As has been said in previous debates, the evidence is against that. The experience of a workplace ban on smoking in Australia is that it resulted in people smoking less at home because of the greater awareness that the campaign had raised.

The process of denormalisation that the minister spoke about will be set in motion by a ban. People will smoke less in front of people—a societal change is happening anyway and the ban will ensure that it continues. I support the majority of the committee on that point.

Many of the alternatives that have been proposed for the protection of non-smokers in public places would, in my view and in the view of others, be ineffective. We have had extensive lobbying from the licensed trade. I take Stewart Stevenson’s point about having to protect the small village pub, but three quarters of the residents of the small village—the three quarters who do not smoke—might be more inclined to go to the pub if they knew that it was a smoke-free environment. There might be a slight, temporary dip in licensed trade, but afterwards we could expect an increase, a healthy licensed trade and a much healthier environment.

In a previous debate, I mentioned my brief visit to Ireland and the sheer pleasure of being in a pub that was full of music, full of people and full of good humour and great conversation, but not full of smoke. The smokers occasionally went outside, but they smoked a lot less.

Mr Stone: As Eleanor Scott knows, I have visited Ireland quite frequently. Would she not agree that when smoke is taken out of the environment in which one is eating and drinking—I sound as if I am a heavy drinker; I am not—one tastes the beer, tastes the whisky and enjoys the food more? That is a marketable benefit.
Eleanor Scott: I agree. The pubs are cleaner and there is a much more pleasant environment. As I said, as three quarters of people do not smoke, many people will find going out to be a much more pleasurable experience.

I take Nanette Milne’s point that there is a fairly short lead-in to the ban compared with that in some countries that have introduced similar bans. There is a definite need for a pre-ban publicity campaign. However, there is a lot of awareness and many people are talking about the issue. I share with members a conversation that I had with my son, who is an allegedly non-smoking student, who proposed to share a flat with some of his friends, some of whom I knew were smokers. I jarred with him a little bit about that in relation to passive smoking in the home. He said, “Well mum, they will stop anyway when the ban comes in.” There is a general expectation among young people who go out a lot that the ban will be introduced and that they will modify their behaviour accordingly. That shows that the denormalisation that the minister spoke about is already starting to happen.

I agree with the committee that some enforcement issues need to be addressed. I also note the committee’s comments on the crucial role and effectiveness of the Office of Tobacco Control in Ireland and the fact that we do not have an equivalent. Perhaps we do not need one, but the matter should be considered as the bill goes through Parliament. We should also consider the level of fines for breaches of the legislation.

I will move on to the proposals for free oral examinations and dental checks and eye examinations and sight tests. We have already debated extensively the dental side. As Nanette Milne mentioned, my views are on record. I have concerns about the ethics of doing examinations that may reveal a need for treatment if that treatment cannot then be provided. However, I support that part of the bill—I see that point not as a reason not to carry out the checks but as a reason to treat the dental staffing issue with great urgency. I know that the matter is being examined. The committee mentioned capacity issues, which are real.

I will put on my former school doctor’s hat and talk about the committee’s strong recommendation that comprehensive dental and sight screening should be done at the start of primary and secondary school. I agree with that, but in the case of sight screening I make a plea for it to take place earlier. When we screen vision or screen for eye pathology in young children, we are not necessarily looking only for their need for glasses to be able to see the blackboard or for the kind of eye conditions that occur in older people. We are looking for the condition of amblyopia, where there is a permanently poor-sighted eye. That can result from a squint, when the image of one eye is suppressed because otherwise the child would see double, or when the two eyes are very unequal in terms of long-sightedness or short-sightedness, so again the image is suppressed. The condition can be treated—we probably all know of children in our families who have had to have patching on an eye to treat the problem, for example—but that must be done at an early stage. There is a window of opportunity, which decreases. By the time screening takes place, a primary 1 child might be coming up to their sixth birthday, which is getting a bit late. I make a plea for screening to be done earlier. I also ask for the staffing implications of carrying out screening at that stage to be considered, in particular the possible need for more orthoptists, because they will pick up children who cannot be tested effectively in the community or who will need follow-up treatment.

I have a lot of sympathy for Carolyn Leckie’s amendment. I share some of her concerns about the impact of joint ventures and LIFTs, in particular about their use in future in ways that were perhaps not intended. I intend to support the amendment in Carolyn Leckie’s name and also the bill.

10:30

Mr Brian Monteith (Mid Scotland and Fife) (Con): It is a pity that there is not more time for the debate. Given that the bill is so broad, a great deal of issues and details need to be explored. Matters such as the provision of free eye tests and free dental checks are worthy of debate in themselves. I would have preferred an all-day debate; if the bill is the landmark that it is regularly claimed to be, that would have been fitting.

I make two simple observations on eye tests and dental checks. First, some opticians are already prepared to offer free eye tests—I pulled out an advert from Yellow Pages this morning that shows that Dolland & Aitchison offer free eye tests, as other opticians have done before them and continue to do. That means that taxpayers’ money will be poured down the drain, or poured into the bank accounts of the opticians, many of which—as I am sure Carolyn Leckie will be aware—are rather big businesses.

Secondly, why should I, on £52,000 a year, be given a free eye test by the taxpayer when before the bill I was content to pay for it?

Dr Jackson: Will the member give way?

Mr Monteith: No, I am making a point. I will see if I have time for interventions later.

Why, when to attract my custom opticians offer me all sorts of attractive deals—two for the price of
one, free sunglasses and free eye tests—and I am willing to pay more than £400 for a pair of spectacles, should the taxpayer pay someone such as me £20 to have an eye test?

Mike Rumbles: The answer is simple. The free eye test will lift public health throughout Scotland. Can Brian Monteith answer the point that I made to him directly earlier on? Is anybody against—

Mr Monteith: I will come to that point. It is clear that if one goes round opticians and dentists and says, “We will pay for some of your services directly instead of you having to ask the customer to pay,” it is a no-brainer. They will not submit evidence and say, “Of course not;” they will take the taxpayers’ money. Mike Rumbles must think that they are mugs if he thinks that they would do anything else.

I will move on to the stigmatisation of cigarette smokers—I say that because that is what the ban on smoking in enclosed public places is about. The minister talked of denormalisation, but I prefer to call it stigmatisation. It is about trying to ensure that because it is more difficult to smoke, people begin to give up. Behind the proposal is an issue that has not been addressed, which I touched on in an earlier intervention. How is it possible for two different ministers to reach two different conclusions about what action to take when provided with the same evidence about the dangers—I say “the dangers”—of environmental tobacco smoke? One minister, at Westminster, believes that the evidence is inconclusive and that a partial ban is required, and another minister, in Edinburgh, believes that the evidence is conclusive and that a total ban is required. The evidence is the same—and, by the way, it is not medical evidence; it is statistical evidence and it is disputed.

The total ban is not about protecting people; it is about stigmatising cigarette smokers, making it harder to smoke and bullying them into giving up. If the advocates of a total ban could get away with it, they would introduce a ban on the sale of tobacco. The minister talked of prohibition. In the America of the 1920s, there was prohibition and they had speakeasies. In the Scotland of the noughties, we will have the prohibition of cigarette smoking and we will have smokeasies.

Scottish people are generally law-abiding and I expect them, generally, to observe the ban. However, I also expect that, in some instances, people will be turned into criminals because they choose to smoke in enclosed spaces. For that reason, it is important that amendments will be made to the bill to broaden the exemptions. It is important that private clubs should be able—as has been suggested in England—to choose to allow smoking.

Stewart Stevenson: We could exempt Tory clubs.

Mr Monteith: I say to Mr Stevenson that, were there to be an exemption for Conservative and Unionist Party clubs, they would become particularly popular. I have no doubt that, if offered the opportunity, Mr Stevenson would not vote for that.

There could be other exemptions for cigar shops, cigar bars and premises with a high standard of ventilation. As in Japan and Italy, where they have smoking legislation, such exemptions could make a difference.

We must act to protect public health; I do not advocate doing nothing and I do not support the status quo. However, we should reject coercion and we should be conscious of civil liberties. This bill marks out Scotland as an intolerant and less free society. For that reason, I cannot support it in principle.

10:36

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The Smoking, Health and Social Care (Scotland) Bill will bring direct improvements to the health of people in Scotland. I am part of the majority on the Health Committee which believes that the bill will have a positive impact and will help to save lives.

Members who sit on subject committees might agree that some evidence-taking sessions are less than illuminating, consisting largely of people whom we would expect to be giving evidence giving the evidence that we would expect them to give. The Health Committee’s stage 1 evidence on this bill—on part 1 at least—was a prime example. In one corner, we had the fundamentalists; in the other, the libertarians. Round after round, they traded statistics and counter-statistics and bashed each other with studies and counter-studies. In the end, they boxed themselves to a standstill.

Did anything emerge from that? It is pretty clear, and accepted by all, that active smoking kills. We knew that already. Passive smoking can kill—especially when people are exposed to high levels of second-hand smoke. As the minister pointed out, people who live with smokers are at a greater risk of smoking-related disease. However, that is not the same as saying that environmental tobacco smoke in public places is, on its own, going to kill people. It would be interesting to see the results of a study that focused purely on people who were exposed to tobacco smoke only, for example, in a pub on a Friday night. We did not see such a study.

We heard a lot about the Irish experience. Some elements in the chamber are desperate for us to
copy Ireland at every turn. I sometimes think that, to have an influence in Scottish politics, a person would have to be elected to the Dáil. However, in this case, we could learn from the Irish approach. As the committee heard, the Irish did not turn down the choice versus health cul-de-sac. They bypassed the argument between the right to smoke and the right to clean air. That is an argument in which we have become bogged down, turning the debate into one between smokers and anti-smokers.

Instead, the Irish concentrated on the working conditions of employees in the hospitality industry. By doing so, they united smokers and non-smokers in support of the ban. We all know that employees do not have the choice that customers have over whether to enter particular premises. Employees also spend far longer in such environments or atmospheres than their customers do; sometimes employees will spend long periods in those atmospheres seven days a week.

I have campaigned across the whole range of industries for the right of workers to have a safe working environment. If the health of workers in the hospitality industry is damaged by working in a smoky environment, I cannot stand here and argue that they should be denied the same protection that is afforded to every other worker.

However—I borrow an argument from the Green party when it talks about genetically modified crops—just because we can do something does not automatically mean that we should do it. We must ensure that smokers do not feel stigmatised by this process. We cannot just impose our will from on high; we need to win smokers round to our arguments and we need to take them with us. If we are to tackle the large number of active smokers, we need to offer them the opportunity to become part of the debate. As others have said, we cannot marginalise them.

We cannot sweep the problems of addiction under the carpet. We all know that most smokers would like to stop. All smokers wish that they had not started and I think that they would back moves to help them to stop. They would also want to prevent their children and grandchildren from starting in the first place, and to protect them from being harmed by smoke at their workplace.

We are serious about tackling the damage that is done by tobacco and I think that smokers will join us in welcoming new legislation. Smokers and non-smokers will also support us in using the powers that we already have. What about illegal sales of tobacco to children? We know that it happens—from ice-cream vans to corner shops. Smokers and non-smokers disapprove of that, so let us have some action.

Should we allow anyone—including parents and teachers—to stand smoking in school premises or adjacent to them as they wait to pick up children? We can see that happening as we go by our nurseries and schools. We have powers and we should use them. Smokers and non-smokers would agree that it is wrong to set that bad example.

We need to reduce the harm that tobacco does in our communities—particularly in communities such as my own, where smoking is clearly killing people who are too young to die. The need to reduce harm is not up for discussion. In new legislation, we must not worry about the comfort or the agendas of unelected lobbyists, however well-meaning they might be. Instead, we must pursue the principle of reducing smoking and the damage that it does in our communities.

10:42

Mr Stewart Maxwell (West of Scotland) (SNP):
What a long way we have come since June 2003, when I first proposed a ban. At that time, I was ridiculed by members in this chamber and, unfortunately, by members of the illustrious press corps. However, less than two years later, we have almost unanimous support for such a ban. I am glad that we have reached this point so soon. This is a great day for Scotland, as we take the first tangible step towards a smoke-free future and towards protecting the health not only of the current generation but of future generations.

I express my gratitude to all the people and organisations outside the chamber who have fought for smoke-free laws for a long time. I also express my gratitude to the Health Committee for its work not only on this bill, but on my bill.

However, I disagree fundamentally with the committee’s comments in paragraph 38 of its report. As Irene Oldfather suggested, the idea that day care centres should be exempted from the ban makes no sense whatsoever. At the committee, the Minister for Health and Community Care argued correctly that allowing the exemption would lead to complex problems. It would also be a slippery slope. If day care centres are exempted on the ground that some people may spend some time during the day there, the way will be clear for all sorts of other places to be exempted on the same ground. A day care centre is not a temporary home; it cannot reasonably be argued that it is.

Turning to the debate over what has been called the level-playing-field approach and to the debate over enforcement, I believe that the two are inextricably bound together. Throughout the debates, one of the big arguments in favour of a complete ban has been that it would create a level
playing field. The committee took much evidence on that point and the Executive has used the level-playing-field argument to support its bill. The committee makes it clear that it agrees with that line of argument and it states expressly that any partial ban would not be as effective as a full ban. I agree with that absolutely. We need a comprehensive, clear and—most important of all—agree with that absolutely. We need a partial ban would not be as effective as a full ban. I line of argument and it states expressly that any committee makes it clear that it agrees with that playing-field argument to support its bill. The committee took much evidence on that point and the Executive has used the level-playing field. The committee took much evidence from the dangers of second-hand smoke.

Unfortunately, the Executive’s bill does not achieve a level playing field because it contains a loophole that will allow smoking to continue in enclosed public places. Everyone is well aware of my unswerving support for a ban on smoking in enclosed public places. The minister is aware of my concerns on the definition that is contained in section 4(1); I wrote to him to point out the problem as I see it on the matter. The minister is also aware of my intention to lodge an amendment at stage 2 to close the loophole.

The bill, as it is drafted, fails to ban all smoking in enclosed public places. Although the bill bans the smoking of tobacco cigarettes, it continues to allow the smoking of non-tobacco cigarettes. The definition in my bill was not limited to the smoking of tobacco cigarettes, it continues to allow the smoking of non-tobacco cigarettes. The definition in my bill was not limited to the smoking of tobacco but covered all smoking. I urge the Executive to support the amendment that I will loge at stage 2.

I intervened on the minister to ask him whether he could tell me which of the two cigarettes that I held up for his inspection was covered by the bill and which was exempt. He could not give me an answer. I will hold them up again for members’ inspection. It is clear to see that they look identical; it is impossible to tell which one will be exempt. If the minister could not differentiate between them—certainly, I cannot—how will enforcement officers, the police and other licence holders be able to tell the difference?

The point is important because, as the bill stands, the ban will not be as easily enforceable as it could be. The cigarette that I am holding up is a herbal cigarette—it contains a plant other than tobacco. A herbal cigarette produces tar and carbon monoxide just like a tobacco cigarette, yet it will remain perfectly legal to smoke this cigarette in an enclosed public place after the ban has been introduced.

The smoke from herbal cigarettes will affect non-smokers, particularly those with asthma and other chest problems or breathing difficulties, in exactly the same way that tobacco smoke does. The lack of voluminous research on non-tobacco cigarettes is sometimes used as an argument that those cigarettes may be less dangerous to health than tobacco cigarettes are. The argument is flawed, however. Given that herbal cigarettes contain similar and sometimes higher levels of tar and carbon monoxide than tobacco cigarettes do, we can easily deduce that herbal cigarettes are at least as dangerous as tobacco cigarettes are and perhaps even more so.

The Lancet published a study into the effects of smoking non-tobacco cigarettes, in which it said:

“Our data showed that smoking these vegetable-based cigarettes led to a similar degree of exposure to carbon monoxide as smoking tobacco cigarettes, and may exceed the latter. Thus this product is a potential hazard to health.”

Others agree. The British Lung Foundation stated:

“A lot of people try herbal cigarettes because they think that since they don’t contain nicotine they are safer. Nicotine is addictive, but it’s the other stuff that gives you lung cancer and emphysema.”

Mr Monteith: The Federation of Scottish Theatres has raised its members’ concerns about the use of cigarettes on theatre stages. It has been suggested that the alternative would be to use herbal cigarettes. If the bill contains no exemption for the use of tobacco on stage, does the member concede that it should contain an exemption for the use of herbal cigarettes on stage?

Mr Maxwell: No; I do not accept that proposal. I am sure that another technical way can be found of producing smoke from a small tube without the person who is at work on the stage having to inhale tar, nicotine or any other hazardous substance.

Because of the evidence about the dangers of herbal cigarettes, the Federal Trade Commission in the United States of America has ensured that companies display the following warning prominently on their products:

“Herbal cigarettes are dangerous to your health. They produce tar and carbon monoxide.”

In Ireland, the council of the Pharmaceutical Society of Ireland stated:

“in light of recent information on the serious health risk posed by herbal cigarettes, it is no longer ethical for herbal cigarettes to be sold from Irish pharmacies”.

The secretary of the society said:

“herbal cigarettes ... pose just as serious a health risk as tobacco products’. 

If our real intention is to create smoke-free enclosed public places and workplaces, we must change the definition of smoking in the bill. If we want to win the health war against smoking, we must pass legislation to ban all smoking in enclosed public places and not introduce a partial ban on some smoking products.

The biggest health gain that we can achieve with the bill is to denormalise smoking in Scotland, and we can achieve that only by amending the bill so that it covers all smoking. That is the only way of
ensuring that there is no possibility that anyone can try to get round the provisions of the bill.

Banning smoking in enclosed public places will be a major step forward for public health and all members should support it. However, excluding some smoking products, even though they produce tar and carbon monoxide and have been shown to damage health, will mean that we go only 90 per cent of the way. Let us go 100 per cent of the way: let us ban all smoking in all enclosed public places.

10:49

Kate Maclean (Dundee West) (Lab): I apologise to the chamber for being late this morning; unfortunately, I was held up in traffic. I apologise to the minister for missing the first part of his speech. I will scrutinise the Official Report to ensure that I have not missed anything.

The issue of smoking has been well covered this morning. Apart from a brief response to a point that Irene Oldfather and Stewart Maxwell made, I will concentrate on a different part of the bill. I agree with Shona Robison and the other members who said that the provisions of the bill are too wide. It was difficult for the Health Committee to scrutinise the bill fully; in fact, if the committee had not taken evidence on a ban on smoking in its scrutiny of Stewart Maxwell's bill, it would have been impossible for us to produce a stage 1 report in the time that was available to us.

I fully support a ban on smoking in enclosed public places and, like other members, I support as few exemptions as possible. In paragraph 38 of its report, the committee recommended that adult day care centres be treated differently, and I want to explain the reason for that recommendation. If the Executive is to grant exemptions on humanitarian grounds, adult day care centres should be included in that category of premises. I am not saying that that should be the case for every centre in which adults spend the day, but some adult day care centres are, in effect, people's home for the day. If carers are on respite care or away for therapeutical reasons, the person in question has no choice of where they go for the day as they cannot choose to go somewhere else. It is important that members are aware that the Health Committee had that specific group of adults in mind when it made the recommendation in paragraph 38. The Executive's policy of exemptions on humanitarian grounds should cover such day care centres, or consideration should at least be given to that recommendation.

Mr Maxwell: Surely the comments that the member has just made undermine her argument. She spoke about a small number of people in a given set of circumstances, yet that situation will cause real problems in the attempt to achieve a level playing field. The committee agreed that the bill needs to be obviously and easily enforceable, but the member argues that there should be exemptions in some places, at certain times and for certain people. Surely that proposal is too complicated and would be difficult to enforce.

Kate Maclean: There are problems when we look at the issue on humanitarian grounds. I was not suggesting that we do not look at things for humanitarian reasons, but that, if we do so, we will get no black-and-white solutions and there will be grey areas in between. Perhaps the issue should be monitored after the bill has been enacted. If we look at things for humanitarian reasons, it is not always easy to decide what to do. I understand why people are confused on the issue. That said, the Health Committee made that recommendation and I support it.

In relation to oral health assessments and eye examinations, I will focus on paragraphs 89, 90 and 91, which address uptake of services. In paragraph 89, the committee recommended follow-up work, including advertising, to encourage uptake. We also made reference to the nature of the new eye examination and oral health assessments. We want to ensure that they will provide positive health benefits. The committee heard evidence about the huge difference between an eye test and a proper eye examination. The point is crucial and I look forward to the minister clarifying it. I look for him to do so not today, but after the consultation that must take place with the professional bodies on the subject.

In paragraph 90, we refer to vulnerable groups, which is an issue that I feel strongly about. Some groups are difficult to assess and others can be far more time consuming. I am thinking of adults with learning disabilities or people with Alzheimer's disease. It is important that time and funding are given so that those people can get the full benefit of an eye test and oral health examination—they should benefit from them in the same way that everybody else will.

We should encourage uptake from people in more disadvantaged areas; historically, they do not take up any type of screening even although they have always had it for nothing. That point was demonstrated in some of the figures on oral health in more disadvantaged areas that were quoted in last week's dental debate.

I feel particularly strongly about the introduction of a comprehensive dental and sight-screening programme for children. I am pleased that the committee included that subject in the report and that it made a strong recommendation on it. Although I will concentrate on sight screening, the argument applies equally to dental checks.
The cross-party group on visual impairment, which I chair, and the Royal National Institute of the Blind Scotland have campaigned for several years on sight screening for pupils when they enter primary and secondary school. The bill is a convenient vehicle with which to introduce that measure. One in five children has significant undetected sight impairment, in spite of the fact that they are entitled to free sight tests, spectacles and eye care if they need them. I strongly support the recommendation, and look forward to hearing the minister’s comments. The minister did not refer to the recommendation in his opening speech, but being an eternal optimist I assume that that is because he intends to lodge amendments at stage 2 to address the committee’s recommendation. I am sure that if he does not do that, somebody else will.

I look forward to scrutinising the bill further at stage 2. I fully support the principles of the bill.

10:55

Donald Gorrie (Central Scotland) (LD): I have two preliminary points. First, I agree with those who oppose bills in which a lot of things are put together. Bills should not be like a plate of hors d’œuvres. I hope that ministers will take account of the fact that it is much better to have a single bill on a single issue. Secondly, I regret that Stewart Stevenson mentioned James VI, as I had intended to do so. James VI is an underrated gentleman, who not only opposed smoking but tried to limit the growth of London; those are two very good ideas.

I will talk mainly about smoking, because I have studied the issue and have strong views on it. I welcome the dental and eye checks and various other parts of the bill.

A bill that bans anything causes us, as liberals, concern and we have to think carefully about it. Liberals are not people who wander round the world seeking to ban everything. However, it is obvious that there are occasions on which it must be accepted that a ban is the right thing. The proposed ban is acceptable for two reasons. First, we have to balance one person’s right to breathe clean air with somebody else’s right to smoke. Those two separate freedoms are in conflict. The issue is not just the deaths, which are important, but the unpleasantness. I have a colleague in another field who is asthmatic, and she cannot go into any pub in Edinburgh. It was a great pleasure to go into a pub in New York last year and breathe clean air. Officials in New York are happy with the success of their ban. The issue of two rival freedoms is important.

Stewart Stevenson: Having quoted James VI at Donald Gorrie, I wonder whether I might also quote Molière:

“The greater the obstacle, the more glory in overcoming it.”

In relation to smoking, the obstacle is clearly great. Does not Donald Gorrie accept that, in this context, the rights of non-smokers and the support that we should give to smokers to cease overwhelm any countervailing requirement?

Donald Gorrie: Yes. In the end, as I was going to say, we come down on the side of the non-smokers. There are various red herrings. There is the question of partial bans and voluntary systems, but they do not work. Smoke does not recognise partial bans; it goes everywhere. Neither do partial bans or voluntary systems deal with people’s working conditions, which are important.

The second reason for the ban being acceptable is that sometimes severe legislation is necessary to improve public health. The greatest steps to improve public health in Scotland were taken by the Victorian public health pioneers who insisted that there be decent drainage systems. I am sure that there was great opposition from the Conservatives of those days saying, “We have the right to put up houses with no drainage, and you can have water and sewerage systems that join up together.”

Severe action has to be taken to deal with public health issues. I try to represent citizens in Central Scotland, many parts of which have a really bad health record as a result of smoking, cancer, asthma and other problems. We must pay attention to that. There is the question of balancing freedoms, but it is important that we do something strong to improve public health.

I do not conceal the fact that the objective should be to reduce smoking overall. We want to persuade people not to smoke. Some of the evidence to support a ban in public places comes from other countries, where bans have helped to reduce smoking overall. People take up smoking because of peer pressure—at 12 or 14, they do what is cool and they smoke. We must create the idea in people’s minds that it is not cool to smoke.

I am not keen on the word “denormalise”, but I am keen on the idea. Propaganda has a bad name, because of Joseph Goebbels and spin doctors, but propaganda in a good cause is a good thing. Religions use propaganda, and on the whole it is helpful. We need to have strong public education. I do not know whether we need an Office of Tobacco Control like the Irish have, or some other system, but we need to have a strong public education programme, which will lead to support for the bill. The bill will do a huge amount of good for Scotland and I am happy to support it.
Dr Sylvia Jackson (Stirling) (Lab): It gives me great pleasure to speak in this important stage 1 debate. I am not a member of the Health Committee, but the Subordinate Legislation Committee, of which I am convener, has examined the delegated powers provisions of the bill. Almost 30 such powers were examined, and after correspondence with the Executive only one issue remains, to which I now refer.

The bill seeks to create offences of smoking or permitting smoking in no-smoking premises. What constitutes “no-smoking premises” is left entirely to regulations that will be made under sections 4(2) and 4(7). The Subordinate Legislation Committee recognised the need for the definition of “no-smoking premises” and exemptions to be contained in regulations rather than be on the face of the bill, in order to provide the necessary flexibility. The committee also acknowledged the high level of consultation that was undertaken on the first draft regulations that are proposed to be made under the bill. However, the committee was concerned that there should be sufficient consultation on future regulations that seek to amend provisions. The committee was keen that consultation on future substantive regulations should be as wide as that which was conducted on the first regulations.

As the minister knows, the committee has written to him suggesting enhancing the power at section 34(4), so that while the Executive will be required to consult such persons as it considers appropriate before laying a draft of an instrument, it will also be required to circulate the draft instrument. The committee accepts the potential problem with developing procedures that will be applied in every circumstance, even with minor technical changes, and therefore suggests amending the bill to require that draft instruments be circulated only when substantive changes are proposed.

Behind specific issues in the bill lies the general issue of ensuring that there is adequate consultation on sensitive and important matters when new instruments are being introduced. The Minister for Parliamentary Business knows about that and other issues that are being considered as part of the Subordinate Legislation Committee’s on-going review of the regulatory framework. We welcome her readiness to have on-going dialogue on the issues.

I will share with members representations that have been made to me on the bill. One community council stated:

“We all support the idea of a ban, mainly because of the health risks associated with active and passive smoking. Several of us stated that we would be more likely to use the local pub if it were smoke-free”.

Another community council stated:

“it was unanimously agreed that something has to be done to discourage smoking—especially in young people.”

Section 10 deals with eye tests. I have been approached by Optometry Scotland, which asks that the general ophthalmic services sight test and the eye examination be defined. It also asks that the two be inextricably linked, fully resourced and introduced together. The minister is aware of the good work that is being done in the Glasgow integrated eye care scheme and I am sure that he would be willing to consider how such schemes could be extended.

As Irene Oldfather said, we must thank the many people—such as Stewart Maxwell and those in various associations—who have been involved with the bill and in earlier work.

I return to what the Conservatives do not want to hear—the points that BMA Scotland makes on the smoking ban:

“The BMA fully supports the principles outlined in the Bill which seeks to provide comprehensive legislation to create smoke-free enclosed public places.

Smoke-free enclosed public places would save hundreds of lives each year and reduce the impact of chronic disease on individuals and the health service. Recent research published in the BMJ reports that passive smoke kills 30 people a day in the UK.”

We must support the bill to improve public health in Scotland.

Carolyn Leckie: I start with the bill’s provisions on smoking. Nanette Milne suggested that publicans were moving voluntarily, but I make the point to her—unfortunately, she is not in the chamber—that publicans are responding only under the pressure of the political debate. If it were not for that debate and pressure, publicans would not respond with voluntary bans.

The tobacco lobby has been ably represented by the Tories—

Stewart Stevenson: Surely not.

Carolyn Leckie: Perhaps the lobby has not been ably represented and the Tories could have done a better job.

The tobacco lobby, which disputes the health effects of passive smoking, lied and deceived people about the effects of smoking for decades. The Tories take their cue from the people in that lobby, who are culpable for the deaths of thousands who were hooked on tobacco when the tobacco companies, which knew fine well the harm that they were causing, issued propaganda claiming that smoking had health benefits.
That is why e-mails to me from the tobacco lobby go straight into the junk folder, which is where they belong. Obviously, in the case of the Tories, such e-mails go straight into the members’ speeches. I have heard Tories argue that to have smoking and voluntary no-smoking pubs side by side is an alternative to a ban—Phil Gallie and I were on opposing sides in a debate on the matter at the University of Strathclyde, and he made that suggestion—which demonstrates zero concern on the Tories’ part for the workers in such establishments. When Phil Gallie was challenged on that point, he offered the justification that pub workers have the freedom to choose to work in smoke-free pubs. Unfortunately, workers rarely have any choice about where they work or the jobs that they do. Moreover, history shows that workers will invariably compromise health in favour of income and that employers will do the same in favour of profit.

Like other members, I am concerned that the bill’s broad-ranging nature has reduced the opportunities for full and proper public and parliamentary scrutiny and debate. I hope that the burying in the bill of other controversial measures was not an intentional ploy to reduce public involvement, but I am a suspicious person and think that that might have been the case. The fact that it is impossible for members to cover all the parts of the bill in their speeches demonstrates that there is a problem.

Brian Monteith asked why he should get a free eye test. I presume that he pays taxes—perhaps we should check that—and that that is how he will pay for his eye test but, as far as I am concerned, he does not pay enough tax. He should not worry, however, because if the Scottish Socialist Party ever gets its way, he will pay more taxes and we will help him to avoid having a guilty conscience.

Mr Monteith: Carolyn Leckie has still not answered my point: if I am prepared to pay £20 for my eye test every six months, why should the taxpayer pay for it instead of me?

Carolyn Leckie: Brian Monteith is a taxpayer and can pay for his eye test through his taxes. What is more, he will pay more than poorer people and lower-waged people, which is how it should be in the great socialist paradise.

In response to Andy Kerr’s comments, I say that public borrowing is much greater value for money for the simple reason that it is cheaper. PFI and LIFT are the only additional money because the Executive ideologically restricts the ability of health boards and other public bodies to take the public procurement route. As Dave Watson of Unison said:

“The only guarantee in PFI is that the bankers always get their money.”—[Official Report, Health Committee, Tuesday 8 March 2005; c 1752.]

I would have expected Janis Hughes, as a sister Unison member, to deal with section 31 in her speech—especially as Dave Watson has acted as her election agent in the past—but, unfortunately, she did not.

The greatest danger of section 31 is that business interests will outweigh public need. The section will replicate the detrimental effects of PFI on public services that we have seen in many documented examples, such as the Skye bridge, the Edinburgh royal infirmary and innumerable schools projects.

Elaine Smith: Will Carolyn Leckie give way?

Carolyn Leckie: I am sorry, but I am in my last minute.

The Scottish Trades Union Congress has raised serious questions about the potential for conflicts of interest in the running of LIFT schemes. There are already examples of that in England, where the fiduciary duty that all directors have to shareholders can mean that decisions on the leasing of premises are made on the basis of the rent that the prospective tenants are willing to pay rather than as a response to clinical need and as part of planning the service that the community needs to be delivered from those premises.

LIFT will distort clinical priorities, and I encourage the Executive to remove section 31. I appreciate Eleanor Scott’s support for our amendment and regret that, so far, no other member has addressed it. It is a reasonable amendment and, as I have heard no arguments against it, I presume that it will attract support from other parties.

11:12

Robert Brown (Glasgow) (LD): I am delighted to close the debate for the Liberal Democrats and to speak on the bill’s provisions, including the central ban on smoking in enclosed public places, which is probably the most important public health measure in a generation.

It is also important to highlight the implementation of the key Liberal Democrat commitment to free eye and dental checks—I will deal with Brian Monteith’s point on that. The main reasons for the provision are health promotion reasons: to increase take-up of such checks and to ensure that no one is financially debarred from taking them up.

I will deal primarily with the debate on the smoking ban. It has been an unbalanced debate because of the Conservatives’ bizarre and extreme commitment to the line that they have taken on the matter. We should be talking about ways in which we can make the smoking ban effective and we should be considering the other
measures in the bill, but we have not been able to do that because of the way the debate has been dominated by the need to answer Conservative criticisms.

I will not rehearse the medical arguments; although the tobacco industry can twist and duck all it likes, it is clear that smoking kills. Smoking is the biggest contributor to premature death in Scotland through coronary heart disease and lung cancer. In answer to Nanette Milne’s attempt to bring a feminist aspect into the Tories’ argument, I point out that a recent report from NHS Scotland indicates that more than 75 per cent of deaths that are related to environmental tobacco smoke are among women. She should take that fact into account before she finalises her views on the matter.

Smoking is closely associated with shorter lifespans and greater illness in deprived areas, where addiction is greater. Tobacco is heavily addictive—possibly more addictive than heroin—and extraordinarily difficult to kick. My mind is clear that the time for half-hearted, halfway-house measures has long since passed. Incidentally, if I had to choose between taking advice from the BMA, the various medical unions, the NHS, Macmillan Cancer Relief and all other medical interests on one hand or Brian Monteith on the other, my mind is clear about which advice I would take.

I will deal with the social effects of a ban on smoking in enclosed public places and workplaces. I have no sympathy with the tobacco industry or its funded mouthpiece, FOREST, which have distorted scientific investigation of the issue for far too many years. It is clear that the effect of a ban would be to cut tobacco consumption substantially, which is why they are against it and I am for it. Surveys throughout the world indicate that a workplace ban is likely to reduce the number of smokers by something like 4 per cent, and to reduce total tobacco consumption by something like 29 per cent per employee. Similar effects could be predicted from a ban in enclosed public places.

Many of the people who will be saved from addiction will be young people, such as students, who smoke socially or to appear cool. I particularly dislike the idea that 17, 18 or 19-year-olds who are smoking in pubs are exercising a free and mature choice, fully aware of the risks that they face: they are not. They believe that they will live for ever and are seduced by the culture that the tobacco industry has done much to foster.

On the other hand, I have quite a lot of sympathy for publicans who worry about their livelihoods, but I think that they are wrong. The reduction in bar sales in Ireland following the ban there is often cited, but although the reduction that was reported by the Central Statistics Office in Ireland was 2.6 per cent, there had been a long-term decline in bar sales, which had gone down by 7.1 per cent in the year before the ban was introduced.

Brian Adam: Does the member agree that, as well as the introduction of the smoking ban in Ireland, there was a significant change in the licensing laws with regard to children being allowed in bars, and that that curfew is believed by many people to have contributed to the decline in bar sales?

Robert Brown: That is correct.

A similar picture emerges from consideration of the number of businesses in the sector that went bust. After the ban, the number was slightly smaller than it had been before the ban. The recent study that was commissioned by NHS Scotland and to which I referred earlier suggests, if anything, that the effects of the ban will probably be economically neutral for the hospitality industry. The impartial observer would be entitled to conclude that, although the position might vary between different establishments, a tobacco ban is highly unlikely to damage pubs and restaurants across the board. Indeed, there is every reason to think that it might attract back some of the 70 per cent of people who are non-smokers and who have in the past been put off going to smoky bars. That sounds like a much more solid customer base on which to build for the future.

There is an interesting point to be made about public support. We have heard various statistics—of course, the figures depend to some extent on how the questions are asked—but, according to the Scottish Executive’s survey, 56 per cent of people support the ban. The foreign experience is that support for a smoking ban rises substantially after it is introduced. In Ireland, support went from 59 per cent to 93 per cent after the ban came in. That links to the 97 per cent compliance with the new laws that is reported in Ireland. It is perfectly natural that those two elements are connected.

I have a huge amount of sympathy for smokers. Tobacco is terribly addictive and we must do everything possible to support people who want to quit. Of course, people have the general right to smoke in their homes and gardens, in the street, in the park and elsewhere. However, as Donald Gorrie rightly said, the right to smoke must cede to people’s greater right to a smoke-free atmosphere in their workplace or in places of public entertainment.

Since the beginning of the Scottish Parliament, Liberal Democrats have pressed the cause of health promotion. The consultation is in the partnership agreement because of our contribution, and we were the first political party to
back the ban. However, support for the ban goes right across the board and a series of contributions have been made by all sorts of people. The issue has developed a head of steam of its own, fuelled by public opinion, the New York and Irish experiences and particularly by Scotland’s appalling health record. It is an idea whose time has come. Let us strike a blow for freedom to breathe clean air and—to ensure that we provide our young people with a future that is free of addiction—let us ensure that the bill passes stage 1.

11:18

Mary Scanlon (Highlands and Islands) (Con):
It was interesting to hear the Minister for Health and Community Care welcome the bill and speak of the degree of urgency that he attaches to the legislation. I have to say that, when Kenny Gibson and Nicola Sturgeon introduced bills on the subject during the first session of Parliament, those bills were not welcomed and there was no rush to legislate.

I was also surprised that the Minister for Health and Community Care allocated only two minutes of his speech to measures in the bill other than those that relate to smoking. I hope that, throughout the next stages of the bill, a bit more time will be allocated to those important measures.

Mr Kerr: I accept fully Mary Scanlon’s point. However, in the interests of the debate, I took a number of interventions during my speech. Indeed, I accepted every intervention that was made.

Mary Scanlon: Fair dos. We will see how the minister performs at later dates.

I would like to pay tribute to Duncan McNeil, who made an excellent and balanced speech.

Members who are not on the committee that has dealt with a bill are always at a disadvantage in stage 1 debates, because committee members have heard all the relevant evidence. However, I read the Health Committee’s stage 1 report on the bill and I would hardly say that it is a ringing endorsement of the bill, or that it expresses much confidence about the success of the measures that are proposed. For example, the committee states that free oral health assessments and eye examinations have the potential to improve standards “if properly implemented”. On dental services, the committee states that the policy could work “if properly funded and implemented”. On pharmaceutical care services, the committee again states that the measures could ensure a wider range of services “if properly implemented”. That is hardly a ring of confidence.

It is interesting that the voices on the Conservative benches are speaking in support of the late Donald Dewar who, when he was in Westminster, worked with the industry and responded to consumer and health needs by introducing the voluntary code for better signage, better ventilation, smoke-free areas and other measures that provide choice for consumers.

We want to work with the licensed trade sector to enhance choice for smokers and to provide practical help, support and encouragement to people who want to stop smoking, with the ultimate goal being—as Dr Nanette Milne said—of achieving a smoke-free environment for everyone. I welcome the measures and the increased resources to assist people to stop about which the minister spoke.

Sylvia Jackson constantly talks about the BMA. If she looked back to the BMA’s stance on—

Helen Eadie (Dunfermline East) (Lab): Does Mary Scanlon accept that when the licensed trade sector was given the opportunity to operate voluntarily as she described, there were major problems? Although targets were met, the number of people who participated in the voluntary scheme was so small that it was not worth while, which is why legislation was needed.

Mary Scanlon: From memory, I can tell Helen Eadie that something like £132 million was spent in one year on ventilation alone. I do not accept the view that the licensed trade was not co-operative. According to a poll in January this year, 75 per cent of Scots believe that smokers have the right to smoke in public, provided that they do not inconvenience non-smokers.

I regularly visit Donegal, as does Jamie Stone, and I can say that the licensed trade industry has been affected by the smoking ban. Many publicans have tried to increase food sales, but many others have at the back of the pub built the equivalent of bus shelters, which have three walls and one side open to the area and which serve as the smoking areas. The ban is hardly stopping smoking in Ireland.

At the heart of the bill is the effect of smoking on the health of smokers and the effect of passive smoking on the health of non-smokers.

Mike Rumbles: Will the member take an intervention?

Mary Scanlon: Certainly not from Mike Rumbles—no way on earth would I take an intervention from him. We have heard enough of his—oh, there are no words for what we heard from him today.

There are many measures, short of the draconian ban on smoking in public places, that can help people to stop smoking. If the aim is to
stop people smoking, surely it is better to try tested methods that are known to bring success rather than to risk making more people smoke in their homes, where young children are present.

Tricia Marwick (Mid Scotland and Fife) (SNP): Will the member give way?

Mary Scanlon: I am sorry, I have only one minute left and I have quite a lot of ground to cover.

I think that we dealt last week with dental checks. However, given that £7.7 million is being allocated for free dental checks and that the minimum cost for a dental check, at least in the Highlands, is £25, that means that only 308,000 people could get a dental check.

We constantly forget about chiropody and podiatry. Recently, the father of a 12-year-old footballer came to me and said, “If he is to keep playing football, my son needs an orthotic fitment costing more than £200. I can pay for that, but many others can’t.” If the Executive is going to be generous in relation to eye and dental care, it should re-examine the needs of podiatry and chiropody, because much has to be done in that regard.

I would like to have said more about the disciplinary provisions in the bill. It is surely an error that no reference is made in the relevant section to the General Medical Council. General practitioners raised concerns during the passage of the Adults with Incapacity (Scotland) Bill but were ignored. I am glad that the situation is being rectified in this bill.

11:24

Brian Adam (Aberdeen North) (SNP): Today is a great day. We are about to pass one of the most far-reaching measures that we could ever pass to improve public health in Scotland, and it is a great privilege to be associated with it. I give credit to the many people who have brought us to this point, particularly people outside Parliament who have campaigned long and hard for the measure, but also members in the current and previous sessions of Parliament. I acknowledge the efforts that were made by my colleague Kenny Gibson—who is no longer in Parliament—in introducing his bill. I also acknowledge the efforts of Stewart Maxwell, who introduced a bill on smoking in the current session, and Nicola Sturgeon, who introduced a bill on tobacco advertising controls.

It is not just SNP members who have done work on the matter; Irene Oldfather is convener of the cross-party group on tobacco control. She was preceded by myself and Kenny Gibson. The cross-party group, which even includes Conservatives, has striven to improve the situation. I also pay tribute to the previous Deputy Minister for Health and Community Care, Tom McCabe, for the sterling work that he did in bringing us to this point. Mr McCabe conducted the Executive’s consultation exercise superbly; the measure of that is that people participated in it. As convener of the Standards Committee, I was perhaps a little disappointed that we received only a few more than 30 responses to our consultation, just over 20 of which were from members of the public. In contrast, 54,000 responses were received on the smoking ban. It is a measure of the success of Parliament and its procedures that we have engaged with the public on the matter, and it is clear that we are delivering what the public wants.

It is right for us to debate the matter. I am pleased that the Conservatives are contributing to the debate, although I do not agree with the position that they take. I found the point that was made by Phil Gallie rather odd—I hope that the Tories do not advocate increased tobacco use for weight control. I am sure that that is not the case, but that was, nevertheless, the implication of what Phil Gallie said.

Mr Monteith: Will the member take an intervention?

Brian Adam: If the member will let me develop the point, I will let him in after that.

It is not surprising that the Tories look to market forces to deliver the change, but they slavishly follow the line of industry interests rather than that of the health service.

Mr Monteith: The member is sailing close to the wind with the idea that Phil Gallie, who is not here to defend himself, suggested that tobacco use should be increased to fight obesity. His point was that there could be unintended consequences that would not be popular in respect of public health. I would have thought that Brian Adam would support that view.

Brian Adam: We should always be aware of unintended consequences, but the unintended consequence of the market-led approach is that nothing happens. The voluntary code to which Mary Scanlon referred—which was introduced, I believe, in 1998—was not working. That is why we have got to this point: the voluntary approach did not work. The industry did not deliver, and ventilation did not deliver; there is clear evidence to suggest that the key carcinogens are not removed by ventilation.

At the risk of being accused of misquoting Mr Monteith, just as I was accused of misinterpreting what Phil Gallie said, I understand that Mr Monteith concedes that environmental tobacco smoke is dangerous. He does not suggest—I have not heard any of the Conservatives suggest it—that it is not dangerous. We should take action
against it. That is why we should go ahead with the ban, which is the principal measure in the bill. The softly-softly-catchy-monkey approach, which suggests that we should move at the pace at which the industry wants to move, will not deliver. Market forces do not deliver on everything and they will certainly not deliver on smoking. Public action is required for public health protection, which is why I support the bill.

Elaine Smith: On the slightly different issue of public services, I have concerns about joint ventures, as does the Health Committee. What is Brian Adam’s opinion on the amendment in the name of Carolyn Leckie? Does he think that it is rather sweeping, in that it says that

"section 31 of the Bill compromises the general benefits to health from the Bill"?

I have not heard much about the amendment this morning.

Brian Adam: There is merit in considering closely the point that is made by the mover of the amendment. It raises an important issue and I suspect that we may have some sympathy with it, but I hope that we will not be distracted by it on what is a significant day for public health.

The Deputy Presiding Officer (Murray Tosh): One minute.

Brian Adam: As well as the mortality effects of environmental tobacco smoke, we should consider its morbidity effects. It damages people’s health: people do not die immediately as a consequence of inhaling someone else’s smoke, but environmental tobacco smoke creeps up on people gradually. It has an impact on their hearts and lungs and they might end up with lung cancer or coronary heart disease. It is a significant additional risk factor in both those diseases. It has an impact on people’s health over a long period of time and it also has unpleasant side effects, such as the smell. That, in itself, would be enough to encourage us to deal with it, but it also has effects on morbidity and mortality.

We need to be careful about how we enforce the ban. The best enforcement will be by the public themselves, through general acceptance and by persuasion. Duncan McNeill argued along those lines and that is the view of the Health Committee.

The Deputy Presiding Officer: You must close now.

Brian Adam: I noticed that members of the Health Committee nodded their heads in response to earlier comments on that point. I am—

The Deputy Presiding Officer: You must close now.

Brian Adam: I am just about to do so.

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The Deputy Presiding Officer: No—now.

Brian Adam: I am delighted to support the bill today.

The Deputy Presiding Officer: I now call the minister. You have a very strict 10 minutes.

11:32

The Deputy Minister for Health and Community Care (Rhona Brankin): I echo what other members have said: this is an historic day for our Parliament. I, too, pay tribute to all the people who have worked so hard to bring the bill about. I notice that Tom McCabe is with us; I pay tribute to the work that he has done.

The Smoking, Health and Social Care (Scotland) Bill will deliver some of the most important public health measures for a generation. The introduction of free eye and dental examinations will bring significant benefits in the early detection of eye and oral disease and will support further development of ophthalmic and dental services. The role of community pharmacists will be secured and extended to ensure that they play a significant role in delivery of primary health care. The NHS disciplinary system will be strengthened to ensure that protection of patients remains paramount. The bill makes provision to capture in legislation a scheme for ex gratia payments to certain persons who contracted hepatitis C as a result of NHS treatment.

For the first time, Scottish ministers will have the power to enable health boards to enter into joint ventures. That will allow health boards greater choice in how they deliver health care facilities and services to the people of Scotland, by allowing them to take a strategic approach to provision of health care facilities in the community.

Carolyn Leckie: Will the member take an intervention?

Rhona Brankin: I will address later in my speech some of the points that Ms Leckie made.

The bill will also provide an opportunity to tap into Scottish scientific and technical genius by making the most of intellectual property for the benefit of NHS Scotland.

I turn to the provisions on smoking. The bill is not about banning tobacco; it is about protecting people’s health. There is overwhelming evidence that demonstrates the harm that environmental tobacco smoke does to people and their families. Smoking is also a major factor in health inequalities. We need to act now and must not shy away from making unpopular decisions so that we can deliver health improvements for Scotland, which is why the key measure of the bill is the prohibition of smoking in certain enclosed places.
The bill aims to improve the health of the nation and to increase the choice that is available to the vast majority of the people of Scotland, who do not smoke. It aims to offer freedom to enjoy the pleasures of life, whether going out for a drink or a meal, pursuing a pastime or simply shopping in a smoke-free atmosphere. In short, the bill offers a healthier way of living, in which smoking is not the norm and young people know that they do not have to follow the bad habits of past generations or suffer the appalling consequences.

I will respond to some of the points that members made. I say to Carolyn Leckie that involving the private sector is nothing new. Some 50 per cent of general practitioner premises are already privately owned. The Scottish Trades Union Congress protocol with Scottish ministers and the guidance on it clearly indicate that the protocol applies to all public-private partnerships. Public-private joint ventures are a form of PPP, so the protocol would apply in such cases.

Carolyn Leckie: Will the minister give way?
Rhona Brankin: No, thank you. I want to address many points and I have already referred to what Carolyn Leckie said.

Several members mentioned the Office of Tobacco Control in Ireland. It is important that enforcement be carried out as effectively as possible and we are developing an effective network throughout Scotland to ensure effective implementation. However, our minds are not closed on the matter.

Delivery of free dental checks for all will be challenging, but we are convinced that the measures in the dental action plan will help us to meet that challenge. Indeed, the extended oral health assessment that is being discussed as part of the modernising dentistry process is not a specific deliverable of the bill. The extended eye examination is also subject to discussions as part of the ophthalmic services review—again, such examinations are not a specific deliverable of the bill.

On screening of schoolchildren, we already have provision for dental inspection and education for all school pupils. The inspection programme targets primary 1 and primary 7 children and the huge investment in children’s oral health that we recently announced will immeasurably strengthen provision on the ground.

On eye screening for children, the “Health For All Children: Guidance on Implementation in Scotland” draft consultation, which was issued to all health boards earlier this month, states:

“All children should be screened by an orthoptist in their pre-school year, between the ages of four and five years” and adds that

“The evidence for screening in secondary school remains inconclusive.”

However, it is made clear that any child who undergoes assessment for educational underachievement or other school problems should have a visual test. We will continue to consider that issue before stage 2.

Ministers have great sympathy for the relatives and dependants of people who died before the eligibility date of the hepatitis C scheme, but we must consider the effects of financial outlay on the scheme on our ability to provide treatment for other patients. For that reason, the scheme focuses on people who are currently suffering. We are considering with other United Kingdom Administrations the issue of overseas residence and may lodge an amendment in the light of those discussions.

At the moment, we are not minded to exempt day care centres and I note what has been said about the bill’s being potentially opened up. We believe that people who spend time in day care centres who do not smoke also deserve to be protected.

Stewart Maxwell talked about the definition of smoking. Our minds are still open about the definition and we will continue the dialogue before stage 2. Sylvia Jackson talked about the Subordinate Legislation Committee. I confirm that ministers received a letter from that committee yesterday and that we are considering it.

I would like to quote comments by schoolchildren to the Health Committee about the effects of smoking. One said:

“people should not have to breathe in other people’s smoke when they go into a pub or restaurant.”

Another said:

“It has been proved that Scotland has one of the worst rates of coronary heart disease, which can be caused by smoking.”—[Official Report, Health Committee, 15 June 2004; c 1014.]

Another child said:

“It is not fair that we are getting cancers and diseases because other people have chosen to smoke!”

and another said that

“the future is pretty bleak unless we do something right now.”

Finally, one child said:

“For Scotland’s sake let’s stop people smoking in regulated areas.”

This will be the most important legislation on public health for a generation. Members have an opportunity to endorse principles that will bring benefits for generations of Scots to come. We must seize this opportunity for the sake of future generations—for the sake of the young
schoolchildren who wrote to the Health Committee and those who have talked to the First Minister about their health and that of their future families. The opportunity is too important to miss for the future health of the people of Scotland. I urge members to support the motion and to reject Carolyn Leckie's amendment.

**Mr Maxwell:** On a point of order, Presiding Officer. Will you investigate a situation that has occurred in respect of the public galleries? Last night at a reception with the First Minister, a number of organisations and individuals who were interested in the debate on the Smoking, Health and Social Care (Scotland) Bill approached me and said that they had tried to get tickets for it, but had been told that the galleries would be full and that no tickets were available. However, the galleries have been virtually empty this morning. Will you investigate that matter?

**The Presiding Officer (Mr George Reid):** I will do so and I will write to you.
Decision Time

17:03

The Presiding Officer (Mr George Reid): There are seven questions to be put as a result of today’s business. The first question is, that amendment S2M-2667.1, in the name of Carolyn Leckie, which seeks to amend motion S2M-2667, in the name of Andy Kerr, that the Parliament agrees to the general principles of the Smoking, Health and Social Care (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Fox, Colin (Lothians) (SSP)
Harper, Robin (Lothians) (Green)
Harvie, Patrick (Glasgow) (Green)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)

Against
Aitken, Bill (Glasgow) (Con)
Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Bailie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Davidson, Mr David (North East Scotland) (Con)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Douglas-Hamilton, Lord James (Lothians) (Con)
Edie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Gallie, Phil (South of Scotland) (Con)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Goldie, Miss Annabel (West of Scotland) (Con)
Gorrie, Donald (Central Scotland) (LD)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
The Presiding Officer: The result of the division is: For 9, Against 75, Abstentions 17.

Amendment disagreed to.

The Presiding Officer: The second question is, that motion S2M-2667, in the name of Andy Kerr, that the Parliament agrees to the general principles of the Smoking, Health and Social Care (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Sturgeon, Nicola (Glasgow) (SNP)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

AGAINST
Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Jackson, Gordon (Glasgow Govan) (Lab)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteleth, Mr Brian (Mid Scotland and Fife) (Con)
Mundell, David (South of Scotland) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)

ABSTENTIONS
Fox, Colin (Lothians) (SSP)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)

The Presiding Officer: The result of the division is: For 83, Against 15, Abstentions 3.

Motion agreed to.

That the Parliament agrees to the general principles of the Smoking, Health and Social Care (Scotland) Bill.
The Presiding Officer: The seventh and final question is, that motion S2M-2284, in the name of Tom McCabe, that the financial resolution in respect of the Smoking, Health and Social Care (Scotland) Bill, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

For
Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Bailie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Ballantyne, Chris (Falkirk East) (Lab)
Baker, Richard (North East Scotland) (Lab)
Brown, Robert (Glasgow) (LD)
Brankin, Rhona (Midlothian) (Lab)
Butler, Bill (Glasgow Anniesland) (Lab)
Barnes, Mr Howard (North of Scotland) (SNP)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Brown, Robert (Glasgow) (LD)
Brankin, Rhona (Midlothian) (Lab)
Butler, Bill (Glasgow Anniesland) (Lab)

ABSTENTIONS

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Finnegan, Mr Kieran (North East Scotland) (SNP)
Ferguson, Patricia (Gloucester) (SNP)
Gillan, John (Edinburgh South) (SNP)
Garratt, Mr Andrew (West of Scotland) (Con)
Gillespie, Mr Alexander (North of Scotland) (SNP)
Goldie, Miss Annabel (West of Scotland) (Con)
Kane, Rosie (Glasgow) (SSP)
Leckie, Carolyn (Central Scotland) (SSP)
McGhee, Mr John (East of Scotland) (LD)
Mclean, Mr John (Dumbarton) (Lab)
Mackay, Miss Margaret (Highlands and Islands) (SNP)
Macfarlane, Mr Andrew (Glasgow) (SNP)
MacIntosh, Mr Kenneth (Eastwood) (Lab)
Macleod, Mr Iain (Kincardine) (SNP)
Maclean, Mr John (Glasgow) (SNP)
Macmillan, Mr Frank (Glasgow Shettleston) (Lab)
McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
Mcfee, Mr Bruce (West of Scotland) (SNP)
McMullen, Michael (Hamilton North and Bellshill) (Lab)
McNeill, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeilly, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morris, Mr Alasdair (Western Isles) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Unilithgow) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peat, Mike (Glasgow) (SNP)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan ( Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Elaine (Coatbridge and Chryston) (Lab)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicor (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)

The Presiding Officer: The result of the division is: For 83, Against 0, Abstentions 18.

Motion agreed to.

That the Parliament, for the purposes of any Act of the Scottish Parliament resulting from the Smoking, Health and Social Care (Scotland) Bill, agrees to any expenditure or increase in expenditure of a kind referred to in Rule 9.12.3(b)(ii) or (iii) of the Parliament's Standing Orders arising in consequence of the Act.
I am writing to you in response to the Health Committee’s Stage 1 Report on the Smoking, Health and Social Care (Scotland) Bill published on 21 April 2005.

I am pleased to note that the Committee broadly support this important Bill. The report raises a number of points that are addressed in the attached annex. I hope that this addresses any concerns that the Committee may have on these issues.

I look forward to working with the Committee at Stage 2 to deliver this, the most important piece of public health legislation in a generation for Scotland.

I trust that you find this information helpful.

Andy Kerr MSP
Minister for Health and Community Care
13 May 2005
## INTRODUCTION

The Committee has some concerns that the diverse nature of bills of this type increases the difficulty of carrying out effective scrutiny. **The Committee recommends that the Executive bring forward bills that are more discrete in nature to avoid the difficulty of having to deal with very different subject matter.**

<table>
<thead>
<tr>
<th>Para. No.</th>
<th>Committee’s Comment</th>
<th>Executive Response</th>
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<tbody>
<tr>
<td><strong>10</strong></td>
<td>The provisions in the Bill are wide ranging and all are important pieces of legislation in their own right. However, a balance has to be struck between separating individual areas of legislation into Bills in their own right and the demand that this would place on resources within the Scottish Executive and, of course, the Scottish Parliament. An increase in the number of Bills would place increased demand on Parliamentary time, including valuable Committee time. In addition, the process would become lengthened with subsequent delays to important pieces of legislation. The Executive believes that the approach taken means that a number of separate but related legislative areas can be given the appropriate degree of Parliamentary scrutiny whilst being considered together to allow rapid progression to the conclusion of the Parliamentary process.</td>
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<td></td>
<td><strong>PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES</strong></td>
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<td>25</td>
<td>In its stage 1 report on Prohibition of Smoking in Regulated Areas (Scotland) Bill the Committee accepted ‘that evidence exists of adverse health effects from passive smoking’ and that reducing exposure to environmental tobacco smoke, through a partial ban on smoking, would have a positive impact on health. The Committee remains of the view that this is the case.</td>
<td>The Executive welcomes the Committee’s acceptance of the harmful effects of environmental tobacco smoke.</td>
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<td>26</td>
<td>The majority of members of the Committee are of the view that a ban on smoking in enclosed public places would impact positively on public health and that a voluntary approach to tobacco control would not ensure the same outcome. The majority of members, therefore, support the proposal contained in this part of the Bill, believing that it will help to save lives.</td>
<td>The Executive welcomes the Committee's view that a ban on smoking in enclosed public places will have a positive impact on public health.</td>
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<td>28</td>
<td>The Committee recommends that action is taken to monitor the health impacts from a ban should the Bill be enacted.</td>
<td>The Executive will monitor the health, economic and cultural impact of the legislation. Work has already commenced lead by NHS Health Scotland to ensure that baseline data are in place for 2005. A seminar outlining the proposed research and evaluation will be held on 8 June and all MSPs have been invited.</td>
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<td>32</td>
<td>The Committee acknowledges that there are some concerns about a potential impact on exposure to passive smoke in a domestic setting arising from the ban although no specific evidence was available. It</td>
<td>This is an important issue. The Executive will be determining changes in second-hand smoke exposure in adult non-smokers and children. In addition, the Executive is currently exploring the feasibility of</td>
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<td>recommends that any implementation of a ban on smoking in enclosed public places be monitored to establish the impact on exposure to passive smoking in the home and that public information campaigns continue to highlight this issue.</td>
<td>monitoring exposure in the home. If an objective methodology can be established then further research into this area will be undertaken. The Executive will continue to raise awareness of the dangers of passive smoking through public awareness campaigns.</td>
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<td>38</td>
<td>The Committee is of the view that, as long as a smoking policy is in place, an exemption on humanitarian grounds should be extended to adult day care centres. These centres provide important respite services for the carers of vulnerable adults and effectively fall into the category of ‘home for the day’.</td>
<td>The Executive notes the committee's view that the exemption should be extended to adult day care centres. Exemptions are dealt with in the regulations and this issue will be considered carefully once the consultation period is complete. Day Care Centres are not a place of residence and on that basis the Executive is not minded to exempt Adult Day Care Centres. As a health measure, the ban would protect the health of those users of Adult Day Care Centres who do not smoke as well as those who work in them. Such an exemption may also create a dangerous precedent.</td>
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<td>39</td>
<td>The Committee supports an exemption from the proposed smoking ban for designated hotel rooms.</td>
<td>The Executive welcomes the Committee’s support, though final decisions will only be taken once the consultation is concluded.</td>
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<td>49</td>
<td>The Committee believes that the timetable for implementing the smoking ban is not unreasonable. However, the Committee considers it important that</td>
<td>The Executive is working with the Smoke-Free Areas Implementation Group to prepare a public information campaign aimed at all employers, licensees and the</td>
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<td>awareness-raising about the ban and ongoing work with industry to prepare for the ban is intensified.</td>
<td>public. The campaign will seek to ensure everyone understands the new legislation and is prepared for it.</td>
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<td>55</td>
<td>The Committee recommends that action is taken to monitor the economic impacts arising from a ban should the Bill be enacted.</td>
<td>See response to paragraph 28. The Executive intends to monitor the economic impact of the legislation.</td>
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<td>61</td>
<td>The Committee recommends that enforcement be focused primarily on the role of those in control of a no-smoking premises and that the Bill is amended at Stage 2 to this effect. The Committee also recommends that guidance be issued centrally on enforcement strategy and that enforcement activity is monitored over time.</td>
<td>The Executive is working with CoSLA and REHIS to develop guidelines for the enforcement of the smoking ban. The emphasis of these guidelines will be on a non-confrontational approach and on dealing with people who have control of no-smoking premises in the first instance. Nonetheless, it is important that the legislation contains a specific offence for individuals who continue to smoke when requested to stop in a no smoking premise. The objective will be to achieve a consistent approach across Scotland.</td>
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<td>63</td>
<td>In a supplementary written submission addressing enforcement issues, COSLA indicated that it plans to meet with the Association of Chief Police Officers in Scotland to discuss enforcement issues with a view to developing jointly badged enforcement guidelines to ensure a consistent approach across Scotland. Given concern over the potential for differing enforcement strategies, the Committee welcomes this development but recommends that enforcement activity is monitored over time.</td>
<td>The Executive accepts this recommendation</td>
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<td>Para. No.</td>
<td>Committee’s Comment</td>
<td>Executive Response</td>
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<td>65</td>
<td>To the extent that the Bill will add to the duties of environmental health officers, the Committee considers it important that enforcement costs are fully funded and monitored over time in order to avoid any deterioration in other services they provide.</td>
<td>The Executive has already indicated that funding will be available towards the additional costs of enforcement that Local Authorities will incur. The level of this funding is subject to discussions between the Executive and CoSLA.</td>
</tr>
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</table>
| 66       | The Committee is of the view that the activities of the OTC contributed to high compliance rates in Ireland and notes that the Bill does not propose an equivalent to the OTC for Scotland. | It is important that enforcement be carried out as effectively as possible and we are developing a network throughout Scotland to ensure effective implementation. The OTC in Ireland is responsible for a number of regulatory duties which are undertaken by the Westminster Government on a UK basis. The functions of the OTC are as follows:  
1. To advise the Minister for Health and Children, and assist him or her in the implementation of policies and objectives of the government, on the control and regulation of tobacco products generally;  
2. To consult with relevant national and international bodies on developments in tobacco control;  
3. To advise the Minister on any further actions that should be taken to reduce or eliminate smoking or its effects;  
4. Organise research and disseminate the results;  
5. Coordinate a national inspection programme in cooperation with the health boards;  
6. To advise Ministers as required on the manufacturing and marketing activities of the |
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<td>may assign to the Office from time to time.</td>
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<td>Of these functions 1, part of 2,3,4 and 7 are broadly</td>
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<td>covered within the Health Improvement Directorate of the</td>
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<td>Scottish Executive. This allows us to deal with a broad</td>
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<td>ranging tobacco control programme as part of the wider</td>
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<td>health improvement drive in a holistic fashion rather than</td>
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<td>simply trying to tackle individual strands. The</td>
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<td>international element function 2 is led by the UK</td>
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<td>government on behalf of all UK Health Departments in</td>
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<td>lieu of its membership of such organisations as WHO</td>
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<td>and the EC. Function 5 is carried out by Environmental</td>
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<td>Health Officers in Ireland and in relation to the smoking</td>
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<td>legislation we plan the same in Scotland. However in</td>
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<td>Ireland EHOs are brigaded with health boards not with a</td>
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<td>separate tier of government as in Scotland. In addition</td>
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<td>EHOs in Ireland are also responsible for a range of</td>
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<td>duties going beyond those carried out by Scottish EHOs.</td>
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<td>These duties around the advertising and sale of tobacco</td>
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<td>carried out by Trading Standards Officers in Scotland.</td>
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<td>On function 6 the powers to control the marketing and</td>
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<td>manufacture of cigarettes are reserved. The Health</td>
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<td>Improvement Directorate works closely with the UK</td>
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<td>government on those areas which fall out-with devolved</td>
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<td>responsibility to enable Scottish Ministers to play a full</td>
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<td>role in promoting tobacco control policies at UK and</td>
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<td>The different national and local structures and the reserved/devolved split of responsibility in Scotland compared to Ireland make it difficult to draw together an organisation such as the OTC. In addition a new body would absorb resources that might be better used in tackling the damage done by tobacco. Nonetheless, the Executive is mindful of the focus the OTC has brought to the issue in Ireland and I am happy to consider how we might achieve this in Scotland.</td>
<td>The level of fines is an issue dealt with in the regulations. In light of the committee’s view the Executive will consider the level of fines once the consultation period is completed. However, a Fixed Penalty Notice is a simple, effective and easily understood way of punishing a smoking offence. A fine escalator would require the creation of a centralised records database of all Fixed Penalty Notices issued in Scotland. This is the only way that the fine of an individual served with a FPN in 2 different local authority areas could be escalated. To escalate a fine an enforcement officer would have to log a FPN on the database and then check the data to see if the individual had previously committed an offence. If the individual has an offence then the officer would have to write to the individual indicating the fixed penalty will be higher than they were originally told. This seems unduly bureaucratic and confusing for what we intend should be a simple easily understood system. There would also</td>
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<td>69</td>
<td>The Committee recommends that consideration be given either to increased levels of fines or to an escalating penalty for repeat offenders.</td>
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<td>need to be a process for determining when a previous FPN was “spend” when offences are accrued for escalation purposes.</td>
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<td>77</td>
<td>PART 2, SECTIONS 9 AND 10: FREE ORAL HEALTH ASSESSMENTS, DENTAL CHECKS, EYE EXAMINATIONS AND SIGHT TESTS</td>
<td>The Executive welcomes the support of the Committee for the measures.</td>
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<td>77</td>
<td>The Committee supports the Executive’s proposals to introduce free oral health assessments and eye examinations and believes that, if properly implemented, they have the potential to improve standards of oral health and reduce the number of long term sight problems in Scotland.</td>
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<td>80</td>
<td>The Committee shares the concerns raised by the BDA about the capacity of existing dental services to implement the proposal.</td>
<td>The Deputy Minister for Health and Community Care’s announcement on 17 March 2005 outlined steps that the Executive will take to improve accessibility to NHS dentists.</td>
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<td>81</td>
<td>While the Committee welcomes the funding brought forward in the Executive’s Action Plan to seek to address this issue, the majority of the Committee supports the view of the Finance Committee that this information should have been available at the Bill’s introduction.</td>
<td>The Executive notes the Committee’s concerns that the Action Plan was not available before introduction of the Bill. However, the Executive is of the view that the Financial Memorandum accurately reflects the costs of implementing the specific provisions of the Bill.</td>
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<td>84</td>
<td>The Committee believes the Executive’s calculation does not take into account the additional cost of providing oral health assessments and eye examinations in place of standard dental checks and sight tests. The Committee reiterates its support for the view of the Finance Committee, namely that information</td>
<td>See response to paragraph 81.</td>
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<td>on the cost of these assessments and examinations should have been available at the Bill’s introduction.</td>
<td>The Executive confirms that it will make funding available for the implementation of oral health assessments and eye examinations, following discussions with the professions.</td>
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<td>85</td>
<td>The Committee seeks assurances from the Executive that additional funds will be made available should the cost of implementation of this proposal exceed the amount outlined in the Financial Memorandum.</td>
<td>The Executive notes the Committee’s concerns. The negotiations with the health professions about revising or developing these tests are ongoing.</td>
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<td>86</td>
<td>The Committee is of the view that negotiations with the dental and ophthalmic professions to agree the nature of the oral health assessment and eye examination should have occurred in advance of the introduction of the Bill. In the absence of this information, the Committee is unable to scrutinise accurately the cost of the proposal and is therefore only in a position to approve the policy in principle.</td>
<td>The Executive undertakes to provide this information following discussion with the professions.</td>
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<td>87</td>
<td>The Committee recommends that the Executive should update the Committee on further negotiations with the professions and the impact on the cost of the proposal of decisions taken in these discussions.</td>
<td>The Executive agrees with this recommendation and will undertake the follow-up work.</td>
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<td>89</td>
<td>The Committee recommends that, in order to maximise the benefit of the proposals, the Executive should undertake follow-up work to ensure its effective implementation. This work should include educating and advertising on the availability of and the nature of the new eye examination and oral health assessment. It should also undertake the collation of information on uptake levels.</td>
<td>The Executive agrees with this recommendation and will undertake the follow-up work.</td>
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<td>90</td>
<td>The Committee also strongly recommends that the Executive should work with health boards in targeting those vulnerable groups which are already eligible for free sight tests.</td>
<td>The Executive agrees with this recommendation.</td>
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<td>91</td>
<td>The Committee strongly recommends the introduction of a comprehensive dental and sight screening programme for children at the start of primary and secondary school education, in order to treat problems at an early stage and encourage the habit of receiving oral health assessments and eye examinations. The Committee strongly recommends that Ministers bring forward amendments to legislate for such screening programmes at Stage 2.</td>
<td>The Executive does not consider that such amendments are required. Part III of the 1978 Act already provides for dental inspection and education in dental health for all school pupils. The National Dental Inspection Programme in Scotland specifically targets children in P1 and P7. Part III of the Act also provides for the medical supervision of all school pupils, which covers any health related aspect, including eyes. The guidance on Health for all Children 4 issued in April 2005 states that all children should be screened by an orthoptist in their preschool year, between the ages of four and five. The guidance also confirms that the evidence for screening in secondary school remains inconclusive. It does, however, state that arrangements should be made for any child undergoing assessment for educational under achievement or other school problems to have a visual acuity check.</td>
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<td>93</td>
<td>The Committee believes that detailed definitions of both the eye examination and the oral health assessment could usefully have appeared on the face of the bill to clarify that they are more extensive in nature than the existing tests and checks.</td>
<td>The Executive believes that it is more appropriate to capture the detailed definition of eye examination and oral health assessment in regulations and the Statement of Dental Remuneration respectively. This allows for changes to the definitions to be made in the future if required.</td>
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<td>94</td>
<td>The Committee is aware that for enabling legislation such as this ‘the devil is in the detail’ and therefore encourages the Executive to actively engage with professional bodies, patient representatives and health boards in the production of the subordinate legislation which will define the nature of eye examinations and oral health assessments.</td>
<td>The Executive is currently engaged in detailed discussions with the professional bodies.</td>
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<td>95</td>
<td>The Committee also recommends that the Executive provides the Committee, at the earliest opportunity, with draft regulations defining the examination and the assessment to allow members to comment on the regulations before they are formally laid before Parliament.</td>
<td>The Executive will provide the Committee with draft regulations as soon as possible on eye examinations, following discussions with the profession. The oral health assessment will be defined in the Statement of Dental Remuneration, following discussion with the profession.</td>
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<td>PART 2, SECTIONS 11, 12, 13, AND 14: GENERAL DENTAL SERVICES</td>
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<td>103</td>
<td>The Committee supports the proposals in sections 11 to 14 on general dental services and the wider policy intention stemming from ‘Modernising NHS Dental Services in Scotland’ of enabling health boards to take a more active role in securing and providing general dental services. The Committee believes that, if properly funded and implemented, the policy will provide for</td>
<td>The Executive welcomes the Committee’s support for the general dental service provisions.</td>
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<td>104</td>
<td>While the Committee welcomes the funding brought forward in the Executive’s Action Plan which is intended to implement the policy, the Committee supports the view of the Finance Committee that this information should have been available at the Bill’s introduction.</td>
<td>The Executive notes the Committee’s concern. The Executive’s Dental Health Action Plan addresses a wide range of dental health issues. The scope of these is far wider than the measures introduced by the provisions in the Bill.</td>
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<td>106</td>
<td>The Committee supports the BDA’s view and recommends that the Executive actively engages with professional bodies, patient representatives and health boards when considering the specific details of the new charging system.</td>
<td>The Executive confirms that it will actively engage patient, professional, and service representatives in considering the details of any new patient charging system for dental services.</td>
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<td>107</td>
<td>The Committee also recommends that the Executive provide the Committee, at the earliest opportunity, with draft regulations defining the new system to allow members to comment on the proposed system before the regulations are formally laid before Parliament.</td>
<td>The Executive will provide draft regulations on any changes to the charging system for dental services, following discussion with interested parties.</td>
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<td>109</td>
<td>The Committee is concerned that only 25% of services are physically accessible for those with restricted mobility, making it difficult for these individuals to find suitable local dental services. The Committee recommends that the Executive ensures that the accessibility of premises is treated as a priority by health boards when providing financial assistance to practices under section 13.</td>
<td>The Executive agrees with this recommendation</td>
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<td>112</td>
<td>The Committee appreciates the importance of employing professionals complementary to dentistry in order to maximise levels of service delivery and to allow for an increase in the provision of preventative care. The Committee therefore recommends that health boards ensure that, when providing financial assistance for the establishment of new dental practices, the premises for these practices can accommodate professionals complementary to dentistry.</td>
<td>The Executive agrees with this recommendation.</td>
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**PART 2, SECTIONS 15, 16 AND 17: LISTING ADDITIONAL CATEGORIES OF DENTAL PRACTITIONERS, OPTOMETRISTS AND OPHTHALMIC PRACTITIONERS**

<p>| 117      | The Committee supports the Executive’s proposals to extend health board lists to include all dentists and ophthalmic medical practitioners and believes they will allow health boards to ensure all practitioners are regulated and can be held directly accountable for their actions. | The Executive welcomes the Committee’s support for the extension of health board lists. |
| 121      | The Committee believes that those on the existing health board lists should be required to disclose the same information as new entrants to ensure that all those on the extended lists are regulated on the same basis. The Committee recommends that individuals on existing lists should be required to disclose information under the same timescale as those newly required to register. | The Executive accepts the principle of this recommendation, and will discuss with the practical implications with the relevant bodies. |</p>
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<td>PART 3: PHARMACEUTICAL CARE SERVICES</td>
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<td>130</td>
<td>The Committee supports the Executive’s proposals for the provision of planned pharmaceutical care services. The Committee believes that, if properly implemented the proposals could ensure the provision of a wider range of pharmaceutical services throughout Scotland on the basis of the needs of individual communities.</td>
<td>The Executive welcomes the Committee’s support for the measures for pharmaceutical care services.</td>
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<td>132</td>
<td>Executive officials have agreed to provide the draft regulations to the Committee for Stage 2. The Committee recommends that the Executive actively engage with professional bodies, patient representatives and health boards when considering the specifics of the new system.</td>
<td>The Executive agrees with this recommendation</td>
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<td>134</td>
<td>The Committee recommends that the Executive, in consultation with the key stakeholders, produce national criteria and guidelines on pharmaceutical care services to support the effective implementation of the legislation.</td>
<td>The Executive agrees with this recommendation and has already initiated work with representatives of the profession and the service</td>
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<td>PART 4: DISCIPLINE</td>
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<td>139</td>
<td>The Committee supports the Executive’s proposals to strengthen the disciplinary procedures contained within part 4 of the Bill.</td>
<td>The Executive welcomes the Committee’s support for the disciplinary measures.</td>
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<td>144</td>
<td>The Committee recommends that the Executive should strive to ensure that the disciplinary process created by the Bill, and the definitions under which it operates, are harmonised with those of the professional regulatory bodies.</td>
<td>The Executive agrees with this recommendation and will undertake discussions with the relevant regulatory bodies.</td>
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<td>PART 5, 24: HEPATITIS C PAYMENTS</td>
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<td>claimants whose...</td>
<td>the Fund. This is...</td>
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<td>dependants have...</td>
<td>an important issue...</td>
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<td>been excluded...</td>
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<td>order to ensure fairness and equity for claimants. Details of how this will work are currently being developed by the four administrations. The Minister for Health and Community Care has discussed this issue with the Secretary for State for Health and he has indicated that this is being developed urgently with a view to it being operational as soon as possible. The Minister intends to contact the incoming Secretary of State for Health to alert her to this issue.</td>
<td>160 The Committee recommends that the Bill be amended to include the requirement for an appeals procedure, and that detail of the appeals procedure should be included in the regulations. Ministers have already given an assurance to the Committee that there is to be an Appeals Procedure. Officials from the four administrations are aiming to have the procedure agreed by the end of July 2005. The Bill provides statutory cover for the Scottish Ministers to make payments from the Skipton scheme to Scottish claimants. The Skipton Fund was set up in July 2004 to avoid any delay in making payments to claimants, and a significant number of claims have already been processed. These administrative arrangements are operating successfully and it is not thought appropriate to include the details of the scheme in subordinate legislation. The process of taking evidence on the Bill has already enabled the Committee to scrutinise certain aspects of the scheme, specifically the eligibility criteria, awards and appeal procedures.</td>
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<td>161</td>
<td>The Haemophilia Society also suggested that the proposed appeals panel should contain a haematologist rather than a</td>
<td>The Executive is currently working with the other three UK Administrations on the details of the Appeals Panel.</td>
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<td>GP. It would seem to the Committee that there should be scope for including both a haematologist and a GP on the appeals panel.</td>
<td>The Executive supports this proposal and will argue for this at national level.</td>
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</table>
| 166      | Committee believes that the definition of Scottish claimant in the Bill should be amended to reflect those who have been infected by NHS treatment in Scotland, irrespective of current residence.                               | The Skipton Fund payment scheme has been agreed amongst the four UK administrations. Each administration meets the cost of ex-gratia payments to those people currently resident in their area. Providing the claimant meets the criteria, the place of current residence is used only by the Skipton Fund for internal administrative purposes to identify which country will pay.  
It has been agreed that the cost of payments to successful claimants now residing outwith the UK will be met by the administration of the country within the UK in which the claimant was last resident.  
The Executive would support an amendment to the Bill that enabled this approach to be clearly defined and to be taken for sufferers no longer resident in the UK but who would otherwise qualify for an ex-gratia payment. |
<p>| 167      | The Haemophilia Society pointed out in oral evidence that guidance from the Skipton Fund indicates that these payments will not be affected by payments received by beneficiaries from litigation or other schemes. However, it argued, that the wording of section 24(3) (b) of the Bill appears to allow for Skipton Fund payments to be taken into account in any other claims. |                                                                                                                                                                                                                         |</p>
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<td>168</td>
<td>In his written submission the Minister stated, ‘Clearly this section must properly reflect what has previously been said by Scottish Ministers. I will consider this section and amend as appropriate.’</td>
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<td>169</td>
<td>The Committee welcomes the Minister’s clarification on the issue, and looks forward to the submission of an amendment to ensure that sufferers receive the full benefit of Skipton Fund payments.</td>
<td>The Executive is considering an amendment at Stage 2 to address this issue.</td>
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<td>170</td>
<td>The Committee was disappointed to learn that difficulties appeared to have been encountered by some claimants in receiving assistance from clinicians in completing application forms to the Fund. The Skipton Fund representatives reassured the Committee that this issue now appeared to have been dealt with.</td>
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<td>172</td>
<td>The Committee believes however that this matter should be kept under review and that should problems reoccur, the Executive, through the Chief Medical Officer should write to all consultants underlining their responsibility.</td>
<td>The Executive accepts this recommendation and will consider how best to monitor this issue and support applicants where delays are brought to our attention.</td>
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<td>173</td>
<td>The legal advisers to the Haemophilia Society also questioned the Skipton Fund rule which states that if eligible persons died after 5 July 2004, they must have made a claim whilst alive in order for their dependants to benefit.</td>
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<td>174</td>
<td>In his oral evidence, the Minister recognised this point as valid and gave a commitment to examine the issue and return to the Committee with clarification. (HC Col 1865)</td>
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<td>175</td>
<td>The Committee welcomes this commitment.</td>
<td>The Executive has considered this carefully. It is a key principle of the scheme that it is intended to alleviate the suffering and hardship of those people who have contracted Hepatitis C through NHS treatment by making ex-gratia payments. The Executive is sympathetic to the views of the Committee and witnesses but remains of the view that, in order to strike a reasonable balance between recognising the suffering of those alive who have contracted the disease this way and meeting the demands for healthcare of other patients within the NHS, this is an important part of the basis of the scheme and that it would not be right to depart from it for this group.</td>
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<td>180</td>
<td>The Committee supports the Executive’s proposal under sections 25-27 of the Bill.</td>
<td>The Executive welcomes the Committee’s support.</td>
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<td>184</td>
<td>The Committee recognises the case for making this legislative arrangement, but regrets the need to do so due to the oversight in implementing the previous legislation.</td>
<td>The Executive notes the Committee’s comments. Administrative arrangements have been put in place to ensure that this situation is not repeated.</td>
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<td>188</td>
<td>The Committee supports the Executive’s proposal to extend the types of professionals who can issue an</td>
<td>The Executive welcomes the Committee’s support for the extension in the types of professional who can issue</td>
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<td>incapacity certificate.</td>
<td>incapacity certificates.</td>
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<td>196</td>
<td>The Committee believes that the introduction of this legislation and the extension of powers to dentists, nurses and ophthalmic opticians must be accompanied by accredited training for these groups.</td>
<td>Agreed, NHS Education Scotland is refining a training specification, which will be the subject of consultation with relevant stakeholders. The Executive anticipates introducing a pilot version of the training by autumn 2005.</td>
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<td>197</td>
<td>The Committee supports the proposal that professionals will not be empowered to sign off incapacity certificates until they have received accredited training.</td>
<td>The Executive agrees that additional health professionals will need to be trained however registered medical professionals will retain the power to issue certificates by virtue of their medical training. In addition, the multi-disciplinary training will be available to them for their continuous professional development.</td>
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<td>199</td>
<td>The Committee supports the view expressed by witnesses that this training should be provided on a multi-disciplinary basis by NHS Education. It also recommends that the patient representative bodies be consulted on the design of the training. This does not appear to have happened to date.</td>
<td>NHS Education Scotland is refining a training specification, which will be the subject of consultation with relevant stakeholders. The Executive anticipates introducing a pilot version of the training by autumn 2005. The training will be multi-disciplinary.</td>
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<td>200</td>
<td>The Committee recommends that the requirement for training be included in the regulations covering this section of the Bill, and requests that draft regulations be published before the Bill is considered at stage 3.</td>
<td>The Executive agrees with this recommendation</td>
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<td>201</td>
<td>The Committee notes that there is no provision within the Financial Memorandum for the costs of training that will be necessary under the Bill.</td>
<td>The Executive will fund the cost of developing the training package; professionals who wish to take up the training will be able to do so as part of their ongoing continuing professional development. In developing the</td>
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<td>training package the Executive will seek to keep ongoing costs to a minimum.</td>
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<td>206</td>
<td>The Committee believes that the principle that it is the individual’s level of capacity that is being assessed, and not their need for treatment must remain paramount.</td>
<td>The Executive agrees with the view of the Committee and believes that the measures proposed put the needs of the patient foremost.</td>
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| 214      | The Committee shares Enable’s view that changes to the legislation should be governed by patient welfare and for this reason is not minded to support the extension of incapacity certificates to 3 years. | The Executive believes that, following extensive consultation, it has reached conclusions on measures that remain true to the principles of the 2000 Act and will not result in a reduction of patient care.  

It will only be appropriate to issue a three year certificate for those patients who come within the conditions or circumstances prescribed by Scottish Ministers. Healthcare professionals will not have discretion to widen the conditions or circumstance. Any proposed changes to the conditions or circumstances will have to be subject to consultation, agreed by Scottish ministers and approved by the Parliament, by secondary legislation subject to negative resolution.

The Quality & Outcomes Framework of the new GP contract seeks to reward GPs who review their patient’s medication on an annual basis as part of improving the quality of the service. In the revised Code of Practice to Part 5 of the 2000 Act, which will be subject to consultation, we plan to inform healthcare professionals that in line with best practice patients with a 3 year certificate should, as a minimum, have their medication...
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<td>215</td>
<td>The Committee believes that, even with tight regulation, there is a significant risk of three year certificates being employed much more extensively than is intended, with a consequent reduction in patient care. If it is good practice to carry out an annual review for patients, then the assessment of capacity and issue or not of a certificate should remain part of that process.</td>
<td>See response to paragraph 214.</td>
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<td><strong>PART 5, SECTION 31: JOINT VENTURES</strong></td>
<td>COSLA is also in favour, in principle, of joint ventures to the extent that they recognise advantages in shared premises</td>
<td>The Executive has responded to the Committee on the issues regarding CoSLA’s involvement in the</td>
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<td>for health and local authority services. COSLA, however, raised some concerns about the practical application of the policy and about the level of involvement of local authorities in policy development discussions in this area.</td>
<td>development of policy to date. They have been engaged since 2002. The Executive welcomes the fact that CoSLA and local authorities (through CoSLA) are represented on the Joint Premises Project Board to reflect local authority chief executives, property and finance interests as well as social services and organisational development. We are committed to involving local authorities and continue to engage with them.</td>
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<td>226</td>
<td>Much of the evidence available to the Committee related to the experience of NHS LIFT projects in England. While a number of these projects are now underway, the Committee is of the view that it is too soon to make an objective judgement about the performance of this model. The Committee is also aware that other joint venture models are possible under the Executive’s proposals; however, it appears that a limited amount of consideration has been given to alternative models by the relevant public sector agencies. The Committee considers it important that a range of alternative joint venture models are considered, including the mutual model.</td>
<td>The terms of the Bill are generic and do not limit Ministers or Health Bodies to one particular commercial model. The focus is on service led premises development. We are seeking to create a vehicle that can bring all parties with an interest in service provision together. Joint ventures simply facilitate the development of premises. The services provided to support such premises will vary significantly but it is important to recognise that they are determined by the local public sector partners. These provisions will give NHS Boards the same flexibility as other areas of the public sector. Joint ventures can be particularly effective as a vehicle to bring together a wide range of organisations with mutual interests and aims.</td>
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<td>The PPP/PFI sector has been an evolving process and the lessons already learned have been incorporated into the LIFT model which itself has evolved from conception to the model that has now 42 examples across England. It is the Executive’s view that the joint venture model provides a real and genuine opportunity for partnership.</td>
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<td>We are convinced that with 42 LIFT schemes in England there is ample evidence of the processes used to develop the strategic service planning processes that support the LIFT development as well as the bankability of the commercial model. If the model did not work, deals would not be signed.</td>
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<td>We await the publication of the National Audit Office report with interest to provide an independent assessment (end of May) and will be mindful of its findings before we proceed.</td>
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<td>The Executive has stated that the powers are generic and we will examine the applicability of other models and the circumstances in which their application would be applicable.</td>
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<td>That said the Executive is seeking to provide a strategic framework for service led premises development and a proliferation of models that require to be developed, tested and implemented will have time and cost implications.</td>
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<td>237</td>
<td>The Committee welcomes the Minister's confirmation, in a written submission, that the Scottish PPP staffing protocol will apply to joint venture companies established under the Bill's provisions, on the basis that public private joint ventures are a form of PPP.</td>
<td>The Executive welcomes the Committee’s reassurance.</td>
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<td>238</td>
<td>In evidence, witnesses from UNISON and the STUC raised concerns about potential conflicts for public sector employees serving as directors of joint venture companies. Dave Watson, of UNISON, raised the issue of directors’ fiduciary duties to shareholders and potential pressure to pursue commercial activity over health related functions where, for example, a higher rent for premises was offered by a commercial operator as compared to a health related service provider, such as a doctor.</td>
<td>The Executive is firmly of the view that this is an issue that can be adequately addressed within the governance arrangements within the joint venture companies and the public sector bodies by which non-executive Directors are employed and represented.</td>
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<td>240</td>
<td>In earlier correspondence with the Committee, the Minister indicated that influence on the direction taken and prioritisation of the scheme would be achieved through the governance arrangements established for the joint venture company. In the context of a LIFT type development, the Strategic Partnering Board fulfils this role via the Strategic Development Plan’.</td>
<td>The Executive holds to this view.</td>
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<td>241</td>
<td>Dave Watson, of UNISON, also raised a concern that local priorities may become distorted because of the need to ensure the ‘critical mass’ necessary to attract private finance. (HC Col 1751)</td>
<td>The Executive does not agree with Mr Watson’s view. Our view is that the critical mass will have to be generated through meeting local needs.</td>
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<td>242</td>
<td>The Committee notes that, as drafted, the Bill does not</td>
<td>The powers sought are generic and therefore the</td>
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<td>guarantee that appropriate governance arrangements will be established to ensure that health related priorities are given sufficient weight in joint venture companies. The Committee invites Ministers to address this point at Stage 2.</td>
<td>Executive would not see it as appropriate to legislate for specific governance arrangements. In the context we believe the LIFT model gives us a basis to ensure, through a Strategic Partnering Board approach, health related priorities can be given sufficient weight. One of the key learning points from England however is the need to engage other stakeholders such as local authorities to derive maximum benefit from a joint strategic approach to service planning and delivery as well as look at the complementary nature of public services.</td>
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<td>PART 5, SECTION 32: SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST</td>
<td>The Committee supports the Executive’s proposal to convert the Scottish Hospitals Endowments Research Trust from a Non-Departmental Public Body to a charitable trust.</td>
<td>The Executive welcomes the Committee’s support.</td>
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Dear Sylvia

RE: SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL: DELEGATED POWERS
Section 4(2) and 4(7): Meaning of “smoke” and “no-smoking premises”

I am writing to you in response to your letter of 26 April 2005 regarding consultation on regulations made under sections 4(2) and 4(7) of the Smoking, Health and Social Care (Scotland) Bill.

I am grateful that the Committee appreciates the importance of placing the definitions in regulations in order to retain sufficient flexibility. You have acknowledged the high level of consultation that the Executive has undertaken on the first draft of the regulations and I appreciate your concern that future regulations should also be subject to adequate consultation.

As I understand your concerns, the Committee is suggesting a provision requiring the Executive to consult on a draft of future regulations before making these regulations. I can see the merit in this suggestion in the context of the provisions of sections 4(2) and 4(7) of the Bill and I am happy to come forward with an amendment to make such a provision at Stage 2.

I hope that you find this information helpful. I am copying this letter to Roseanna Cunningham, Convenor of the Health Committee.

All the Best,

Andy

ANDY KERR
SUPPLEMENTARY SUBMISSION BY TOBACCO MANUFACTURERS’ ASSOCIATION

During the Stage 1 debate of the Smoking, Health and Social Care (Scotland) Bill in the Scottish Parliament on the 28th April, Stewart Stevenson MSP referred to the evidence submitted by the TMA to the Health Committee on the Prohibition of Smoking in Regulated Areas (Scotland) Bill. This was an earlier bill, introduced by Stewart Maxwell MSP, which did not reach the statute books. In our evidence (April 2004) on that bill we stated:

"... the bill is stated to have a number of objectives, namely to: prevent people, including children, from being exposed to the effects of passive smoking in certain public areas; raise awareness of the dangers of passive smoking and smoking; assist in changing the attitude of the public towards smoking, and encourage smokers who want to quit smoking and help ex-smokers from relapsing.

The TMA does not believe it to be appropriate or legitimate that the last three of those aims should be objectives of this legislation. That they should be stated to be so appears to betray a much broader agenda than the principal stated purpose of this Bill and its provisions.

The TMA therefore believes that it is appropriate only to consider the Bill in the context of its first stated objective."

As can been seen, our purpose was to draw attention to the irrelevance of the last three aims to a bill whose declared objective was "to prevent people from being exposed to the effects of passive smoking in public areas where food is being supplied and consumed". We were, in effect, addressing what we considered to be the unwarranted extension of the scope of the consultation on Mr Maxwell's bill.

Mr Stevenson however, during the Stage 1 debate, is on the record as stating:

"Let me deal with just a few of the claims that are made by the smoking lobby in one form or another. Nanette Milne claimed that the industry is keen to co-operate, but I need only refer her to the TMA's evidence to the Health Committee on the Prohibition of Smoking in Regulated Areas (Scotland) Bill. 'The TMA does not believe it to be appropriate or legitimate'

to

'raise awareness of the dangers of passive smoking and smoking; assist in changing the attitude of the public towards smoking, and encourage smokers who want to quit smoking and help ex-smokers from relapsing' ".

There has been a clear, and it would appear deliberate, distortion of the TMA's position by Mr Stevenson. We are keen to cooperate with legislators where and whenever possible and believe in open dialogue based on sound evidence. We do argue that claims made about the health effects of
environmental tobacco smoke are not sufficient to warrant complete bans on smoking in public places but we have never questioned the appropriateness or legitimacy of public health messages on smoking or smoking cessation programmes. To imply otherwise is completely wrong and for Mr Stevenson to distort the context of the TMA's earlier submission in an attempt to demonstrate lack of cooperation is most regrettable.

We should like to make it known to all members of the Scottish Parliament that the TMA will continue to act in good faith and will cooperate fully with whatever provisions legislation might require. That is not to say that we will not cease to argue our case robustly and will do so in the expectation that any submissions we make will not be misrepresented.

Yours sincerely,

TGF Lord
Chief Executive
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

13th Meeting, 2005 (Session 2)

Tuesday 10 May 2005

Present:

Roseanna Cunningham (Convener)  Helen Eadie
Janis Hughes (Deputy Convener)  Kate Maclean
Mr Duncan McNeil  Mrs Nanette Milne
Shona Robison  Mike Rumbles
Jean Turner

Also present: Brian Monteith.

Smoking, Health and Social Care (Scotland) Bill: The Committee considered arrangements for its consideration of the Bill at Stage 2.

The Committee agreed to hold an oral evidence session on 17 May on the Executive’s proposal to remove the requirement for annual inspections by the Care Commission.

Roseanna Cunningham moved motion S2M-2765—

That the Health Committee considers the Smoking, Health and Social Care (Scotland) Bill at Stage 2 in the following order: sections 9 to 36, schedules 2 and 3, sections 1 to 5, schedule 1, sections 6 to 8, section 37 and the long title.

The motion was agreed.
SUBMISSION FROM AGE CONCERN SCOTLAND

Reduction in frequency of Care Commission inspections

We welcome the establishment of the Care Commission in Scotland. Its role and function as a national, independent regulatory body is a significant improvement on the previous systems which now allows for important comparisons of similar services across Scotland and for the establishment of uniform standards of care.

However, as care standards are not themselves enforceable through regulation but serve as guidance only, the protection they provide individuals cannot fully ensure their rights are always upheld. For example, as care home residents do not have security of right of tenure we are aware that this leads to a clear disincentive to complain or raise grievance for fear of recrimination. There is another tier to this issue: often it is a resident’s relative who is prepared to state concerns about care standards, but still there is an underlying fear of a detriment to the named resident. This detriment is more acute among those residents without relatives or access to advocacy services. Furthermore, it is incumbent upon the Care Commission to mainstream equalities into all its policies and processes thereby ensuring fair and equitable treatment.

Age Concern Scotland is therefore concerned at the proposal to introduce an amendment which will allow the Executive to reduce the frequency of inspections of care services by the Care Commission to fewer than two per year. Currently, residents can expect a minimum of two inspections - one announced and one unannounced. We maintain that this is the absolute minimum requirement to ensure good and effective monitoring of care standards.

Indeed, we would wish the inspection process to be more wide reaching and integral through the inclusion and involvement of residents, and/or their representatives, such as independent advocates. This would encourage an open and transparent process, building trust and confidence amongst residents, particularly in respect of the two key issues we have identified which relate to the regulation of care:

- Lack of security of tenure in care homes
- Fear of raising complaint or grievance

It is only when there is trust alongside regulation can the concerns outlined above be addressed. We would therefore urge the Health Committee to reject this amendment, which can only serve to undermine a mechanism that should be strengthened in order to improve the quality of service delivery and promote the principles of dignity, privacy, choice, safety, realising potential, equality and diversity which underpin the national care standards.

We further welcome the opportunity to give oral evidence to the Health Committee on 17 May 2005.

Andrew Sim, Health and Community Care Policy Officer
Helena Scott, Equalities Policy Officer
Age Concern Scotland

SUBMISSION FROM ASSOCIATION OF DIRECTORS OF SOCIAL WORK

Thank you for the opportunity to respond to the issue of a proposed reduction in the frequency of inspections to care services by the Care Commission.

In response the Association of Directors of Social Work would make the following observations. In principle the Association agrees that a reduction, where there is a more targeted approach which concentrates on identified areas of difficulty, would be beneficial. There is a view that the two
inspection visits annually can become routine and if standards are being met, they can be seen as unnecessary.

In order to safeguard service users, we would encourage the development of some risk assessment model to be agreed which could be consistently applied in order that where a second visit is undertaken, this is fair and transparent. This could be based on a variety of considerations, ie:-

Past record/change in registered manager
- Self-assessment
- Analysis of complaints
- Written questionnaires to residents and carers
- The extent to which the host local authority is acting in relation to contract compliance
- Care Management Reviews

In relation to the attainment of standards, we would obviously want to ensure that the interests of service users are paramount. Creating more flexibility may allow for limited resources to be targeted in the most effective way.

In conclusion, the Association would have no difficulty in principle with the idea and I would be pleased to be involved in more detailed discussions should you require.

I trust this information is helpful but please do not hesitate to contact me should you require further assistance.

Harry Stevenson
Secretary
Association of Directors of Social Work

Marie Gillespie
Secretary to Head of Strategic Services

SUBMISSION FROM BARNARDO’S SCOTLAND

As requested I am writing to give a response from Barnardo’s Scotland to the suggestion of a reduction in frequency of Care Commission inspections.

This proposal seems fairly sensible to us as it gives the Care Commission discretion to pay more attention to those services which are not meeting standards. At the moment they have to make the same number of visits to all services.

The only potentially contentious issue we can see is in relation to fees. Care Commission fees are high and are supposed to cover their running costs. We presume that this is based on two visits per year. So if some organisations (like us - as we get consistently positive reports) only get visited annually and others get 2 or 3 visits, you could say that we would be subsidising those organisations that are not meeting the standards.

However it is difficult to see a way round this that wouldn't be complicated and create more costs, so I guess we could live with it.

I hope that this suits your needs but please do not hesitate to contact me if you require any further information from us.

With best wishes

John Watson
Barnardo’s Scotland
SUBMISSION FROM BUPA CARE HOMES

I regret the lateness of our reply to you but I have been in Crieff at the ADSW annual conference and have only just seen your message to Duncan Innes. As the Director responsible for BUPA Care Homes in Scotland I can confirm that we would be pleased to see a change in the regulation which reduced formal inspections to one per year.

Kind Regards

Bob Maclean
BUPA Care Homes

SUBMISSION FROM CAPABILITY SCOTLAND

Capability Scotland is the country’s leading disability organisation working for a just Scotland. We work with children, adults and families living with disability to support them in their everyday lives. Capability Scotland also works with disabled people for a fair and just Scotland by influencing policy, legislation, practice and attitudes.

As one of the largest providers of care services to disabled children, young people and adults, Capability Scotland is also one of the largest employers in the voluntary sector. We reach over 6000 people with a wide range of disabilities every year, working particularly with people with complex and/or multiple support needs. We employ 1200 people and work in partnership with 29 out of Scotland’s 32 local authorities to deliver a broad range of quality services.

Capability Scotland is a member of Community Care Providers Scotland (CCPS) and recently held its convenorship. We would refer to CCPS’s written evidence and would concur with the points made therein.

General:
In particular, we share CCPS’s ambivalence about the proposed amendment to the Smoking, Health and Social Care (Scotland) bill on the frequency of Care Commission inspections. As a service provider, we are not aware of any request from the sector for this change. We would welcome clarification from the Scottish Executive about the rationale behind this change and indeed, much greater detail from the Executive as to what the change will mean in practice for service providers like Capability Scotland. Consequently, our position is that we are not convinced this change is necessary or indeed, timely. Inspection is necessary and rightly so. All care providers must demonstrate to their clients and contractors that they can provide a quality, secure service that enhances people’s lives. That can only be achieved through a system of registration and inspection that is independent, is seen to be independent and provides the appropriate checks and balances. If the current system is to be amended, then Capability Scotland would obviously accept such change and the impact on our own services. However, we would be keen to ensure that the following issues are adequately addressed:

Clear Definitions required:
The intention would appear to have less frequent inspections of “good” services. There has to be a clear definition of what “good” means in this context. Capability Scotland considers that the amendment should contain a detailed definition.

Application to services not organisations:
Organisations like Capability Scotland can be registered and inspected in terms of providing management services. But it is our individual services that require registration and inspection. If there are to be different status for different services, it has to be applied to all the services within an organisation and not just the organisation itself. To allow a whole organisation providing several services to be inspected less frequently would create potential loopholes for poor practice to slip through. The new system should not enable such slippage. Capability Scotland would welcome clarification of the extent of the change and how it will be applied.
Risk of Duplication and Increased Local Inspection:
Even though responsibility for registration and inspection shifted from local authorities to the Care Commission, many local authorities do maintain some level of inspection to ensure contract compliance. We accept the need for such practice at a local level, but the contractor is not always clear of the extent of its role in this regard. Capability Scotland would be concerned that a more flexible national system of inspection simply creates a gap that local authorities feel bound to fill without having any clear guidance on how to fill it. The result for care providers could be duplication of the registration and inspection process, creating the usual associated burdens on staff resources. Capability Scotland would welcome assurances that the Scottish Executive will monitor the situation to assess the impact of change on care providers.

Accountability and public confidence:
The inspection process still needs to be accountable and ensure that the public and most importantly, users of services have confidence about the quality of services. All providers should still be subject to the same regime and there should be a consistency of approach in terms of conducting actual inspections applying to services no matter their “rating”. We would welcome monitoring of the application of the changed process by the Scottish Executive or indeed, Audit Scotland.

Movement by Services within the New Inspection System:
Any new provisions that create different “ratings” for different services must also provide for movement up and down those ratings. Services must be able to move from being poorer quality to good quality and be able to move to a different rate of inspection accordingly. Similarly, there must be a clearly defined, robust process in place for catching services moving down the ratings to ensure that measures are taken including increasing the frequency of inspections to address any decline. We would welcome the inclusion of such provisions in the amendment.

Capability Scotland has accepted the invitation to give oral evidence to the committee on Tuesday 17 May. We are happy to expand on any of the points above then, and to discuss other issues relating to this proposed amendment.

SUBMISSION FROM CARE COMMISSION

Care Commission evidence regarding the proposed amendment to Section 25 of the Regulation of Care (Scotland) Act 2001 to vary (below but not above the current statutory levels) the minimum frequency of inspection of care services by the Care Commission.

The Care Commission supports the proposed amendment, to Section 25 of the Regulation of Care (Scotland) Act 2001, to vary (below but not above the current statutory levels) the minimum frequency of inspection of care services by the Care Commission.

The main reasons for this are:

- Inspection is only one element of regulation, the others being registration, complaints investigation and enforcement.
- There is a need to ensure that regulatory activity is delivered in an effective and efficient manner.
- Two of the main principles of good regulation are that regulation, including inspection, should be:
  - Proportionate – Regulators should only intervene when necessary and remedies should be appropriate to the risk posed;
  - Targeted - Regulation should be focused on the problem and minimise side effects;
- That the current two levels of frequency (twice in twelve months for services providing 24 hour accommodation and once for all other care services) take very little account of the differences there are in respect of the fourteen different care service types defined in the Act.
- While not suggesting that the frequency of inspections for all inspectorates/registrars should be the same, greater flexibility in frequency of inspection allows the Care Commission to work more effectively with other regulators in minimising the burden of inspection.
That a more proportionate and targeted approach would be achieved by developing a risk assessment approach to the determination of inspection frequency for different types of care services.

Resources released from unnecessary inspections could be redirected towards:
- better involvement of people who use care services and their carers in the inspection process;
- increased inspection activity, and the development of advice for those service providers assessed as having significant room for improving the quality of care they provide and therefore requiring a higher level of scrutiny;
- increased activity in respect of complaint investigations;

In summary, the purpose of inspection, as part of a wider regulatory process, is:
- To monitor and improve quality in care services and build confidence in them
- To confirm good practice and provide public information about the quality of care services locally and nationally
- To protect service users by identifying areas for development of practice and requiring action to be taken

Clearly, members of the public expect the regulator to provide safeguards. However, there are never any guarantees that risks can be eliminated and inspection activity in itself does not provide safeguards, but intelligent and informed targeting of scrutiny does.

The Care Commission would wish to use this flexibility to work with stakeholders about how to get the most effective system of scrutiny - i.e. what would most encourage improvement and be most likely to drive out poor practice.

David Wiseman
Director of Strategic Development
Care Commission

SUBMISSION FROM CARERS OF EAST LOTHIAN

Carers of East Lothian supports all adults in a caring situation in East Lothian to get information and services to help their individual caring role, enhance their own well-being, and strengthen their collective voice to improve services.

We believe it would be against the best interests of carers to reduce the frequency of Care Commissions inspections.

Both types of inspection – planned and unannounced – have value. Planned inspections are an incentive for providers to reflect on their policies and practice. Unannounced inspections show services as they are day-to-day.

Any reduction in the current frequency of inspections would reduce the impact of inspections. If the Care Commission is under pressure to match its resources to the number of inspections, the Scottish Executive should give the Care Commission more money. Any increase in Care Commission resources to allow it to increase its inspection capacity should not come from increases in its charges.

Tony Segall
Centre Manager

SUBMISSION FROM THE CITY OF EDINBURGH COUNCIL

With regard to the proposal to amend Section 25 of the Regulation of Care (Scotland) Act 2001 on the minimum frequency of Care Commission inspections, this local authority wishes to make the following comments: -
We acknowledge that there will be further consultation on the implementation of any amendment and advise that this would be essential given the following position statements:

In order to successfully achieve any reduction in inspection frequency for some services, a robust, transparent and workable risk assessment tool requires to be developed and agreed by both the Care Commission and service providers. The evidence used to determine the performance of a service has to be well thought out and defensible. If this is not achieved, service providers, service users and members of the public will not feel reassured about the effectiveness of an expensive regulatory system. The system has to be effective in protecting vulnerable service users otherwise all stakeholders in this process will be culpable.

With any reduction in the frequency of inspection there requires to be a reassessment of fees for regulation. In each consultation on Maximum Fees, the Executive has been at pains to pursue the policy of full-cost recovery suggesting that this is necessary to deliver an accountable, transparent and 'value for money' regulatory system. The consultations have further suggested that the level of fees are based on the amount of regulatory activity undertaken presumably, for each service provided. If this is the case then those services which are assessed to be operating effectively and are therefore 'low risk' should not have to shoulder the financial burden of badly performing services otherwise, we would question the 'value for money' for service providers.

It is clear however, that badly performing services may be doing so simply because they are unable to resource the service sufficiently. Adherence to standards costs money and targeting regulatory activity with subsequent increases in fees to services which are under resourced, may lead to further service closures. As the Health Committee may already appreciate, The City of Edinburgh Council and Lothian Health is already experiencing an acute problem with the closure of privately provided 'nursing homes' leading to an issue with 'delayed discharge' and, this authority shouldering on several occasions, its duty of care with respect to service users living in these services. This leads back to the debate about whether the Care Commission should remain a subsidised organisation.

Implementing a risk assessment method will absorb Care Commission resources in the short-term. It will also require to be an ongoing feature as clearly the performance of service providers will fluctuate. If complaints on 'higher performing' services increase this will inevitably lead to a reassessment of the service and frequency of inspection. If fee levels are adapted to the level of regulatory activity for each service these will also fluctuate which, does not allow service providers to effectively plan budgets.

If the frequency of inspection is reduced for some services it is essential that decisions are made on the type of inspections undertaken. It is our opinion that providers are able to engineer more successful outcomes within announced inspections. This is obvious under circumstances where providers are able to prepare for inspection. Therefore, more emphasis and consideration needs to be given to the use of the unannounced inspection and complaints investigations. It is our opinion that the protection of vulnerable service users is best protected under these forms of regulatory activity. However, we also believe that with more emphasis on complaints the Service Provider must have a right of appeal to complaints upheld by the Care Commission.

At first sight the proposal to target Care Commission resources is a good one but, it is fraught with potential problems if it is not handled through meaningful consultation with service providers. We would also question whether the drive to amend this section of the Act is motivated by the need to reduce the cost of regulation (full cost recovery policy). It is essential that the regulatory body has teeth and ultimately the resources to properly regulate in the interests of the most vulnerable individuals in society.

Yours sincerely

Duncan MacAulay General Manager, Social Care
Department of Health and Social Care
SUBMISSION FROM CLYDE HEALTHCARE LIMITED

The current two inspections (one unannounced) for those care services offering overnight stay should, in my opinion continue.

However, annual inspection of services provided by nursing agencies could be reduced to enable resources to be utilized more effectively. Nursing Agency Managers should then undertake to notify the Commission of any relevant changes to the service between inspections.

Yours sincerely,
Clyde Healthcare Limited.

SUBMISSION FROM COMMUNITY CARE PROVIDERS SCOTLAND

CCPS represents 57 of Scotland’s most substantial voluntary sector providers of care services. Our members support approximately 50,000 older people, adults, children and their families with a range of services including care at home, housing support and care homes.

CCPS members have mixed views about the proposed amendment. On the one hand, pre-inspection returns and post-inspection action plans entail a great deal of paperwork for service providers and a reduction in the frequency of inspections will clearly mean a corresponding reduction in the ‘burden’ of regulation.

On the other hand, inspections provide a degree of protection and reassurance for service users, parents and families, by checking the extent to which services are meeting the national care standards and complying with the associated regulations, and taking enforcement action where necessary. A reduction in the frequency of inspections may therefore reduce the capacity of the Care Commission to fulfil these important regulatory functions.

CCPS’s understanding of the proposed amendment is that it is intended is to enable the Care Commission to move towards a more proportionate, targeted and risk-based form of regulation. We understand that the amendment relates to a reduction in the minimum frequency of inspections, meaning that good quality services may only be inspected (say) once every eighteen months, whilst poorer quality services will receive inspections more frequently than at present. If this understanding is correct, then CCPS would on balance be broadly in favour of the proposed amendment. However, we believe that in order to mitigate the possible unintended consequences of the amendment, a number of additional provisions should be put in place. These are as follows:

- **A system of validated self-audit and quality assurance.** When CCPS gave evidence to the Health Committee during the passage of the Regulation of Care (Scotland) Act 2001, we expressed the hope that the new regulatory system would work in harmony with service providers’ own quality assurance systems, to the effect that providers would systematically measure their own performance and the inspection process would validate, monitor and review their methods for doing so. We would hope that the amendment might allow us to move more closely towards this kind of regulation, at least for the higher quality providers. This might help to deal with some of the anxieties relating to the reduction in frequency of inspections, since Care Commission-validated quality monitoring would in effect be taking place continuously, not just every six or twelve or eighteen months. This may also address a related issue, which is that the Care Commission does not inspect against all the national care standards at each visit: it takes several years of inspections to cover all the standards for a service.

We would also hope that local authorities, many of whom have begun to introduce monitoring systems in relation to purchased services that largely duplicate the Care Commission’s own regulatory processes, might take a similar approach based on providers’ quality assurance systems. Our fear, however, is that if the Care Commission reduces its regulatory activity in relation to specific services in the voluntary sector, then the relevant local authority will simply step up its own activity to compensate. This would be in direct opposition to the policy objectives of the Regulation of Care (Scotland) Act 2001, and we would encourage the Health
Committee to explore this area with local government representatives and the Scottish Executive.

- **Abandonment of Scottish Executive policy in relation to Care Commission fees.** Committee members will know that Scottish Executive policy in relation to the Care Commission’s operating costs is that it will be self-financing through charging fees to providers for its regulatory services, on a ‘full cost recovery’ basis. CCPS has consistently opposed this policy and continues to press for the Care Commission to be centrally funded. If this cannot be achieved, then CCPS maintains that the level of fee paid should be directly linked to the regulatory service provided, on a value-for-money basis. It is already the case that the Care Commission spends more time with some providers than with others, whilst all services continue to pay a uniform fee regardless of how much scrutiny they undergo – in other words, providers of good quality services are already subsidising regulatory activity in relation to providers of poorer quality services, in direct opposition to the Executive’s ‘value for money’ argument. The proposed amendment is likely to exacerbate this situation, with providers paying a significant annual fee whilst potentially receiving no service of any kind from the Care Commission during the period for which that fee is paid. In our view then, the amendment considerably strengthens the case either for proportionality in relation to fees as well as to inspection activity, or alternatively (and preferably) for abandonment of the full-cost-recovery policy and the establishment of central funding for the Care Commission. We would encourage the Health Committee to pursue this with the Executive; it would certainly be a matter of some considerable concern if the amendment is being introduced purely because the Care Commission cannot maintain current inspection levels within its existing budget.

- **Agreement with providers on how to determine the frequency of inspections.** As noted above, we support the intention to move towards greater proportionality in regulatory activity, but we are bound to ask how the Care Commission will differentiate between those services requiring more attention and those requiring less. The implication is that services may have to be ‘rated’ in some way, and whilst we are aware that the Care Commission has been looking at ways in which this might be taken forward, we have some concerns firstly about its capacity to implement such a system, and secondly which elements of service quality would be included in any eventual judgement about what ‘rating’ to award. Moreover, this problem exposes once again the problems inherent in a full-cost-recovery uniform fee system. For if the Care Commission is in effect intending to work more intensively with some services to improve their quality, whilst leaving others alone for lengthy periods – as opposed to engaging in enforcement activity with all services equally – then it becomes even more unacceptable for the already good to be subsidising the improvement of the poor.

CCPS has been invited to give oral evidence to the Health Committee on 17 May; we look forward to meeting committee members then to discuss these and other issues arising from the proposed amendment.

*CCPS
May 2005*

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1 Note that the Executive’s regulatory impact assessments state that “If central government met the full cost of the Care Commission, there would be little incentive for the Commission to keep costs down or ensure that its procedures were seen as value for money by providers.” (our italics)
SUBMISSION FROM CORINTH HEALTHCARE SERVICES

With regard to the proposed amendments to the Smoking, Health and Social Care (Scotland) Bill, stage 2, Corinth Healthcare (Scotland) as a member of the REC has no objections to reduce the frequency of inspections of care services by the Care Commission.

Please let me know if you require any further statements.

Kind regards,
David Berry
Regional Manager, Scotland.
Corinth Healthcare Services Ltd.

SUBMISSION FROM COSLA

1. COSLA has consulted its member Councils for their views on the Minister for Health and Community Care’s proposal to introduce an amendment which would allow the Scottish Executive to reduce the frequency of inspections of care services by the Care Commission. This written submission outlines the main issues raised by Councils within the eight working days made available by the Committee for this consultation. Further issues or detail which may be raised by Councils will be conveyed to the Committee when COSLA gives oral evidence on 17 May.

2. Local authorities provide and procure a range of care services. As providers of care services they are acutely conscious of the bureaucratic and financial burdens, and disruption to services, which the Care Commission’s current inspection regime can entail. As procurers of care services they are equally conscious of the need for inspections to safeguard vulnerable recipients of care services. As both providers and procurers, local authorities are committed to the constant improvement of care services.

Councils’ Majority View

3. It is clear from this initial consultation that Councils are broadly in favour of the Minister’s proposal. Councils believe that the Care Commission should target its resources where they are most needed and will be most effective. The proposal would free inspection teams to focus more on those services that currently do not meet the required standards and also on those services where concerns have been made through the customer complaints system. It would also enable the Care Commission to monitor more effectively the outcomes of inspections where requirements have been identified, and to monitor improvement following serious user complaints. Where risk is identified, inspection and monitoring levels would be made proportionate to the risk.

4. It is important to make clear that, while these are Councils’ expectations of the likely beneficial effects of a reduction in frequency of inspections, it is essential that those expectations should actually be realised. COSLA therefore welcomes the Minister’s commitment to further consultation on this issue before exercising any powers which may be granted by legislation.

Caveats

5. While Councils broadly favour a reduction in the minimum frequency of Care Commission inspections, and broadly welcome the proposal that the Minister’s power would be capable of being exercised in different ways in respect of different categories of care, they have done so with a number of caveats.

- The proposal may not be appropriate for Residential Child Care Units, where it is at the point of inspection that children as service users have a real opportunity to speak to an independent regulator on the level and quality of service they receive.

- The proposal may not be appropriate for services where there is a particularly high turnover of staff and management, where standards are less embedded in organisational culture and more likely to slip.
There is a need for a robust, transparent and workable risk assessment tool to be developed and agreed by the Care Commission with service procurers and service providers, so that decisions on the frequency of inspections can be evidence based.

A reduction in inspection frequencies should not be at the expense of unannounced visits, since the prospect of these helps maintain compliance with standards by some service providers.

6. A number of Councils have identified a need to actively consider, and where appropriate to promote, a proportionate model of inspection similar to that in use by HMIE. Under proportionate inspection the nature of follow-up is determined by the assessments in the original inspection report, including the timing of the next inspection. The proportionate inspection regime appears to work well and COSLA believes that its promotion should be addressed within the Minister’s further consultation on reduced frequency of inspections.

**Fees**

7. Councils are concerned that the Care Commission is able to charge for both registration and inspections on a full cost recovery basis on the one hand, while potentially being able to reduce the frequency off inspections on the other hand. COSLA would therefore encourage the Committee to consider the link between inspections and fees.

8. COSLA has previously expressed strong concern to the Scottish Executive that its move to full cost recovery for Care Commission fees brings additional financial burdens to local government. With no additional central financial support to meet these costs, the routes for funding will either be to take money directly out of the services the Care Commission will be regulating, or from other front line services, or to add the costs onto an already pressured Council Tax.

9. Perhaps the best example of the impact of full cost recovery is in care home registration costs. COSLA, Care Providers and the Scottish Executive worked hard to develop a clearer understanding of cost drivers in the sector. An independent report, accepted by all parties, accepted that there was a funding gap. Additional resources were secured to help close this gap and at the same time it was acknowledged by all parties that the gap continued to move as additional or new costs hit the sector.

10. In announcing a proposal to increase the registration costs for care homes by over 30%, one part of the Scottish Executive has undermined the work of another. The potential consequence of the proposals is immediately clear. Care providers have no access to additional funding to meet these costs and local authorities similarly have no access to extra funds to meet these costs. This will result in the threat of top up fees for vulnerable residents or reduced services.

11. COSLA therefore believes that the Care Commission’s costs should be met centrally. Scottish Ministers should reconsider the policy on charging and remove these ever increasing costs from local government and its partners, rather than forcing Councils to fund such costs from resources that would otherwise be spent on frontline services.

12. The Scottish Executive has suggested that full cost recovery is necessary to deliver an accountable, transparent and ‘value for money’ regulatory system. Its consultations have further suggested that the level of fees are based on the amount of regulatory activity undertaken for each service provided. If this is the case then those services which are assessed to be operating effectively and are therefore ‘low risk’ should not have to shoulder the financial burden of badly performing services. Otherwise, we would question the ‘value for money’ which would be received by responsible service providers.

**Councils’ Minority View**

13. While only a minority of Councils oppose any reduction in the frequency of inspections by the Care Commission, they are very clear that this is because the Scottish Parliament has set a statutory basic minimum frequency of inspections to protect all vulnerable people using these services. If the
Care Commission is unable to deliver that minimum of protection then the solution should be to address the resourcing and/or performance of the Care Commission, rather than simply trying to reduce its task. Some Councils opposed to a reduction in the frequency of inspections feel that, as responsible procurers of services on behalf of vulnerable people, they themselves might have to ensure that the current minimum frequency of inspections is maintained, if the Care Commission is allowed to avoid doing so.

14. Finally, COSLA again welcomes the Minister’s commitment to further consultation on this issue before exercising any powers which may be granted by legislation.

COSLA
11 May 2005

SUBMISSION FROM EARS INDEPENDENT ADVOCACY SERVICE FOR OLDER PEOPLE

My name is Will Mallinson and I am the manager of the EARS Independent Advocacy Service for Older People, covering Edinburgh and the Lothians. We are by nature of our service role and being advocates a voice for older people in or moving into long-term residential care services. I have also previously worked in residential care for older people and recognised the need for them to have access to an independent voice, hence my move into advocacy.

It is the opinion of EARS, the Glasgow Advocacy Project and the Fife Advocacy Project that this move may water down the role of the Care Commission in inspections and perhaps it needs to look not necessarily at the quantity of inspections but the quality of the inspection process. If this change was to be made to the legislation there would have to be checks and balances included to make it work.

Perhaps the Health Committee could consider the following:

☐ That the Care Commission makes it their responsibility to compare and contrast the way they carry out their role with that of other agencies, i.e. QIS.

☐ To avoid the smell of fresh paint and baking only unannounced visits should be undertaken. An example of this working in practice is how successful the recent unannounced QIS visits made to various hospitals across Scotland was, I believe, in identifying how the lack of care with the disposal waste contributed to the prevalence of MRSA.

☐ Ensure that the Care Commission collect and collate information prior to inspection visits (or those made via Lay Inspectors visits) on which they base their annual inspection visit.

☐ Building capacity by using Lay Inspectors to make further unannounced visits – whether or not the Commission consider staffing to be an issue? These Lay Inspectors could also offer a social contribution to the process and may prove more useful for contact with the users of those services.

☐ Ensure that the National Care Standards are given the teeth they require to be observed in the care sector. Everyone is aware that these are merely guidance and they there is a difference between people being able to say that they are doing something but there is no legislative framework by which they can be asked to prove they are doing so and if not face consequences. Perhaps another amendment to the Act to enshrine these in law should be considered.

In conclusion advocacy agencies working with people in the care system would be against anything that would reduce the quality and meaningfulness of inspections.
SUBMISSION FROM EAST DUNBARTONSHIRE COUNCIL

From Performance Development

Thank you for the opportunity to comment on the above.

My view, having responsibility to support services who are subject to registration and inspection is that there should be no reduction in the number of visits to registered services as there should be no compromise (not that any would be intended) with regard to the policy and practice of safeguarding vulnerable people.

If there were to be any decrease in the number of inspections, this should also be met with a corresponding decrease in the fees paid to the Care Commission for inspection costs.

Thank you

Stewart Smith
Performance Development Manager

SUBMISSION FROM EAST DUNBARTONSHIRE COUNCIL

The undernoted is an observation on the likely implications of reducing Care Commission inspections to registered establishments.

If we consider the recent tragic fire in the Uddingston care home, whilst inspection would not have prevented the fire, the consequence is to have smoke detectors installed in all new care homes. This as far as I am aware does not apply to existing care homes (unless there are transitional timeframes). What it means though in my opinion is that the risk of fire and fire protection per se are now in the public domain. Any reduction in inspection must increase the likelihood of things awry going undetected from an external inspectorate perspective.

Also as we move increasingly towards self-assessment and extended user choice, then the role of professionals and inspection based governance, particularly in the independent sector, will become more necessary in context of risk, quality and choice.

Please consider the above comments in the context of your deliberations, hopefully not from a simple analysis of volume.

Tony Keogh
Head of Social Work
East Dunbartonshire Council

SUBMISSION FROM ENABLE SCOTLAND

ENABLE Scotland is the largest voluntary organisation of and for people with learning disabilities in Scotland. ENABLE Scotland has a voluntary network of members with over 500 national members of whom about two thirds have a learning disability. ENABLE Scotland provides a range of services for children and adults with learning disabilities including supported employment, small care homes, supported living services, community day services and short breaks and out-of-school care for children. We have around 4,000 members in 63 local branches across Scotland and provide an Information and Legal Advice Service and we campaign on behalf of people with learning disabilities and their carers.

ENABLE is grateful for the opportunity to comment on the proposed amendments the Executive is considering introducing at Stage 2 of the Bill process.
Proposals to reduce the frequency of Care Commission Inspections

ENABLE believes that children and adults with learning disabilities deserve the highest possible standards of care. We welcomed the establishment of the Care Commission and actively volunteered to participate in the initial pilot inspections. We take the view that the Commission should perform a dual role – being both a regulator and as a body to promote the spread of best practice.

ENABLE has mixed views about the proposed amendment. The administrative workload for staff may be reduced, enabling them to spend more time delivering care. On the other hand inspections do provide a degree of reassurance for those that use our services, their relatives and indeed for our staff.

Our experience of participating in three pilot inspections has been very beneficial. Our staff have found the inspections supportive and they have provided confirmation that our practices, policies and systems are of high quality and robust standard. It would be unfortunate if we were to lose this because the Care Commission had to focus its energies on other services.

In addition, whilst we accept that the Care Commission should have a degree of flexibility and be able to target its resources in areas of particular need, it should be recognised that there is no flexibility in the fee rate – organisations that are not being inspected as frequently as others are therefore paying a disproportionate share of the costs of these. A solution to this would be for the Care Commission to be fully funded centrally.

SUBMISSION FROM EVALUDT NURSING & EMPLOYMENT AGENCY

We suggest the inspection of care services that offer overnight accommodation should be once a year and all others should be once every two years.

Regards

SUBMISSION FROM HIGHLAND CARERS PROJECT

Statement of Views:

Section 25 Regulation of Care of (Scotland) Act 2001 Amendment

I am the advocate for the families of people with learning disabilities who will be moving from a longstay hospital into homes in the community. Because of the tight timescale in operation, I am unable to consult with families directly on the above proposed amendment. However, families feel that regular inspections, both announced and unannounced, will be of the utmost importance when their relatives move into the community, to ensure their welfare is safeguarded effectively. I therefore believe that they would consider that a reduction in the number of inspections carried out by the Care Commission would be a retrograde step, with possible negative implications in terms of their relatives’ safety and welfare.

Yours sincerely

Diana Wortham
New Craigs Carers Advocacy Worker
Highland Carers Project
Highland Community Care Forum

SUBMISSION FROM MOTHERWELL DISABILITY FORUM

We at the Disability Forum believe that by reducing visits to premises people may experience a drop in standards and become at risk of poor service delivery. Visits by the Care Commission keep
standards at an acceptable level and offer protection to people and any complaints can be addressed during these visits.

Ann Morton  
Citizen Advocacy Co-ordinator

**SUBMISSION FROM NUFFIELD HOSPITALS**

Nuffield Hospitals generally supports the principles of the Health and Social Care (Scotland) Bill.

In particular, the intention to introduce an amendment which will allow the Executive to reduce the frequency of inspections of care services by the Care Commission is welcomed and seen in the context of reducing the burden of inspection on organisations such as Nuffield Hospitals, which can demonstrate robust arrangements for Clinical Governance.

However, Nuffield Hospitals does ask the Minister to consider asking the Care Commission to adopt a risk based approach to that inspection visit, so that the limited resource is applied to areas of greatest risk and consequently patient safety. We assume that the Care Commission will reserve the right to continue its more regular monitoring of compliance to enforcement activity, should the need arise. Fairness across the spectrum of healthcare regulation is another Nuffield Hospitals’ expectation and we would be delighted to work with the Care Commission as it further develops its methodology to encompass a mixed portfolio of NHS and Independent Healthcare.

We remain concerned that the fees associated with regulation in Scotland for Independent Healthcare providers has risen by 24% p.a. over the 3 financial years 2003-2006. Taking a risk based approach to regulation should reduce the cost of regulation by achieving operational efficiencies. At the very least, Nuffield Hospitals does not expect to see any further increases above the rate of inflation in the short to medium term.

Yours sincerely

Ros Gray (Mrs)  
Clinical Director and Responsible Individual for Nuffield Hospitals

**SUBMISSION FROM RCN SCOTLAND**

The Royal College of Nursing (RCN) is the UK’s largest professional association and union for nurses, with over 380,000 members (35,500 in Scotland). Most RCN members work in the NHS, with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a major contributor to the development of nursing practice, standards of care and health policy.

**RCN Scotland comments on proposed amendment**

Our initial reaction to this proposed amendment is one of caution as it raises significant questions about the way in which inspections are conducted.

Issues that we believe need to be considered include:

1. Why, if two inspections a year for care homes were deemed necessary when this legislation was introduced four years ago, should it be changed now and what is the evidence base on which this decision is being taken?
2. Inspection is a vital component of improving quality and protecting patients and there is a concern about whether fewer inspections would result in more potential problems being missed?
3. If, as suggested in the Minister’s covering letter, this is an issue of targeting resources, has consideration been given to whether additional resources are required by the Commission for it
to properly carry out its functions in the light of large increases in registration fees already,
before a change in the legislation is enacted?

4. If the main reason for this change is to release more time for inspectors to focus on under-
performing services then this must be made more explicit and we would want to know what
evidence there is to support the case for such a change?

5. How are the service users directly affected by this change, e.g. care home residents, being
consulted, as it is they who benefit from improvements and the reassurance brought about by
inspections?

6. As a minimum, consideration should be given to making care homes an exception in this
amendment as these are people’s homes and we would want the Committee to ask why the
services provided by them should not be subject to the level of inspection set out in the original
legislation?

Voices from the Independent Sector, our recently published report on the views and
experiences of nursing staff working in care homes, did identify a number of ways in which the
quality of care provided in care homes could be improved. Reducing paperwork and
bureaucracy scored highly in the survey results and the report recommends that statutory
agencies should undertake a review of the level of paperwork being required of care homes.
However, the key areas highlighted for improving care were increasing staffing levels and
improving staff skill mix, adequate funding of care homes to meet the true costs of nursing care
and the need for Care Commission teams carrying out inspections to include a nurse to ensure
peer review of nursing practice. The frequency of Care Commission visits did not emerge as a
key concern among nursing staff.

While these comments are limited in nature at this stage we are consulting more widely with our
members working in this sector and could provide more detailed comments as the Committee
considers the amendment if required.

Yours sincerely

Pat Dawson
Head of Policy & Communications
RCN Scotland

SUBMISSION FROM SACRO

SACRO provides a range of offender accommodation across Scotland. Our senior management
team has considered the proposal to reduce the frequency of mandatory inspections and has
concluded that it is a sensible change. We consider it appropriate to concentrate finite resources on
those services that clearly require more intensive scrutiny.

Thank you.

Donald Dickie
Criminal Justice Adviser

SUBMISSION FROM THE SALVATION ARMY

Following internal discussions The Salvation Army would wish to make the following observations with
regards to the proposal to reduce the frequency of Inspections by the Care Commission.

The current inspection regime frequency mirrors the regime in place when local authorities were
responsible for registration and inspection of services. That standard we feel was fairly effective. In
our opinion a reduction to the frequency of inspection, particularly if the reduction affected the
unannounced inspection visit, would potentially lessen the effectiveness of the inspection process,
and therefore quality of care service.

At a time when the social care sector is far from settled in terms of Care Standards, changing patterns
of working, and workforce registration requirements, a reduction in the frequency of inspections we
feel is likely to be counter productive. There is the serious risk that some providers would generally
reduce quality of provision on the basis that a good 'show' could be put on for an announced visit etc,

We would make two suggestions:

1. That the consultation is a good time to revise the inspection process and it's effectiveness generally. We agree with the aim of targeting resources where they can best be utilised, but argue that an increase in resources or revision in operational process is more appropriate.
2. Should a reduction of visits be accepted, then we would argue for an increase in the scope of the remaining inspection visits. It would be appropriate to inspect all relevant standards (as is the case in England) at each visit.

I hope these comments are helpful.

Alan Dixon
Major

SUBMISSION FROM THE SCOTTISH ASSOCIATION FOR MENTAL HEALTH (SAMH)

The Scottish Association for Mental Health (SAMH) is the largest voluntary sector organisation in its field in Scotland providing accommodation, support, information, training, employment and day care opportunities for people with mental health and related problems. In addition, we operate an information service, offering general mental health information and specialist legal and benefits advice. SAMH campaigns on a wide range of mental health issues, and works to challenge the stigma and discrimination suffered by people who live with mental health problems, influence policy and improve care services in Scotland.

GENERAL COMMENTS

SAMH has concerns about the Scottish Executive's proposal to amend the Smoking, Health and Social Care (Scotland) Bill to remove the requirement for once or twice yearly inspections by the Care Commission. Care homes have been inspected twice a year for many years and we are not clear why a change is required now. The reasons given in the Health Minister's letter are somewhat vague and require clarification. It appears as though this proposal is driven by concerns about resources rather than quality, and there is a danger that change introduced for these reasons could harm the credibility of the Care Commission. Residential services serve perhaps the most vulnerable and dependent client groups and as such we can see no justification for reducing their frequency of inspections.

Should the Executive's proposal be implemented, we would expect to see a significant reduction in Care Commission fees. We would also seek to find out whether annual inspections would be announced in advance: if so, the value of these inspections would be questionable.

If there is a pressing need to reduce the frequency of inspections, SAMH might support the introduction of a possibility of moving to annual inspections based on a system of rewards. For example, care homes which received an excellent inspection result for three consecutive years could receive a "gold star" rating. This would mean they would only be inspected once a year, on the condition that they retained their star rating. Such a system would motivate providers to improve standards in order to receive a "gold star" rating and thus could be a useful tool to drive up standards.

SUBMISSION FROM SCOTTISH CHILDMINDING ASSOCIATION

There are over 6,000 childminders registered in Scotland with over 80% being members of our Associations. Childminders are inspected once a year so this will be a considerable call on Care Commission time.

Our members would be happy to see the frequency of these inspections reduced for experienced childminders where there have been no changes. This should free up time to carry out more frequent visits on new childminders and those where there is a concern.
However, the Commission need to review their procedures as there appears to be little consistency in the way inspections are carried out. The length of time for an inspection varying from one hour to four hours. This does not seem to relate to the quality of the childminder, rather the area of Scotland they stay in.

Information to parents can come in a variety of ways and would not be reduced if inspections were less frequent.

Maggie Simpson
Maggie Simpson, National Development Officer
Scottish Childminding Association

SUBMISSION FROM SCOTTISH COUNCIL OF INDEPENDENT SCHOOLS (SCIS)

SCIS strongly supports the proposed amendment to Section 25 Regulation of Care (Scotland) Act 2001 for the reasons stated, namely that it would:

- enable the Care commission to target its resources where they are most needed
- free up resources for areas where improvement is most needed
- give the Care commission powers to use its resources proportionately

SCIS’s views are based on long-standing experience of school inspections by HM Inspectorate of Education (HMIE) and more recently of pilot inspections of school care accommodation services by the Scottish Care Commission.

During the consultation process on the Regulation of Care (Scotland) Act 2001 and on the subordinate legislation, SCIS argued strongly for a proportionate approach relative to the nature of the provision being inspected. It is accepted that children and young people placed in special schools or units, children in care and children with personal and specific needs are more vulnerable than those who are in mainstream education. The Care Commission should therefore be able to target resources on those services.

SCIS notes that proper and adequate safeguards are built into the proposal to ensure that powers to reduce the frequency of inspections, for example in mainstream boarding schools, would only be used after appropriate checks had been made. The experience of the first integrated HMIE/Care Commission inspections indicates that a six monthly follow-up inspection is not necessarily required, would tie up further resources for the Care Commission and for the school where time would inevitably have to be spent on additional monitoring and regulation. Over-inspection can become unfocused, burdensome and ineffective.

As standards in schools are already rigorously monitored, the opportunity to reduce the requirement for twice yearly inspections by the Care Commission would be welcome, provided always that the relevant checks had been undertaken.

Scottish Council of Independent Schools
May 2005

SUBMISSION FROM SCOTTISH NURSING GUILD

Thank you for offering us the opportunity to respond to these proposals.

As I understand it the amendment intends to allow the Executive to reduce the frequency of inspections of care services by the Care Commission.

The Scottish Nursing Guild does not support a less regular regime of inspection. In fact we feel strongly that certainly more rigorous and thorough inspections would safeguard service users and other health workers throughout Scotland, by ensuring the validity and quality of those nurses and carers sent to care for vulnerable people. We would in fact support an inspection regime in line with
that currently operated in England which is a two day process including detailed interviews with service users and nurses, and thorough inspection of recruitment and placement policies.

Once again thank you for this opportunity, and if I can be of any further assistance please do not hesitate to contact me.

Sara James

Operations Director
Thornbury Nursing Services and the Scottish Nursing Guild

SUBMISSION FROM SCOTTISH PARTNERSHIP FOR PALLIATIVE CARE

The Scottish Hospices Forum operates under the auspices of the Scottish Partnership for Palliative Care and represents all of the voluntary hospices in Scotland, which are registered by the Care Commission.

As they all provide a 24-hour service the hospices are currently subject to one announced and one unannounced inspection per year.

In 2004 the hospices all had to register their community based clinical nurse specialist services delivered from the hospice separately from the hospice as a Care at Home Service, complying with a separate set of standards to those which apply to the hospices. The Care Commission have agreed that the hospice and Care at Home inspections will be carried out jointly, therefore not increasing the number of inspections to the hospices.

Nevertheless, while this legislation is under review, we would urge the Scottish Parliament to reconsider the requirement to register this service separately. Care at Home is provided by the hospices as an integrated part of the hospice provision and the hospice standards were written with due consideration to the home care service. The Care at Home standards are not applicable to the hospice care at home service, although the Scottish Hospice Forum acknowledges the efforts to which the Care Commission has gone to match the standards to our home care services. The Scottish Hospices Forum would strongly urge the Scottish Parliament to dispense with separate registration of hospice home care services.

The Scottish hospices welcome the introduction of regulation and inspection as a means of assuring quality of care and service delivery. The Scottish Hospices Forum welcomes the positive approach of the Care Commission to work in partnership with the Forum to ensure that the inspection process is as relevant to hospices as possible and recognises that the introduction of the hospice standards has resulted in improved patient care.

The voluntary hospices are all small organisations, the largest having only 36 beds and approximately 150 staff. The majority of the staff are employed to deliver direct patient care, with minimal management, administrative and support staff.

The time required to prepare for and undergo an inspection is considerable and has a significant impact on the hospices’ ability to continue to provide care for patients during this time.

For an announced inspection a Pre-Inspection Return (PIR) has to be returned to the Care Commission in advance of the inspection. This requires the equivalent of one whole time senior clinical person for an entire week to be removed from the ward to complete the documentation. On the day of the inspection staff leave is cancelled where possible and additional staff have to be brought in to cope with normal activities, such as planned patient admissions, ward rounds and case conferences. Support activities such as staff training are suspended as it is impossible to give the time to the inspection team and do these things.

Unannounced inspections can take place at any time of day or night. During the day hospices are busy places with an average of 2 deaths, 2 discharges and 4 admissions every day (at least in the larger hospices). This means that there are always patients coming and going for admission,
discharge, hospital appointments for investigations etc. Families are in and out of the building all day, often in distress. This all requires staff time to deal with this activity. Resources dictate that staffing levels are appropriate to the level of expected activity which means that there are no spare staff available to cope with the inspection team. Often the manager will be out of the building at the time of an unannounced inspection, meaning that front line staff are taken away from caring for patients to support the inspection team.

For these reasons the Scottish Hospice Forum would warmly welcome the removal of the requirement for 2 Care Commission inspections per year. We would like to see a system where each service completes an annual PIR with the Care Commission visiting services at their discretion, prioritising based on need, recognising the right of the Care Commission to visit at any time in the event of a complaint or any other reason that gives rise to cause for concern.

SUBMISSION FROM THE SCOTTISH PRE-SCHOOL PLAY ASSOCIATION

Background

SPPA is Scotland’s largest voluntary sector provider of direct support services to community led childcare organisations, covering the length and breadth of the country, delivering essential support and guidance services to providers of pre-school education and childcare services, including all-day care groups, playgroups, parent and toddler groups and under-fives groups in Scotland.

Section 25 Regulation of Care (Scotland ) Act 2001

SPPA takes the view that the Care Commission’s inspection of day care services should be maintained at one per year.

The reasons for this are:

- It currently takes three years through a rolling programme of inspection, for day care services to be fully inspected against the National Care Standards. Also, this applies if services are in partnership with local authorities to deliver pre-school education, against HMI Education standards. The consequence of changing the frequency of inspection to less than one per year, reduces the likelihood of all the standards being fully inspected in the three year time scale.

- Annual inspections help to ensure that minimum standards are maintained. They help to support development planning and action for quality improvements.

- Many day care services in the voluntary sector are vulnerable to frequent changes in management and/or staff. Lengthening the time between inspections may contribute to a diminution of the quality of service.

Ian McLaughlan
Chief Executive
Scottish Pre-school Play Association

SUBMISSION FROM SCOTTISH SOCIETY FOR AUTISM

Thank you for your mail asking for views in respect of the above. I would offer you the following comments in respect of the proposals to vary the inspection regime as is stands at present. In principle the Scottish Society for Autism welcomes the idea of reducing the inspection schedule. This should lead to less bureaucracy and enable more time to be spent on direct service provision. Subject to the development of alternative activity that supports the development and monitoring of quality a reduction in administrative activity should be beneficial.

It may be worth developing discussion on what might replace annual inspection. It would be of interest to the Society to participate in discussion that might explore the possibility of self evaluation/validation.
approaches that could be monitored through audit by the Care Commission on a two or three yearly basis. There may be lessons to learn from similar approaches that have been developed in the academic world in relation to the validation of Degree level courses.

It would be important to consider the means and criteria by which “failing” services would be identified. The relationship of local authority activity such as contract compliance and audit measures would also need to be considered in discussion to ensure that the removal of annual inspection does not undermine the process of managing quality. The fundamental idea however is welcome. Further discussion would be needed on how to take this forward in respect of issues such as self assessment/validation, longer term audit/monitoring arrangements and avoidance of duplication of local authority activity.

John McDonald
Chief Executive

SUBMISSION FROM THE SUPPORTING PEOPLE ENABLING UNIT

Most housing support providers deliver services that will be subject to inspection by the Care Commission. They have a keen interest therefore, in the legislation and rules that govern the Care Commission’s inspection process.

In putting together this response the Unit has been assisted by three providers.

The providers included:
- 1 large housing association
- 1 medium sized voluntary organisation providing floating support and supported accommodation
- 1 small organisation providing supported accommodation

The Unit asked each provider to comment on the potential advantages and disadvantages for providers of housing support services if the Care Commission had greater discretion on how often inspections of housing support services take place.

Housing Support Services
A wide range of services now fall within the Care Commission’s remit as housing support services, for example, refuges for women fleeing domestic violence, temporary accommodation for people who are homeless and resettlement visiting support services. All services registered as housing support services will be inspected this year for the first time. The inspection process is currently being finalised after initial pilot inspections were carried out at the end of 2004.

Annual inspections can help establish working relationships
Providers have indicated that they anticipate developing a good working relationship with the Care Commission and have been enthusiastic about participating in the development of an appropriate inspection process. They consider annual inspections to be helpful in the first few years of the new regulatory framework in establishing good relationships with the Care Commission.

Discretion may make sense in the future
As both providers and the Care Commission grow in their experience of housing support regulation and inspection it may be appropriate to inspect some services less than once a year. On this basis, providers that the SP Enabling Unit has contacted, broadly support the amendment.

Regulatory and commissioning bodies
Providers frequently express a desire to see the various regulatory and commissioning organisations working together more effectively to avoid duplication. Some providers of housing support are currently inspected by Communities Scotland, local authorities, H.M.O, Licences, Fire master, Environmental Health and the Care Commission as well as complying with their own policies and procedures. This is a heavy burden on housing support providers, and particularly so for low cost, lower level housing support services such as sheltered housing for older people.
Providers of housing support services are keen that local authorities should refer to the Care Commission inspection reports to determine that services meet National Care Standards rather than duplicate the Care Commission’s role. For the proposed amendment to be implemented satisfactorily some arrangements should be put in place whereby local authority commissioners of housing support are brought on board with any decision not to inspect a particular service every year.

About the SP Enabling Unit
The Supporting People Enabling Unit assists and supports independent service providers in the implementation of the Supporting People Programme. The Unit is hosted by Community Care Providers Scotland and by the Scottish Federation of Housing Associations and is funded mainly by the Scottish Executive.

SUBMISSION FROM YOUTH ADVOCACY GROUP (EAST AYRSHIRE)

On behalf of our group I would like you to note our concerns around the proposed reduction in inspections. We feel that there are not enough impromptu visits as it is, reducing the overall number is worrying for us. People in these situations are very vulnerable, often can't articulate there concerns and therefore should be protected by intense monitoring of services.

Shelagh Convery
Youth Advocacy Group (East Ayrshire)
1st Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 9 to 36 Schedules 2 and 3
Sections 1 to 5 Schedule 1
Sections 6 to 8 Section 37
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 9

Mrs Nanette Milne
23 Leave out section 9

Section 10

Mrs Nanette Milne
24 Leave out section 10

After section 10

Mrs Nanette Milne
25 After section 10, insert—

<Uptake of oral health assessments and eye examinations
In making any kind of arrangements under the 1978 Act or arrangements for pilot schemes under Part I of the National Health Service (Primary Care) Act 1997 (c.46) which include the provision of oral health assessments and dental checks or eye examinations and sight tests free of charge, every Health Board must ensure that those categories of persons who would, before 1st April 2006, have been entitled to receive dental examinations or sight tests free of charge are encouraged to attend at appropriate intervals for oral health assessments and eye examinations.>

Kate Maclean
26 After section 10, insert—

<Eye examinations and dental inspections of school pupils
In section 39 (medical and dental inspection, supervision and treatment of pupils and young persons) of the 1978 Act—
(a) after subsection (2) insert—
“(2A) It is also the duty of the Scottish Ministers to provide, to such extent as they consider necessary to meet all reasonable requirements—

(a) for the carrying out of eye examinations, including where clinically necessary testing of sight, for such pupils and young persons as are mentioned in subsection (1);
(b) for their ophthalmic treatment; and
(c) for their education in ophthalmic health.

(2B) The Scottish Ministers must, in carrying out their duties under subsections (2) and (2A), ensure that dental inspections and eye examinations are provided to all pupils in the first year of primary education and the first year of secondary education.”;

(b) in subsection (3), after “subsection (2)”, insert “and ophthalmic treatment made available for the purpose of subsection (2A)”;

(c) in subsection (4), after “subsection (2)”, insert “and for the eye examination, ophthalmic treatment and education described in subsection (2A).”.

Section 12

Rhona Brankin
Supported by: Mr Andy Kerr

2 In section 12, page 7, line 5, at end insert—

<( ) after the words “dental practitioner” insert “or body corporate”>

Section 14

Rhona Brankin
Supported by: Mr Andy Kerr

4 In section 14, page 7, leave out line 27

Rhona Brankin
Supported by: Mr Andy Kerr

5 In section 14, page 7, line 33, at end insert <;

( ) the definition of “pharmaceutical list”, and the immediately preceding “and”, are repealed>
Section 15

Rhona Brankin
Supported by: Mr Andy Kerr
6 In section 15, page 8, line 14, leave out <the first part> and insert <either part (or both parts)>

Rhona Brankin
Supported by: Mr Andy Kerr
7 In section 15, page 8, line 14, leave out <within the part>

Mrs Nanette Milne
27 In section 15, page 8, line 36, at end insert—

<(  ) If regulations under subsection (2A) make provision such as is mentioned in paragraph (j) of that subsection in respect of applicants for inclusion, provision must also be made for the same disclosure of information to be required (on the same timescale) in respect of persons on any previous list of persons undertaking to provide general dental services.>

Rhona Brankin
Supported by: Mr Andy Kerr
8 In section 15, page 8, line 37, after <that> insert <—

(  ) a dental practitioner who, and a body corporate referred to in subsection (1) which, undertakes to provide general dental services under arrangements with a Health Board may not provide such services unless his name or, as the case may be, the body corporate’s name is included in the first part of the Board’s list referred to in subsection (2)(a);>

Section 17

Rhona Brankin
Supported by: Mr Andy Kerr
9 In section 17, page 10, line 11, leave out <the first part> and insert <either part (or both parts)>

Rhona Brankin
Supported by: Mr Andy Kerr
10 In section 17, page 10, line 11, leave out <within the part>

Mrs Nanette Milne
28 In section 17, page 10, line 33, at end insert—

<(  ) If regulations under subsection (2A) make provision such as is mentioned in paragraph (j) of that subsection in respect of applicants for inclusion, provision must also be made for the same disclosure of information to be required (on the same timescale) in respect of persons on any previous list of persons undertaking to provide general ophthalmic services.>
Rhona Brankin
Supported by: Mr Andy Kerr

11 In section 17, page 10, line 34, after <that> insert <—

( ) a medical practitioner or ophthalmic optician who undertakes to provide
general ophthalmic services under arrangements with a Health Board
may not provide such services unless his name is included in the first
part of the Board’s list referred to in subsection (2)(a)(i);>

Section 18

Rhona Brankin
Supported by: Mr Andy Kerr

15 In section 18, page 11, line 37, leave out <a document to be known as>

Section 19

Rhona Brankin
Supported by: Mr Andy Kerr

16 In section 19, page 14, line 18, at end insert—

<( ) The Scottish Ministers must publish directions given by them under subsection
(1) in the Drug Tariff or in such other manner as they consider appropriate.>

Rhona Brankin
Supported by: Mr Andy Kerr

17 In section 19, page 14, line 27, at end insert—

<( ) provide that the Scottish Ministers may give directions as to the manner in which,
and the standards to which, services must be provided;

( ) make provision as to—

( )>

Rhona Brankin
Supported by: Mr Andy Kerr

18 In section 19, page 15, line 16, leave out from <any> to end of line 19 and insert <directions for
the time being in force given by the Scottish Ministers under regulations under subsection (1).>

After section 19

Rhona Brankin
Supported by: Mr Andy Kerr

19 After section 19, insert—
After section 17V of the 1978 Act (as inserted by section 19 above), insert—

“Drug Tariff

17VA Drug Tariff

(1) The Scottish Ministers must prepare, maintain and publish a document (to be known as the “Drug Tariff”).
(2) The Scottish Ministers—
   (a) must include in the Drug Tariff, such information relating to pharmaceutical care services as may be prescribed;
   (b) may include in it such other information relating to such services as they consider appropriate.”.

Section 20

Rhona Brankin
Supported by: Mr Andy Kerr
20 In section 20, page 16, line 2, leave out <17V> and insert <17VA>

Rhona Brankin
Supported by: Mr Andy Kerr
21 In section 20, page 16, line 2, leave out <19> and insert </Drug Tariff>.

Section 22

Rhona Brankin
Supported by: Mr Andy Kerr
12 In section 22, page 18, leave out lines 28 to 30

After section 26

Rhona Brankin
Supported by: Mr Andy Kerr
1 After section 26, insert—

<Frequency of inspection of care services under the 2001 Act

(1) The 2001 Act is amended as follows.
(2) In section 25 (inspection of registered care services), after subsection (5) insert—

“(5A) The Scottish Ministers may, after consulting the Commission and thereafter such other persons (or groups of persons) as they consider appropriate, by order amend—

(a) subsection (3)(a) above by substituting for “twelve months” in either or both sub-paragraphs (i) and (ii) a different period (being a period which is not less than twelve months);
(b) subsection (5) above by substituting for “twelve months” in either or both paragraphs (a) and (b) a different period (being a period which is not less than twelve months).

(5B) An order under subsection (5A) above may make different provision for different purposes.”.

(3) In section 78 (orders and regulations), in subsection (2)(b), after the word “3” insert “or 25(5A)”.>
Rhona Brankin
Supported by: Mr Andy Kerr

31 In section 37, page 32, line 5, leave out <and 35> and insert <, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36>

Rhona Brankin
Supported by: Mr Andy Kerr

32 In section 37, page 32, line 5, after <schedule 1> insert <and paragraph 1(1A) and (1C) of schedule 2>
Smoking, Health and Social Care (Scotland) Bill

Groupings of Amendments for Stage 2 (Day 1)

Free oral health assessments and eye examinations
23, 24

Uptake of oral health assessments and eye examinations
25

Oral health assessments and eye examinations of school pupils
26

Extension of general dental services to bodies corporate
2

Definition of ‘carrying on the business of dentistry’
3, 12, 13, 14

Removal of pharmaceutical care services from existing contractual arrangements
4, 5

Sub-division of dental and ophthalmic lists
6, 7, 9, 10

Disclosure of information for those already on lists
27, 28

Confirmation that main contractors must be on lists
8, 11

The drug tariff
15, 16, 19, 20, 21, 22

Pharmaceutical care services contracts: directions
17, 18

Frequency of care commission inspections
1

Minor and consequential amendments
29, 30, 31, 32
AMENDMENT GROUP 4: Extension of general dental services to bodies corporate
AMENDMENT NO: 2

- This amendment concerns the description of those who may undertake general dental services under section 25(1) of the 1978 Act. It clarifies that, in addition to a dental practitioner, a body corporate (or dental corporation) may also provide dental services.

AMENDMENT GROUP 5: Definition of “carry on the business of dentistry”
AMENDMENT NOS: 3, 12, 13 and 14

- These amendments create a single definition of what “carrying on the business of dentistry” means in terms of the 1978 Act. They do this by inserting a single definition at section 108 of the 1978 Act. Amendments 3 and 12 omit existing definitions in the Bill (sections 12(b) and 22(3)(e) respectively). These are replaced by amendment 13 which inserts a single definition of “carrying on the business of dentistry” in section 108 (interpretation) of the 1978 Act. This will apply to all the references to “carrying out the business of dentistry” in the 1978 Act.

- Section 12(b) of the Bill has the effect of repealing existing section 25(3) of the 1978 Act, which provides restrictions on the remuneration paid to dental practitioners. The omission of section 12(b) (by amendment 3 above) makes it necessary to insert a repeal of s25(3) in schedule 3 (repeals) of this Bill. This is achieved by amendment 14.

AMENDMENT GROUP 6: Removal of pharmaceutical care services from existing contractual arrangements
AMENDMENT NOS: 4 and 5

- These amendments are consequential on the provision in Part 3 of the Bill that introduces new arrangements for the provision of pharmaceutical care services.

- Amendment 4 removes a reference in section 17AA of the 1978 Act to the provision of services to a Heath Board or other health service body by a person on a pharmaceutical list. This is because the provisions in Part 3 introduce new contract arrangements for the provision of pharmaceutical care services which, at new section 17V, provide for the service contracts to be classed as NHS Contracts. Section 17AA makes a similar provision and is, therefore, redundant. Amendment 5 is consequential on amendment 4 and removes the definition of “pharmaceutical list” from section 17AA. This definition is made unnecessary by amendment 4, which takes persons on a pharmaceutical list out of that section.

AMENDMENT GROUP 7: Sub-division of dental and ophthalmic lists
AMENDMENT NOS: 6, 7, 9 & 10
These amendments are concerned with allowing regulations to provide for subdivisions in either part of the lists of persons who provide or are approved to assist in the provision of general dental and general ophthalmic services.

Amendments 6 and 7 ensure that regulations under section 25(2A) of the 1978 Act can sub-divide either part of the list of those providing or who are approved to assist with the provision of general dental services. Amendments 9 and 10 mirror these provisions in section 26 (2A) of the 1978 Act in relation to general ophthalmic services.

**AMENDMENT GROUP 9: Confirmation that main contractors must be on lists**

**AMENDMENT NOS: 8 and 11**

These amendments clarify that regulations may provide that those who provide general dental or general ophthalmic services may be required to be included in a Health Board’s list.

Amendment 8 concerns the providers of general dental services. It amends section 25(2B) as it is inserted into the 1978 Act by section 15 of the Bill to provide that regulations may require that a dental practitioner or dental corporation may not undertake to provide general dental services under arrangements with a Health Board unless his or her name or its name is included in the first part of the Board’s list.

Amendment 11 concerns the providers of general ophthalmic services. It amends section 26(2B) as it is inserted into the 1978 Act by section 17 of the Bill to provide that regulations may require that a medical practitioner or ophthalmic optician may not undertake to provide general ophthalmic services under arrangements with a Health Board unless his or her name or its name is included in the first part of the Board’s list.
Smoking, Health and Social Care (Scotland) Bill: The Committee took evidence on the frequency of Care Commission inspections from——

Helena Scott, Equalities Policy Officer, Age Concern Scotland
Andy Sim, Health and Community Care Policy Officer, Age Concern Scotland
Alan Dickson, Chief Executive, Capability Scotland
Annie Gunner, Director, Community Care Providers Scotland
Councillor Eric Jackson, Social Work and Health Improvement Spokesperson, COSLA
Bob Christie, Corporate Advisor, COSLA
Lesley Aitkenhead, East Lothian Community Care Forum
Susan Munroe, Deputy Chairman, Scottish Partnership for Palliative Care
Will Mallinson, Manager, Edinburgh Advocacy and Representation Service (EARS) Independent Advocacy Service for Older People
George Hunter, Chair, Community Care Standing Committee, Association of Directors of Social Work
Adam Rennie, Head, Community Care Division, Scottish Executive Health Department
Linda Gregson, Head, Care Standards and Sponsorship Branch, Scottish Executive Health Department
Jacquie Roberts, Chief Executive, Care Commission
David Wiseman, Director of Strategic Development and Depute Chief Executive, Care Commission.

Witnesses representing user groups agreed to provide information on incidents where older people in residential care homes have been evicted or threatened with eviction as a result of lodging complaints.
Smoking, Health and Social Care (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 1).

The following amendments were agreed to (without division): 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11.

The following amendments were disagreed to (by division)—
   23 (For 1, Against 8, Abstentions 0)
   24 (For 1, Against 8, Abstentions 0)

Amendments 25, 26 and 27 were moved and, with the agreement of the Committee, withdrawn.

Amendment 28 was not moved.

Sections 9, 10, 11, 13 and 16 were agreed to without amendment.

Sections 12, 14, 15 and 17 were agreed to as amended.

The Committee ended consideration of the Bill for the day, amendment 11 having been disposed of.
Scottish Parliament  
Health Committee  

Tuesday 17 May 2005

[THE CONVENER opened the meeting at 14:00]

Smoking, Health and Social Care (Scotland) Bill

14:01

The Convener: Item 2 is oral evidence on the Smoking, Health and Social Care (Scotland) Bill. Ministers have lodged a stage 2 amendment to allow a variation of the frequency at which the Scottish Commission for the Regulation of Care is required to carry out inspections. A Scottish Parliament information centre briefing setting out the current inspection requirements has been circulated to members. The provision was not included in the bill when we considered it at stage 1, so the committee has decided to take some evidence today, given the nature of the amendment.

We are taking evidence in round-table format, which we have done successfully before, and we have representatives from a number of organisations with an interest in the proposal. All the witnesses are detailed on the agenda, and I welcome every single one of you to the meeting. You may not have participated in a round-table discussion before, but I assure you that it is relatively painless. Written submissions from the organisations that are giving evidence today, and a range of others, have been circulated, and I draw everyone's attention to the round-table introductory paper, which sets out the procedure for the session. There is also a seating plan, so that you can tell at a glance who the folk you are looking at are.

I thank all the witnesses for coming at such short notice, which was not something over which we had any control but was dictated by the arrival of the Executive amendment and the way in which the stage 2 process moves. We were unable to give longer notice, so thank you.

I shall ask the witnesses in turn to indicate whether they represent care providers or consumers—although I know that some represent both at the same time—and to give their view of the proposal. I specifically do not want speeches. However short you think your speech is, that is not what I am looking for. I am not looking for anything more than a couple of sentences—a paragraph at most—to say which side of the divide you are on and what your general view is of the amendment that has been lodged. I shall work through the witnesses on the basis of the order in which they appear on the agenda. A couple of organisations have two representatives at the table; I shall ask those organisations to nominate just one person to respond at this stage.

Once that is over, I shall invite questions from committee members and/or comments from other
witnesses. This is meant to be a slightly more free-flowing event than the straightforward question-answer format, so witnesses are invited to take up an issue with one of the other witnesses directly, rather than sitting back and waiting for committee members to ask questions.

We will invite the Scottish Executive and the Scottish Commission for the Regulation of Care to respond to the issues that participants identify, although that will happen more towards the end of the process.

I ask either Helena Scott or Andy Sim from Age Concern Scotland to start off by commenting very briefly on the organisation's reaction to the amendment.

Andy Sim (Age Concern Scotland): Age Concern Scotland, which represents consumers, is against the amendment, because it could erode some of the protection that is currently available to care home residents. Our response focuses particularly on care homes.

Alan Dickson (Capability Scotland): I represent a care provider. Although we appreciate the need to husband scarce resources, we are concerned that the proposal might represent a step backwards just when confidence is growing in the current system.

Annie Gunner (Community Care Providers Scotland): Community Care Providers Scotland represents almost 60 independent service providers in the voluntary sector. It is fair to say that the membership has mixed views on this matter. On the whole, the prevailing view is one of "Yes, but". We would like the measure to be implemented, but we also want a series of additional measures to be introduced to mitigate unanticipated consequences.

The Convener: I ask one of the two representatives from the Convention of Scottish Local Authorities to give us a brief comment.

Councillor Eric Jackson (Convention of Scottish Local Authorities): I am pleased to represent local government in this afternoon's discussion. Local government is both a provider and a procurer and, as our written evidence makes clear, we are broadly in favour of the minister's proposals because they will help to target resources at where they are needed. However, our submission contains a couple of caveats.

The Convener: We move next to Lesley Aitkenhead from the East Lothian community care forum.

Lesley Aitkenhead (Scottish Community Care Forum): Although I am from East Lothian, I am representing the Scottish Community Care Forum this afternoon. We are against the proposals. We feel that both visits should be retained, because they are essential and serve different purposes.

Susan Munroe (Scottish Partnership for Palliative Care): I represent Scottish hospices in the voluntary sector. We unanimously support the proposals, because the care commission's limited resources should be targeted at where they are really needed: improving the quality of care.

Will Mallinson (EARS Independent Advocacy Service for Older People): We have consulted advocacy services in Glasgow, greater Glasgow and Fife on this matter and feel that we are against anything that would reduce the meaningfulness of inspections. However, we would go with the proposals if there were caveats.

George Hunter (Association of Directors of Social Work): Like Annie Gunner, we broadly welcome the proposal, but take a "Yes, but" view of it. Although we accept the amendment, we seek certain conditions with regard to where and how risk assessment processes would be carried out.

The Convener: We are also joined by two representatives from the care commission.

Jacquie Roberts (Scottish Commission for the Regulation of Care): The care commission is in favour of the amendment, because it wishes to improve safeguards for people who use care services. We believe that having greater flexibility to target resources at services that are not providing a certain level of care will enhance the commission's ability to provide scrutiny.

The Convener: Now that everyone knows where everyone stands, we will move to the discussion of the amendment. It appears that the consumers are unhappy with the proposal; that the providers are happy with it; and that a few folk are ambivalent or take a "Yes, but" view.

Kate Maclean (Dundee West) (Lab): I will ask the Scottish Executive witnesses some general questions that refer to something that the convener said in her opening remarks. Why are the measures being introduced in an amendment at stage 2 instead of having been included in the bill as introduced? The amendment is substantial and would require more consultation and discussion than many measures that are in the bill already. Exactly what is being proposed? What will the new framework be? Because we have not had much time to consider the amendment, I am a bit confused about that. Does the Scottish Executive envisage that the new framework will be cost neutral, that it will cost more or that it will cost less? It is important that those issues be fleshed out, because we have not had the same opportunity to scrutinise the amendment that we had for other parts of the bill.
Adam Rennie (Scottish Executive Health Department): On the timing, the important point is that the regulatory system is relatively new, and the need for the proposed measure did not crystallise until it was too late to get it into the bill as introduced. However, ministers felt that it was sufficiently important to introduce it as an amendment at stage 2 rather than hang on until the next legislative opportunity, as we do not know when that might be. Ministers thought that the bill provided a good opportunity to make this important change at an early date.

It is essential to bear in mind the fact that the Parliament and the public will have ample opportunity to comment on any proposed changes when the power in question is exercised. If the committee agrees to the amendment, that will change nothing in itself, because any changes in inspection frequencies would be subject to consultation with the commission, inspection with the general public and, finally, affirmative resolution in the Parliament. The amendment would introduce a new power, but it would not do anything specific until it was used.

I do not know whether that answers your question.

Kate Maclean: You did not answer the question about costs.

Adam Rennie: I am sorry; I answered your first question, and your second question was about the new framework.

At present, the Regulation of Care (Scotland) Act 2001 specifies the frequency with which the care commission must inspect care services. It distinguishes between services that provide 24-hour accommodation, such as care homes and hospitals, and other services, such as pre-school provision or housing support services, for which the inspection frequency is once a year. The amendment would enable ministers to make an order to reduce that frequency for specified care services or specified parts of care services. That order would then be subject to the consultation procedure that I described.

Kate Maclean: Why would ministers want to decrease but not increase the current statutory frequency of inspection? Would bodies that are opposed to the amendment not think that it could work either way? At the moment, the amendment seems to be about taking something away; it is not about varying the frequency in favour of those who receive care.

Adam Rennie: The point about the statutory minimum frequency is that it is a minimum that the commission is obliged to deliver regardless of the circumstances. It can always inspect more frequently at any time if it has concerns. Therefore, ministers did not think that it was necessary to introduce any provision to increase the minimum frequency but, unless there is a provision that enables ministers to reduce it, the care commission will always have to inspect every care service at the specified minimum frequency. There is no problem with the commission inspecting more often if that seems the appropriate thing to do.

Kate Maclean: However, ministers would not be able to increase the frequency by order, although they are giving themselves the power to decrease the current statutory minimum frequency.

14:15

Adam Rennie: That is right, but ministers have powers of direction and, in principle, they could direct the care commission to inspect care services more frequently. At present, we cannot direct the care commission to inspect less often than the statutory minimum frequency, because ministers cannot tell the commission to break the law.

The amendment does not necessarily have any impact on costs. When the power is exercised, it will enable the commission to target its available resources more effectively at care services. In principle, it would be possible for the commission to reduce the resources available in response to a reduced frequency of inspections, but that would defeat the object of the exercise, which is to enable the commission to increase its input into the services that need more resources. In principle, the measure is cost neutral. It could lead to changes, but it need not do so.

The Convener: A significant cost issue has been raised in evidence from a number of organisations. It has been said that the good providers, which are inspected less regularly, will have to pay for the not-quite-so-good providers that you will want the commission to inspect more often. Consequently, there will be detriment to good providers.

Adam Rennie: What you describe already happens under the present regime. The commission inspects various service providers at more than the minimum frequency, but all providers pay it the same registration fees, annual continuation fees and so on. If the amendment were agreed to and the power were exercised, it is likely that cross-subsidising would increase in affected care services, because there would be more headroom for the commission to inspect some providers more frequently, while keeping the others at the new, lower minimum frequency. There is nothing intrinsically new in that—the principle is already established. It is important to make the point that the annual continuation fee covers a great deal more than inspection. It also...
investigating complaints and more time with the

**Susan Munro:** The cost to some of the smaller organisations of preparing for and undergoing an inspection is not insignificant. The savings from not having to do that twice a year will balance out the feeling that good providers are subsidising poor services.

**Annie Gunner:** This is a significant issue for members of Community Care Providers Scotland. Although I agree with Adam Rennie that cross-subsidising already happens, we believe that the amendment stretches it to breaking point. Fees are paid annually, so if there are to be inspections at a less than annual frequency, we may end up paying a fee for no activity. That undermines the Executive’s policy on fees. All the regulatory impact assessments that were produced said that fees are based on the level of activity that a provider receives, on a value-for-money basis. I agree that cross-subsidising is nothing new, but our opposition to it is not new either. When the committee discussed the original provision, many of the same issues were raised. I do not want to hijack the entire discussion, because there are other matters that we need to consider, but this is a significant issue.

**David Wiseman (Scottish Commission for the Regulation of Care):** We want to make it clear that, if a provider does not have an inspection because a risk assessment determines that it does not need so many inspections, that does not mean that there will be no activity or contact. We will require all care services, regardless of the frequency with which they are inspected, to be subject to an annual assessment. When carrying out risk assessments, we will need to consider providers’ performance and the improvement that they have made. We will also need to take account of the views of service users. That will not be done through inspection visits. In the case of some services, such visits are not required, because the services are provided in people’s homes. Visiting the office of an agency that provides a service does not tell us what the service user is engaged in. We will also consider issues such as how many complaints there were. There will be complaints investigations even against services that are assessed as performing well in inspections.

**Jacquie Roberts:** I want to summarise. Inspection is only one part of the activities that we undertake, and it is dangerous to assume that we scrutinise services only through inspection. It is important to take a broader view of our activities. We would not support the proposal if we did not think that increased flexibility in the inspection regime will enable us to spend more time investigating complaints and more time with the people who use care services. To use the words that Mr Mallinson used, what we are after is more meaningful scrutiny. The proposal is not about reducing any form of scrutiny; it is about targeting more wisely and meaningfully and spending more time with the people who use care services.

It is also important to register that we cover many different types of services and not simply care homes. We might not recommend at this stage that we go any less frequently into care homes, particularly care homes for older people, because there is a higher rate of breaches of regulations in such homes. We seek flexibility across services, which will mean that, instead of undertaking routine activity, we can spend our time carrying out scrutiny that really matters and getting in touch with the people who really matter—the people who use the services.

**The Convener:** Under the new regime, might there be services that will go for a whole year with no inspection?

**Jacquie Roberts:** That could be the case, but we would recommend that only on the basis of a risk assessment, one element of which would be consideration of whether another scrutiny body was going in. For example, Her Majesty’s Inspectorate of Education inspects day care services for children. Under the proposals, we will be able to create a much more intelligent regime and, as David Wiseman pointed out, we will still receive information from those services.

**Alan Dickson:** What Jacquie Roberts says makes remarkable sense, but we would have preferred a fuller evaluation of all the powers and responsibilities of the care commission rather than just one element—the frequency of inspections—being drawn out. We do not wish to see the creation of multiple tiers of and timescales for inspection. In particular, we do not want a system in which a less frequent inspection regime applies to a whole organisation. The regime must be based on individual services. As a large voluntary care provider, we provide a huge number of services and the system needs to be associated with each of those services individually rather than with the organisation as a whole.

**Janis Hughes (Glasgow Rutherglen) (Lab):** As we heard from the Health Department, the amendment does not seek to change the frequency of inspections but it will give ministers the power to do so, if they wish, after consultation with the care commission and any other relevant persons. Will that be done on the basis of one organisation, one home or one facility? An important point has been raised about who will make the decision and how wide it will be.

**Adam Rennie:** The consultation duty will fall on ministers and the first consultation will be with the
care commission—that is clear. The next consultation is the one that you are asking about. The Executive has a standard procedure for consulting a wide range of organisations and individuals and we use that procedure for all sorts of purposes. It is standard procedure for legislation to provide that ministers must consult such persons as they consider appropriate.

Our intention would be to consult all the representative organisations that we know about in relation to the service concerned. Obviously, that will vary from service to service. In some cases large numbers of users will be involved but, in others, the service might be specific to a small group of users. It is not possible to say categorically exactly how we will consult, but our intention will be to ensure that when ministers come to the Parliament with an order there has been enough time for everyone who has input to make to have done so. If we fail to do that, the Parliament, if it thought that the consultation had not been adequate, could use the affirmative resolution procedure to say to ministers, “No, that won’t do. You will have to go and think again.”

George Hunter: I have a question for Jacquie Roberts. Would the care commission take into account the other performance monitoring arrangements that are already taking place? I am picking up a point that was made by Community Care Providers Scotland about local authorities stepping up inspections if the commission was stepping down. Inevitably, local authorities have some responsibilities in relation to the protection of vulnerable people and the proper scrutiny of how the public pound is spent, and there is scope for the care commission to take more account of other performance monitoring processes that might already be in the system. Rather than simply duplicate those processes, the commission could be more co-operative in its approach.

Jacquie Roberts: That is precisely what we wish to do. We would base our risk assessments on existing knowledge of the types of service—that would be one level of risk assessment—and on individual services. We have a number of questions—which David Wiseman could read out to you—about the sort of risk assessments that we would be considering. We would take information from the local authorities, from the care managers and from other scrutiny bodies. The new Social Work Inspection Agency would have information about services delivered in a given area. That is the whole point. Any consultation would have to include not only the providers but other stakeholders in the commission of services, particularly the people who use the care services to ensure that they feel that they can still make complaints to the care commission if they have concerns about the service.

One of the big issues about having to devote so much time to inspection activity is that that can distract from pursuing and investigating complaints in depth, and from following up what needs to be followed up from those complaints. We are stuck to a level of activity and inspections that may not be targeting our time where it should be targeted.

Will Mallinson: I want to ask the care commission what is happening to the recruitment and role of lay inspectors.

David Wiseman: We are in the middle of a pilot of the lay inspection process, and we have piloted the use of lay inspectors in a number of areas in the care commission and in a number of different types of care services. When the care commission came into being, we inherited a position in which the use of lay inspectors had not been consistent throughout the country. We are trying to find the best model for involving lay people in the inspection process. The early indications from the pilot are that lay inspectors bring a perspective to the inspection that adds to the process. As well as bringing an extra dimension to inspection, lay inspectors have been very much accepted by care providers. However, we cannot yet fully evaluate the pilot.

The Convener: From the inspections that you have done so far, what percentage flag up issues that you think need to be pursued? What percentage would you designate non-problematic? We will not hold you to the figures; we are just looking for a broad-brush, across-the-board idea.

Jacquie Roberts: I can give you three broad-brush figures from samples. From the sample of care homes for older people, we would be looking at following up 45 per cent of homes because they are not meeting all the regulations. We make requirements in the report and ask care homes to submit an action plan. For childminders, the figure is about 44 per cent, whereas for day care for children it is only 18 per cent. That shows already that we could reduce the frequency of inspections for some of the services that we regulate. As I said, at the moment we are not recommending any change in the frequency of inspections in care homes for older people or for childminders—we would also be considering the vulnerability of the age groups and the vulnerability of the people concerned. We are looking for greater flexibility to work more intelligently where it really matters.
Jacquie Roberts: It is true that the care commission board decided that we should focus our inspections for all services of a certain type on a specific number of the standards. If we have concerns about a service, we look at all the standards and regulations. That is the routine. If we inspected against all the standards all the time, that would probably take us 10 times longer. We are trying to target our attention. For example, one year we might be particularly concerned about health and safety, especially fire safety, in care homes, in which case we would devote more time in that year to looking at those issues.

The Convener: A number of people have their hands up. We will hear from Councillor Jackson, then Helen Eadie.

Councillor Jackson: My question is for Jacquie Roberts. Jacque, you have mentioned care homes for older people on a number of occasions and you said that you would not reduce the frequency of visits, on the basis that a large percentage of complaints concerned such homes. We have a particular issue with residential child care units and would like to see the number of visits maintained on the ground that they provide an opportunity to young people to speak to someone independently. What is your view on that?

Jacquie Roberts: We agree. The figures that I was talking about were about 36 per cent or 38 per cent of care homes not meeting the regulations. We agree—again on the basis of a risk assessment—that in those cases, service users are more vulnerable and need to have as much external scrutiny as possible.

The Convener: I have a related question. If one aggregates services to older people with services for those young people, what percentage does not meet the regulations?

Jacquie Roberts: There are 1,740 care homes, which account for 11.7 per cent of our registered services.

The Convener: Are those homes for older people?

Jacquie Roberts: That is all care homes—for older people, children and some adults with learning disabilities or sensory impairment.

Helen Eadie (Dunfermline East) (Lab): I note that some of the messages in the correspondence that we have received in our in-boxes about this subject are suspicious that the proposal is driven by concerns about resources rather than quality. In my local authority area, people are most concerned about the protection of vulnerable adults and children; they remember when residential homes were regulated by local authority staff and feel that we should maintain that baseline provision. I am reassured to hear that you are directing some thought towards that.

In its submission, the Scottish Association for Mental Health said that it favoured inspections based on a rewards system—for example, care homes that received an excellent inspection result for three consecutive years could receive a gold star rating and, on condition that they retained that star rating, would be inspected only once a year, for example. Such a system would motivate providers to improve standards in order to receive a gold star rating; it could be a useful tool to drive up standards. We might smile at that, but it happens in VisitScotland and across a whole range of service provision. What are your comments on that?

Jacquie Roberts: I would like David Wiseman to respond to that, because we are doing some detailed work on how we will make information about the quality of services available to providers and service users.

David Wiseman: We are in the middle of developing a framework that will allow us to look in much more detail at quality against the national care standards. It is important to measure the outcome for people who use care services. Saying that a particular care service is a one, two or three-star service might not be as useful as saying how well the service performs against quality standards. To someone wanting to use the service, some aspects of the national care standards might be more important than others. We want to know the strengths of the service and the areas in which it might have to improve, but the approach has to be a bit more sophisticated than offering one, two or three stars.

Another issue is how inspections might relate to incentives. A factor to be considered is how well an organisation is performing. The risk assessment process, about which I may be able to say more later, will consist of two tasks: one will inform our recommendations to ministers on the frequency of inspections; the other will consider individual services within that service type.

Our approach will have to recognise that, for some providers and for some service types, the frequency of inspection could be reduced. However, we have to have a way of knowing about any trigger points or changes, because a good care service or a good care sector can suddenly change. We might suddenly see a high staff turnover or a huge increase in the number of complaints about a service type. In such cases, we might—despite there being a reduction in the minimum frequency of inspections—decide to increase the frequency of inspections ourselves.

The care commission would be able to carry out random surprise inspections. It might have been
determined that the service type should have a minimum frequency of inspections of one a year or one every two years, but there would be nothing to prevent us from doing random inspections. We need to keep people on their toes so that they do not become complacent and think that inspectors will not be coming around. Unannounced random inspections often help to bring about improvements.

The Convener: How do you monitor staff turnover?

David Wiseman: We request information on staff turnover from providers. We do a pre-inspection return every year, during which we ask for details on qualifications and staff turnover. Organisations have to tell us if there is a change in manager—

The Convener: May I cut you off there? A pre-inspection return presupposes an inspection. Under the new regime, that may not happen.

David Wiseman: No. Under the new regime, we would want such information as part of the assessment process every year. As I said, we would need to have an annual assessment.

The Convener: So, you are saying that although some organisations may not get an inspection, they would still have to go through the pre-inspection.

David Wiseman: Yes.

The Convener: So a certain amount of the bureaucracy associated with inspections will continue.

David Wiseman: Some of it will continue, but bureaucracy can lead to information that is crucial to making decisions on priorities.

Annie Gunner: Self-assessments are going ahead for pre-inspection returns. Providers do that, but there is an issue over whether we should pay a significant fee for work that we do ourselves.

I wanted to pick up on a point that George Hunter made, but it is not on the topic that we are discussing now. We should let this one run.

The Convener: All right. I will bring in Shona Robison, who was, I think, involved in the original legislation that led to the status quo.

Shona Robison (Dundee East) (SNP): Yes. I wanted to make a comment before asking a couple of questions. During the passage of the Regulation of Care (Scotland) Bill, the level of inspections was a contentious issue. A number of us wondered whether the existing inspection regime would be adequate and we argued for two unannounced visits rather than one pre-arranged visit. It concerns me slightly that, within a relatively short period, we are back round the table discussing the matter.

Another issue that was raised at the time were the possible repercussions of the care commission being self-financing. Is the fact that we are now sitting round the table again one of the repercussions? Jacquie Roberts said that the care commission would like to be able to spend more time dealing with complaints but that, because of the inspection activity, it is not able to do that to the extent that it would like. That says to me that the commission is having to make a choice, when surely both roles are important. We want to ensure that the care commission is resourced to carry out both roles adequately. Is the fact that a choice is having to be made a result of the self-financing regime? Obviously, that is a ministerial policy decision and I would not expect you to comment on it specifically. However, would you not prefer it if you were able to do both things to the extent that you would wish?

Jacquie Roberts: I chose the example of the complaints and inspection activities competing because the inspection activity is a statutory requirement each year. By January, February and March, we have certain things to complete in order to meet the statutory requirement. If the number of complaints suddenly went up or if we received a serious complaint that we needed to investigate, that would inhibit our inspection activity. That is the sort of competition that I am talking about. It does not help us to look at where the risks in services really are. We have to carry out certain routine inspections, but we should not only be about routine inspections.

The issue is not about full cost recovery; it is about the intelligent use of resources, no matter how we are funded. I assume that members of the Scottish Parliament would not want to spend more and more money on scrutiny at the expense of investing in the delivery of services. We are trying to have a more targeted and intelligent scrutiny regime that helps services to improve and gets information flowing better between the providers, the regulatory body and the service users. The issue is not that we think that we should do more inspection; it is about how we do our work.

I say in response to people who are wondering about the timing that, from quite early on, the care commission and its staff have not been certain that we are doing the best, most meaningful form of scrutiny simply by carrying out inspection activity. We think that we need to look at a more rounded process that includes all the work that we do with the providers in getting the information. We also need to work with other scrutiny bodies, such as HMIE and the people in local authorities who find out information about services.
Shona Robison: One of the difficulties that you will face will be in convincing the public that the agenda is not resource driven—given some of the high-profile cases that have been in the public domain, that is a real concern. The fact that the issue has suddenly arisen without much notice may not help to reassure the public. The proposal is almost like an add-on to which not an awful lot of thought has been given.

During this discussion, we have heard that the policy intention would not be to reduce the inspection level of care homes for the elderly—that is what the care commission has said. However, in reality, would not that be a possibility, if you decided that it was to happen in the future? Although you are saying that, for the time being, the policy intention is not to reduce the level of inspection, the fact that the legislation is being changed makes such a reduction a distinct possibility.

That would be the big concern for many members of the public, as care homes for the elderly are the sector in which the most high-profile cases have been raised. How can you enshrine what you say about the commission's policy intentions a bit more solidly than just in a round-table discussion that is recorded in the Official Report? You say that that is your thinking at the moment, but there is nothing to make it so for ever and a day. The situation is a bit fluid.

14:45
The Convener: Could you come to a question, please?
Shona Robison: What we are dealing with is a fluid situation; we are learning stuff as we are going around the table.
The Convener: You are taking a very long time to ask your question.
Shona Robison: I am suggesting that what we are doing is not the best way—
The Convener: It is the situation that we are in at the moment and you are going on a wee bit, Shona. Focus a bit.
Shona Robison: Can you say whether your intention would be enshrined in some kind of long-term policy?
Adam Rennie: Your question was addressed to Jacquie Roberts, but it is mainly a matter for the Executive, as it would be ministers who would need to consult the commission and the public and bring forward the orders. The decision on whether any particular care service category would be the subject of an order would be for ministers. However, as Jacquie Roberts has made clear, the amendment obliges ministers to consult the commission closely beforehand.

The issue of care homes came up just last week in the media. I am sure that you all saw the Deputy Minister for Health and Community Care’s letter in the press the next day, which said that the Executive has no plans to make an order in respect of care homes for older people. The powers will be used only when it can be demonstrated that the quality of a particular care service will not be affected. Indeed, the purpose of using the power is to enable the overall quality of the particular care service category to be driven up by making more effective use of the regulatory resources that are available for that category.

If the question is whether the change in the legislation opens up the possibility of the power being used in respect of care homes for older people, the answer must be yes. However, to put what Jacquie Roberts said the other way around, nearly 90 per cent of the care commission’s registrations are not overnight-type services and are subject to the once-a-year minimum inspection requirement, not the twice-a-year requirement. The purpose of the amendment is to enable sensible changes to be made to the system over the years, as experience of the use of the system grows, with the safeguard that the Parliament will always be able to say no to any particular proposal.

The committee might or might not find it reassuring to know more about the situation in England. There, nothing is set down in primary legislation about inspection frequencies and ministers have a power to make orders, but those orders are subject to a negative, not an affirmative, procedure. Ministers have never made orders, however, and the inspection arrangements in England are made as a matter of policy. The situation in Wales is similar.

In Scotland, we have a tightly defined situation with regard to inspection frequency. The amendment seeks to introduce the possibility of varying that situation when it seems sensible to do so and subject to the final control of the Parliament.

The Convener: Do you have a follow-up question on that point, Shona?
Shona Robison: No, that is fine.
Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The submission from the Scottish Pre-School Play Association highlighted a point that has been touched on. It says:

“Many day care services in the voluntary sector are vulnerable to frequent changes in management and/or staff. Lengthening the time between inspections may contribute to a diminution in the quality of service.”
Do you have enough staff to scrutinise the information that you collect and to double-check the forms that are submitted? An establishment that might be okay at one point might have a frequent turnover of staff. Many of those workers are not well paid and are in and out of their jobs. In a lot of establishments, I have seen for myself the situation that the Scottish Pre-School Play Association talks about. I have seen qualified staff have a half hour deducted from the morning nurse’s shift and the afternoon nurse’s shift to the point that they did not have a changeover period during which they could pass over information. The workforce is what makes such institutions work.

Jacquie Roberts: Under our current system, the individual care commission officer who is responsible for the regulation of the service receives that information and makes a risk assessment in consultation with their team manager about the relative risks of that service. The commission has the capacity to consider the information that is available and has three years of experience and inspection reports to look back on.

Dr Turner: An establishment that seems to be perfectly good could turn into one that is not so good immediately after a form has come in and staff have visited it. How can it be checked up on? If the period between inspections is lengthened, the fact that the establishment is not so good might not be picked up on as quickly as it was. I am trying to examine that issue.

David Wiseman: The proposal requires us to be provided with information when there have been significant changes, for example. Therefore, we will be required to be informed of a change of manager, which is a potential trigger point for us, as a manager can be crucial to the provision of quality in a service. Obviously, a change of manager means that we must look back and ask whether we should go in and dig deeper.

Of course, concerns can also be raised with us through the complaints process. There have, on occasion, been high numbers of complaints about staffing issues. Changes or reductions in staff levels will start to raise concerns about the quality of care that is provided. The service may have been seen as having performed extremely well over the past couple of years, but we would want a number of trigger points to be in place to ensure that any changes lead us to a position in which we can decide whether to alter our assessment of the need for a more in-depth inspection or more frequent inspections. It is important that we try to focus our time on areas of service that require more scrutiny in order to drive the improvement agenda. Rather than visiting everything every year, we must take into account the fact that some people need more support, encouragement and scrutiny to develop their services.

Alan Dickson: Everyone around the table recognises that any number of inspections will not guarantee that there will never be a problem in any service at any time. Staffing is a particularly important issue. A national workforce group, which is chaired by Euan Robson, is currently considering the whole social care sector and its recruitment and retention difficulties. There may be one, two or 30 unannounced inspections, but that will not guarantee that there will be no problems.

Unlike in England, a system has been put in place here that has gained public confidence—the public and service providers have had confidence in the care commission’s work. In some instances, there is contract monitoring by local authorities and there are all the other inspection processes and monitoring programmes that are in place. It seems to me that we are in danger of considering only one element—the number of inspections that the care commission has carried out—without looking at things in the round and seeing all the various aspects.

We must ensure that we do not look at things in isolation and that the substance of any change—that is, how such a variable system might work—is developed in conjunction with the industry. We must ask how a change will work, what it will look like and what it will mean, but we will not put such matters to bed today. There must be wide consultation with the public, because there is a danger that the confidence that has been generated can be ruined, regardless of who is right or wrong, by the perception that the need for inspections is somehow being reduced.

Lesley Aitkenhead: I speak on behalf of service users and their carers and want to say something about what Alan Dickson has said. There is confidence in the care commission at the moment, but that can be lost. I return to what Shona Robison said: keeping public confidence is important. Service users and carers have made complaints to the care commission and have done so uncomfortably, as they have reported on facilities that they are using, but it is important to understand that many people do not complain.

I am interested to know whether the one visit would be unannounced or scheduled. People want an unannounced visit, because they want to be able to see that the provider is providing. Unannounced visits should not be ad hoc. They should take place once every three years, for example. The issue is how that is built in to the system.

The Convener: I will bring in Andy Sim, because he might pick up on some of the same issues.
Andy Sim: Alan Dickson makes a good point, as does Lesley Aitkenhead on trust and confidence. Without regular contact with inspectors, care home residents' perception of their ability to complain will be eroded. We know that there is a problem around complaints. Care home residents are still afraid to make complaints, because they do not have security of tenure. They can make a complaint and it can be upheld, but the next week they can be evicted from their care home. That is the worry that people have.

Allied to that is the shortage of other protective elements, such as access to advocacy for care home residents. Currently, only around 12 per cent of the advocacy pot for Scotland goes to older people. They are by far the largest group of care service recipients, but they receive a tiny amount of the money.

We talked earlier about agreeing to the amendment. Our caveat is that, if minimum inspections are taken away, we would like further regulation in other areas, such as the right to advocacy and security of tenure.

The Convener: Your written evidence states that you

“would wish the inspection process to be more wide reaching and integral through the inclusion and involvement of residents”

and others. That is partly what you have been saying, but in a sense it runs counter to the proposals. The care commission wants to reduce inspections, whereas you want to strengthen them.

Andy Sim: Will Mallinson asked the care commission about lay assessors and received a good response. He might like to pick up on that.

The Convener: Would the care commission like to pick up on that?

Jacquie Roberts: David Wiseman also wants to come in on this point. We are not talking about reducing the attention that is paid to people who use care services. We are talking about greater flexibility. One of the proposals is to spend more time with service users. If we do not have to go through a lot of routine processes, we will have more time to build even greater confidence.

It is good to know that we are gaining the confidence of people who use care services and that they have confidence in our response to complaints. Having more flexibility will give us even more time to spend with people who are making complaints and to help people who receive care services to feel confident about making complaints, not only to the care commission as an independent scrutineer, but to the people who provide the services, so that they can learn about what they need to do to improve their services.

David Wiseman: We use announced and unannounced inspections in the process—both have a part to play. It is important to recognise that we are not talking about reducing contact. We are talking about reducing the number of inspections in certain cases where there is risk assessment. That will mean that we can develop a lot more contact in some areas, particularly with carers and people who use care services.

Our main contact with people who use care services is during an inspection, so our role is limited in that respect. We want there to be more opportunities during the year to hear from carers and people who use care services about the level of service that is provided. That is not just done by putting in place an inspection process. Other techniques can be used to have contact with people and to meet them outwith the inspection process. We are talking about engaging much more with people who use care services.

The Convener: Andy, do you want to come back on that?

15:00

Andy Sim: I do not think that that is what I was saying. I was saying that tightening other areas of regulation might reinforce the rights of care home residents. I was not making a criticism of where the care commission is going, but the concern is that the proposed reduction of the number of inspections could undermine trust.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I would like to hear more from the people round the table about what we do in the round. As has been said, we should not believe that one inspection—or even 30 inspections—would be a cure-all. The process is hit and miss and pretty negative. My observation is that it allows some care home operators to transfer their responsibility to somebody else and to say, “Well, it’s not really my responsibility, so we’ll wait and see what the report says before we institute any action.” There seems to be a defence of something that is four years old and which is a moveable feast. The purpose of the process is to examine how the legislation is working, because it was made four years ago, so I would like some feedback on what could be done to improve the situation and to support flexibility.

Public confidence is important, although surely it should not override the need for inspections. We should not do anything differently just to appease public opinion. However, I need an assurance, on the record, about what Andy Sim said. Does the care commission, or anyone round this table, have any evidence whatever that an elderly person in a residential home who has made a complaint has been evicted from that home as a consequence? If
that claim cannot be substantiated, we are perpetuating the fear and the myth that people should not and cannot complain and that, if they do complain, there will be dire consequences. We need to clear up that point.

The Convener: Perhaps somebody from Age Concern Scotland can answer that.

Andy Sim: There was a report in the Daily Record about 15 months ago about a lady whose relatives made 10 complaints, of which nine were upheld. She was evicted, or put out—often the situation is not described as an eviction, but will be referred to as a case of the home not being able to meet the resident's needs, the resident exhibiting challenging behaviour or a number of other euphemisms that mean that the care home does not want the resident there. Another advocacy organisation in Edinburgh brought me the case of a chap who was threatened with eviction after making a complaint. That threat was made in front of somebody else. The case was resolved, but partly because there was an advocate there, so there was a safeguard.

Will Mallinson: I can back that up. Eviction is a real threat for many people and we have seen an increase in the number of residents who have been threatened with eviction.

The Convener: Do you have evidence of that?

Mr McNeil: Could you supply that evidence to the committee?

Will Mallinson: Yes.

The Convener: If that is the case, it is quite important for you to provide us with the evidence. Duncan McNeil is right to say that the issue is serious.

Andy Sim: I was given permission to present evidence about somebody's case, so I can give that to the committee.

The Convener: I invite the witnesses from the care commission to comment.

Jacquie Roberts: We have quite a lot of evidence of cases of a breakdown in the relationship between relatives and care home providers and of the resident being moved to another care home. I do not have any direct evidence of people being evicted because of the level of complaints, but I know that there are examples of relationship breakdowns.

Alan Dickson: I want to pick up on that point. I speak for Capability Scotland, and I am sure that I also speak for many of the organisations represented by CCPS. It is not a question of waiting for the care commission or a local authority to judge whether or not our services are appropriate for our service users. We are determined to do that work ourselves and to have our own audit procedures and quality assurance. Indeed, that is a requirement on us and in any case we would be constrained by the care commission's request for information. One of the key roles for the majority of providers, particularly for large organisations and local authorities that require a large number of services, is monitoring their own service provision.

The question is not simply whether the public has confidence in the system. The care providers and the clients of those services must also have confidence. Moreover, I am talking not just about the public perception of confidence. If confidence breaks down in any system, we will not be able to deliver quality services. I realise that our debate should not be constrained simply because some people might not fancy it—that is certainly not my point—but I am concerned that we should move away from the issue of the number of inspections. I take from Jacque Roberts's comments that that is not the intention behind the amendment. However, the danger is that the proposal will be seen solely in those terms and that we will not be able to have enough of a debate about what it will mean. That is why we must interact with everyone before any decision is taken. In other words, any decision to reduce the number of inspections must not be taken before a full consultation has been carried out and people have determined how effective the measure will be.

Annie Gunner: On Duncan McNeil's comment that some care providers might want to hand over responsibility for quality assurance to the care commission, local authorities or anyone else, our submission makes it clear that we want much more harmonisation between the regulatory process and providers' own quality assurance systems, many of which are quite sophisticated, to ensure that the question is not simply whether someone turns up on the doorstep once every six, 12 or 18 months. We want a system that is validated by the care commission, which means that there will be constant monitoring.

For us, the proposal is less about the reduction in the number of inspections than about the reduction in the minimum frequency of inspections, which means that although some people will get less attention, others will get more. The question then is how we determine who gets more and who gets less. If we can tie that in with the quality assurance systems in provider organisations, we will be halfway there.

George Hunter referred to the relevance of local authorities’ own performance monitoring of the services that they purchase. We should remind ourselves that the Regulation of Care (Scotland) Act 2001 removed responsibility for registration and inspection from local authorities and gave it to the care commission. We supported that measure
at the time and still do. We believe that the care commission should carry out that work.

Although I realise that local authorities have a duty of care to the people on whose behalf they purchase care services, the implication that regulation should somehow become a joint venture between local authorities and the care commission concerns me. I have no problem with local authorities agreeing the risk assessment tools that should be used; however, once that is done, they should let the care commission get on with its job. Local authorities in some areas are already beginning to duplicate some of the care commission’s processes, and the committee ought to be concerned about that real problem. There are several factors to take into account, and providers’ own quality assurance systems represent one of the most important that we can come up with.

The Convener: Does Duncan McNeil want to come back on any of that?

Mr McNeil: No.

George Hunter: In response to Annie Gunner’s comments, I fully accept that the care commission is responsible for regulation. However, as Alan Dickson pointed out, we can make sense of this matter only by examining all the broad areas of performance monitoring, including providers’ own quality assurance mechanisms. Local authorities are required to review the situation of individuals who are in the care of or are receiving services from particular providers. We cannot duck that obligation. When we commission a service to a service specification, we have an obligation to ensure that the service is being provided to that specification.

I have some sympathy with the fact that that can appear to duplicate what the care commission does. I am making a plea not to share the regulatory responsibility—we do not do that—but to examine the variety of quality assurance processes that exist in the commission and to take them all into consideration. To me, it is the care commission’s responsibility to do that. If there are regulations, requirements and conditions to be imposed, that is the care commission’s responsibility. I am not looking to share that responsibility; I am simply asking that we consider the performance monitoring framework that exists for all services in its entirety.

The Convener: Does Annie Gunner want to add anything to that?

Annie Gunner: No, thank you. I just welcome that statement.

The Convener: Is anybody waiting to jump in on any specific topic?

Bob Christie (Convention of Scottish Local Authorities): I would like to follow up Duncan McNeil’s useful question on the capacity and flexibility of providers to improve services on their own behalf. We have identified a number of the elements that make that possible. Clearly, the providers’ own service improvement framework is important. There is an onus on them; they should not place the onus on the regulatory bodies. There is the care commission’s inspection regime, with its recommendations and requirements and, where appropriate, the local authorities’ quality assurance frameworks. However, the real capacity and flexibility to make improvements comes from the resources that are available to the provider. Unsurprisingly, that leads us into the cost implications of a full cost recovery policy for registration and inspection. I know that it is not quite the subject of this debate, but it is difficult to see how we can achieve the quality improvement that we are all aiming for when full cost recovery limits providers’ ability to achieve it.

The Convener: It is clear from the evidence that significant contention surrounds that issue, which is not central to the amendment although we are not ignoring it. The Health Committee is about to embark on an inquiry into care in Scotland, and I invite witnesses to consider whether it might be appropriate to raise some of those issues in that context.

I have a couple of mopping-up questions, and I will come back to the care commission and the Scottish Executive for a final round of questions if that is desired. I have noted a couple of minor issues as the debate has progressed.

First, a little way back, Jacquie Roberts commented that the care commission was not about carrying out routine inspections. I would like to take you up on that. Lots of things in society are subject to routine inspection, including schools and prisons. What do you mean when you say that the care commission should not be about routine inspections? Routine inspections are part and parcel of many of the services that are delivered in Scotland.

Jacquie Roberts: I meant that the care commission is not only about routine inspections. I was talking about inspections being part of a much bigger range of regulatory activity. We have been asking how scrutiny can contribute to improved services. We believe that that can be achieved through greater flexibility and by considering scrutiny to be much wider than inspections. That is how we will improve.

The Convener: You were not suggesting that the care commission should opt out of conducting routine inspections altogether.

Jacquie Roberts: No.
The Convener: My second question is for COSLA. Your written submission indicates that you are, quite rightly, representing the majority view, although a minority of the councils that you managed to get responses from did not want a reduction in inspections. I am not asking you to name those councils; that would not be fair. How many councils did you manage to get comment from and how many comprise the minority?

Bob Christie: We got comments from 19 or 20 councils. You will appreciate that it was quite a rushed consultation.

The Convener: Yes, I appreciate that.

Bob Christie: Looking closely at what we received from councils, we feel that the minority view is a view mainly on care homes for the elderly and, to a lesser extent, residential care for children, whereas the majority view relates largely, but not exclusively, to care services such as nursery classes. In the time available, we could consult only officers—directors of education and social work. There was not a coherent, politically approved response.

15:15

The Convener: How many of those consulted took the minority view?

Bob Christie: Six or seven.

Councillor Jackson: The good thing about today’s meeting is that it has given people a chance to express their views. I have certainly understood where people are coming from. Had some of those who took the minority view been here today, they might have changed their response to us, given the evidence that has been presented, in particular by the care commission.

The Convener: I hope that copies of the Official Report of today’s meeting will be sent to all the councils that responded.

My final question concerns a conflict that I perceive between the evidence from Capability Scotland and that from the Scottish Partnership for Palliative Care. Susan Munroe spoke about the issue of care at home, as opposed to care in the hospice. Her view was that the Scottish Parliament should "reconsider the requirement to register this service separately"

and that hospice services should be treated as a singleton. That is in direct conflict with comments by Alan Dickson and the written evidence from Capability Scotland, which states:

"If there are to be different status for different services, it has to be applied to all the services within an organisation and not just the organisation itself. To allow a whole organisation providing several services to be inspected less frequently would create potential loopholes".

Would Susan Munroe and Alan Dickson like to discuss the apparent contradiction that I have identified? It is interesting that there are two opposing views of the situation. Will the witnesses explore what they mean?

Susan Munroe: I suspect that the issue is the definition of key services. On the whole, our care at home services involve one or two clinical nurse specialists working from a hospice as part of the multidisciplinary team that is based in the hospice. The care that is delivered in a patient’s home is advisory, supervisory, supportive care, not physical, hands-on care.

Alan Dickson: The issue is probably as Susan Munroe has described—at least, that is my excuse, and I am sticking to it. Earlier I made the point that a number of different organisations will provide different forms of services of a different size and on a different scale in different parts of the country. I speak on behalf of an organisation that is quite widespread. As we said earlier, organisations need to be able to show that their systems, processes and quality procedures are embedded in and cascaded throughout the organisation. However, I am concerned that, if an organisation is seen simply as a quality provider, there is a danger that a specific service could go off the rails, given the points that were made earlier about high turnover of staff and so on. I am concerned that we could find ourselves in a difficult position as a result.

Susan Munroe: There is also an issue about levels of service provision. I work for Marie Curie Cancer Care, which has two hospices in Scotland. There is one service provider, but I do not believe that the hospices should be regarded as one service and have one inspection. They should be registered and inspected separately. However, all the services that are delivered by each hospice should be regarded as one service.

The Convener: Your comments have resolved an apparent conflict, which is useful.

In a moment, I will seek final comments from the care commission and the Scottish Executive—if the Executive has anything to add. Before that, we have 10 minutes in which to take mopping-up questions from members.

Shona Robison: I have a question about the process. I am still not clear why this issue was not flagged up earlier. Were discussions happening behind the scenes? Did someone suddenly realise that there was an opportunity to change the regime?

Adam Rennie: The Smoking, Health and Social Care (Scotland) Bill was proceeding in accordance
with its timetable. As I said earlier in response to a question from Kate Maclean, the idea of amending section 25 of the 2001 act emerged during the passage of the bill. Ministers had to decide whether to include the provision in the bill or to leave it until a later legislative opportunity.

We were keenly aware that the Health Committee was to review the Regulation of Care (Scotland) Act 2001; various colleagues mentioned that. We have various ideas for other things that could be done to improve the act. The care commission has a shopping list and there have been various other ideas; Susan Munroe made a point about the registration of services. We thought that this idea was sufficiently important to introduce now instead of waiting until the wider review is completed, because at the time it was unclear what the timetable for the review might be and it was certainly unclear what the timetable would be for any legislation that would follow the review.

Shona Robison: I wondered why the issue was not sufficiently important to be raised at stage 1.

Adam Rennie: Do you mean in the course of the stage 1 debate?

The Convener: No, in the course of the evidence gathering sessions that took place in the run-up to the stage 1 debate. Why was the issue not in the draft bill?

Adam Rennie: It was not in the draft bill because the decision had not been taken at that point to go ahead with the legislation. I think that I am right about that, although I would have to check the timing. It happened quite late in the day. We were certainly not sitting on a complete amendment and letting the bill proceed without it, with the intention of producing the amendment at a later stage.

The Convener: Perhaps Linda Gregson has a comment.

Linda Gregson (Scottish Executive Health Department): Adam Rennie is right. Other areas of the country were producing reports on better regulation. The care commission had been in place for a relatively short time but we were not sitting on the idea. We needed time to crystallise our thinking about what we needed to do.

The Convener: Had the representatives of the consumers who are here picked up any rumours that something was in the offing? If so, can they remember when they picked them up? Perhaps they did not pick up anything.

Helena Scott (Age Concern Scotland): We echo what Shona Robison said. We only knew about the amendment about a week and a half ago.

The Convener: So you have not been involved in any conversations about the amendment.

Helena Scott: No.

The Convener: Were any of the other consumer representatives involved? I appreciate that some people are consumers and providers. No one seems to have been involved until now.

Will Mallinson: I wanted to mention something that has been raised a couple of times today: the national care standards. If inspections and assessments are to be measured against those, they need to have some teeth, because providers know that they are for guidance only. That might require to be considered with the legislation.

Mrs Nanette Milne (North East Scotland) (Con): Have any of the consumer representatives who voiced concerns at the beginning of the session gained reassurance or otherwise from what we have heard this afternoon?

Alan Dickson: Yes. I have been reassured by what Jacqui Roberts and David Wiseman said, but I still come back to the fundamental point that more work needs to be done before the decision is taken.

Lesley Aitkenhead: I agree. For example, I do not understand how a mental health service user can inform the care commission, or how the care commission will pick up on stuff if it is making just one inspection per year. I have not got to grips with the process. The care commission seems to be relying on people making complaints and I am not sure about that. The inspections will need to be more thorough.

Councillor Jackson: We were broadly supportive in the beginning and I will talk to those colleagues who expressed concerns and give them chapter and verse on what has happened here to see if that will change their minds at all.

Andy Sim: It is reassuring that there are no proposals to hit older people in care homes with fewer inspections. However, there is still a worry that that could happen in future.

The other point is about unannounced inspections; we really hope that they will continue, otherwise—like the Queen—the inspectors will think that the world smells of fresh paint.

The Convener: I invite the witnesses from the care commission to make a final, brief comment. As you have responded throughout the discussion, I do not think that you need to give a long response, but perhaps you could pick up on some of the concerns that have been expressed.

Jacqui Roberts: It is important to emphasise again the different types of services that we inspect. We have had a lot of pressure from people in the housing sector—we regulate housing
support services, in particular sheltered accommodation for people with lower levels of vulnerability—and the child care sector, who say that it is not right to have a one-size-fits-all approach. It is important to note that the legislation will enable us to consult on what we might do for different types of services. We absolutely do not want to lose the concept of unannounced inspections and we are about to go into a big public consultation about how we do registration and inspection. The amendment will allow us to consult on the minimum frequency of inspection, which is a small part of the work that we do.

**The Convener:** Thank you. I do not want everybody from the care commission to say something if that is not necessary. Does Adam Rennie wish to make a final comment?

**Adam Rennie:** Yes. The strong message that I have heard is that consultation is desirable even if, as in this case, we think that we have good reasons for our proposals. That was a learning point for me. Our thinking was that the proposal will acquire meaning only when it is applied in relation to particular care services. Many of the comments that have been made were about care home services for older people and there will be consultation on that. As Jacquie Roberts said, the proposed power is an enabling power. I can see that we will have to go back to the drawing board next time we have a bright idea. Nevertheless, I think that it is important that we do this.

I give an unequivocal assurance that unannounced visits will continue. It is a requirement of the 2001 act that where services get two inspections per year, one of them must be unannounced. The only difference in our proposal is that instead of there being two inspections per year, there will be two inspections every 18 months or whatever, but one of them will still be unannounced. The commission has the power to do unannounced visits anywhere at any time.

As I have mentioned, we acknowledge that it is desirable to consider issues in the round and the Health Committee’s inquiry will afford a tremendous opportunity to do that. I stress that the amendment will not change anything. The care commission will still be under a duty to do exactly what it does now. It is only when the Executive has consulted the care commission and the public, when it has come to the Parliament with proposals and when the Parliament has approved them that anything will change. That will obviously take some time, and assumes that the amendment is agreed to.

Finally, I stress that the purpose of the amendment is to improve the effectiveness of our regulatory system to drive up service quality for users. That is why it has been lodged.

**The Convener:** It is always salutary to be reminded that what is self-evident to us is not necessarily self-evident to everybody else. Even things that we think are self-evident need to be tested. I remind members that they will have the opportunity to debate the matter with the minister on 31 May. I expect that some of the issues that have arisen in today’s session will be raised at that meeting.

I thank all the witnesses for their contributions. I hope that you found the exercise useful and that you got more out of it than if you had been sitting as panels of witnesses with the normal question-and-answer format. In a sense, you have heard from the horse’s mouth some reassurances that it might otherwise have been difficult to get.

15:29

*Meeting suspended.*
On resuming—

Smoking, Health and Social Care (Scotland) Bill: Stage 2

Section 9—Free oral health assessments and dental examinations

The Convener: I welcome the minister and her officials to this afternoon's session. We expect to reach amendment 11 today. We hope to deal with this item in about an hour—that is the plan.

Amendment 23, in the name of Nanette Milne, is grouped with amendment 24.

Mrs Milne: Convener, you will have to guide me as this is my first experience of stage 2. Do I move both my amendments together?

The Convener: Speak to both amendments, and move amendment 23.

Mrs Milne: Amendments 23 and 24 would remove free dental and eye checks from the provisions of the bill. My colleagues and I consider that to provide free eye and dental checks for everyone by 2007 would not be the best use of public resources—free checks are already available for people who need them. The difficulty lies in persuading those who are eligible for free checks to come forward for them and, in the case of dentistry, in finding sufficient national health service dentists to carry them out. Moreover, once the checks are done, there are in many parts of the country not enough dentists working in the NHS to carry out treatment that may be required. It is neither sensible nor ethical to make a diagnosis and then not to carry out the treatment.

The Executive's recently announced dental health action plan is intended to correct the lack of NHS dentists, but despite the plan, dentists are still leaving the service. Only yesterday in Aberdeenshire, yet another Grampian dental practice left the NHS. As was predicted, dentists are not impressed by what is on offer. It seems pointless to legislate for free dental checks that are unlikely to be carried out. It would make more sense to try to ensure that people who are currently eligible for free services actually make use of them.

On eye tests, many optometrists already offer free eye checks, together with good financial deals for purchasing spectacles. I can see little point in subsidising the system with taxpayers' money that could be put to better use, for instance in improving retinal screening for diabetes or in expanding the use of photodynamic therapy for treatable macular degeneration. The Conservatives do not feel that the proposal for free dental and eye checks for all will be a sensible use of scarce public resources.

I move amendment 23.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): It comes as no surprise to find that the Conservatives are moving to amend completely the bill that will give free eye and dental checks to all. The Scottish Parliament's approach to legislation is evidence-based. Every witness who gave evidence to the committee—evidence to which Nanette Milne listened—accepted that free eye and dental checks would improve the state of the nation's health; some argued that it would improve it dramatically. Every single piece of evidence suggested that that will be the case. I do not like the ideological approach to the bill that the Conservative party, which Nanette Milne represents, is taking. Her group does not approve of the measures, but it could not find anybody who could give the committee evidence to back up its claims.

I am gobsmacked by the suggestion that it would be unethical to approve the measures. If it were the case that we could not provide but were offering free eye and dental checks, the suggestion might have some veracity, but that is not the case. Nanette Milne knows as well as everybody else does that there are already enough optometrists to give free eye checks to all and that the minister recently announced a dental plan, which from my perspective is an excellent plan. Every initiative for which the British Dental Association asked has been provided for in that plan and there is to be a massive funding increase of 75 per cent, which is dramatic by anyone's standards. The measures are designed to ensure that the service exists when the free checks are introduced.

Apart from the Conservatives, all members accept that the provisions are a major part of the bill. Amendments 23 and 24 would ruin the bill—there is certainly no evidence to suggest that we should support them. I urge members to reject completely the Conservative amendments, which are wrecking amendments.

Shona Robison: I hope that that automated blind's movement is not a sign of the curtain coming down, Mike.

I echo Mike Rumbles's remarks—amendments 23 and 24 are ill-advised. Although Nanette Milne raises some important concerns—which many members share—about the challenges of delivery, particularly in relation to the capacity of NHS dentistry, that should not detract from the principle that the measures are the right thing to do. In fact, the pressure on the Executive will be increased,
because it will have to ensure that it delivers the oral health assessments.

One important point is that the bill will introduce oral health assessments, not dental checks in the traditional sense that we understand. The assessments will be far more in-depth than were previous dental checks—they were a cursory look in the mouth—and will be a far better preventive health measure. The amendments are ill-advised and I will certainly not support them.

The Deputy Minister for Health and Community Care (Rhona Brankin): The Executive and, I hope, the committee cannot support amendments 23 and 24. The introduction of universal free eye and oral health examinations is, as has been said, an important part of the Executive’s commitment to improving public health through comprehensive and preventive care. At stage 1, the Health Committee and Parliament accepted the principle of free eye and dental checks for all. The free checks are preventive health-improvement measures—our purpose in introducing them is to assist in early detection of oral cancers, diabetes and conditions such as age-related macular degeneration, detaching retinas and certain cancers and tumours.

Amendments 23 and 24 would prevent members of the public from receiving oral health assessments and eye examinations free of charge. Instead, we would be left with the current situation, whereby only patients who are eligible for free NHS dental treatment or for full help with charges under the NHS low income scheme would benefit. Nanette Milne will recall that the evidence that the committee took on the provisions was wholly supportive of them and that the committee’s stage 1 report recognised the universal support for the measures.

Delivery of dental services is a challenge that the Executive intends to meet. We will do so through the modernising dentistry agenda that we announced on 17 March, under which new funding of £150 million has been made available over three years to support oral health and dentistry. The challenge is one that the Executive intends to meet. For that reason, I cannot support amendments that fly in the face of professional opinion. I invite Nanette Milne to withdraw amendment 23 and not to move amendment 24.

15:45

The Convener: I ask Nanette Milne to wind up and to say whether she will press, or seek leave to withdraw, amendment 23.

Mrs Milne: I have little to add to what I said earlier. My concern is that, despite their eligibility for free eye and dental checks, many of the most vulnerable people do not come forward for them. I would prefer to see the Executive target what is a scarce resource on those people; they need to be brought into the system so that their oral and eye health is checked. It is not good to pass a law when it is pretty well known that the provisions that it contains cannot be carried out. I will press amendment 23.

The Convener: The question is, that amendment 23 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Milne, Mrs Nanette (North East Scotland) (Con)

AGAINST

Cunningham, Roseanna (Perth) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 23 disagreed to.

Section 9 agreed to.

Section 10—Free eye examinations and sight tests

Amendment 24 moved—[Mrs Nanette Milne].

The Convener: The question is, that amendment 24 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Milne, Mrs Nanette (North East Scotland) (Con)

AGAINST

Cunningham, Roseanna (Perth) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 24 disagreed to.

Section 10 agreed to.

After section 10

The Convener: Amendment 25, in the name of Nanette Milne, is in a group of its own.
Mrs Milne: The argument for amendment 25 follows logically from what I said about amendment 23. Given that the aim of amendment 25 is straightforward, it can be dealt with quickly. It would provide that the Executive place a duty on health boards to ensure that people who are eligible at the present time for free eye and dental checks are targeted more effectively. The people to whom I refer are the most vulnerable people in our society, yet their health is most at risk because they escape the net and therefore fail to have the checks carried out. Even if free checks become available to everyone, those people will still need to be targeted.

I move amendment 25.

Mike Rumbles: Again, the Conservatives have missed the point of the bill and of the debate on targeting and universal benefits, which is that we have to ensure that the very people to whom Nanette Milne referred obtain the health benefits that are available to them. Obviously, all experience shows that some people do not take up benefits even though they are eligible for them; those people are either not sure whether they are eligible or find the process too complicated. The point is that, if benefits are provided universally, everyone will be clear that the benefits are freely available to them.

Rhona Brankin: Unlike the previous two amendments that Nanette Milne lodged, I have some sympathy for the principles of amendment 25. That said, I am unable to support it. Its prescriptive nature would mean that an unreasonable duty would be placed on health boards. For example, in terms of the categories of people who would be entitled to receive free sight tests and dental examinations, health boards would in future always be required to refer back to 1 April 2006. The requirement to do so could become excessively burdensome 10 or 20 years down the line.

The Executive has made it clear that it supports measures to increase uptake of free checks. We have made a commitment to work with health boards to target the vulnerable groups who are eligible for those checks. Although I support the principle of encouraging uptake of free eye and dental checks, I believe that amendment 25 is unduly restrictive.

Improving uptake of free checks should be done flexibly and responsively in partnership with health boards. The Executive believes that this is not a matter for primary legislation. I invite Nanette Milne to seek leave to withdraw amendment 25.

Mrs Milne: Given the minister’s reassurance that the people to whom I refer will be covered, I am prepared to seek to withdraw the amendment.

Amendment 25, by agreement, withdrawn.
such checks are carried out on people who might not be aware that their sight is failing, or of other problems associated with their physical well-being. I welcome the amendment as a chance to include that in the bill.

Helen Eadie: In our e-mail today, we received a briefing from the Royal National Institute for the Blind Scotland supporting Kate Maclean's amendment 26. I urge the minister to consider the issue, because the RNIB Scotland supports the amendment strongly. My experience of the need for glasses being picked up at an early age was similar to Brian Monteith's. It is important.

Rhona Brankin: I thank Kate Maclean for raising an issue that is clearly important to the Health Committee and which is important to me, as somebody who worked in education for many years. I, too, came across youngsters in secondary schools whose problems had not been picked up. There is concern.

We need to ensure that suitable provision is made for screening children and we need to ensure that vision disorders in children are picked up early. The Scottish Executive is taking action to ensure that more consistent and effective arrangements are in place throughout Scotland. Kate Maclean referred to the fourth edition of “Health for All Children”—or Hall 4—which was published last month and which recommends vision screening by an orthoptist for all children between the ages of four and five in their pre-school year. That reflects the recommendations of the Royal College of Paediatrics and Child Health's expert working group, which recently reviewed the evidence for all childhood screening and surveillance activity. That working group found insufficient evidence to support more frequent vision screening in schools. It also found that vision screening is significantly less effective when it is carried out by doctors, health visitors and school nurses rather than orthoptists.

The recommendations of Hall 4 have been endorsed by the UK national screening committee, which was established in 1996 to advise the UK Administration on screening policy. In forming its advice, the committee draws on the latest research evidence and the skills of specially convened multidisciplinary expert groups, which always include patient and service-user representatives. The committee assesses all proposed new screening programmes against a set of internationally recognised criteria, which cover the condition, the test, the treatment options, and the effectiveness and acceptability of the screening programme.

I have had some discussions with Kate Maclean and I am aware of the position of RNIB Scotland. I am happy to consider the range of evidence that is available, and RNIB Scotland has agreed to take forward some work in the area. Following that, it would be open to us to submit any new evidence to the national screening committee. I am happy to discuss the matter further with Kate Maclean, and on that basis I ask her to consider seeking to withdraw amendment 26.

Kate Maclean: RNIB Scotland has campaigned on the issue for some time, and I have been involved in meetings on the matter with previous health ministers. Nothing has happened, and this is the first—and probably only—legislative vehicle through which we will be able to deal with the matter for some time. Amendment 26 is based on a strong recommendation of the committee. Also, evidence from the College of Optometrists suggests that the Hall 4 guidance would lead to a decreased service.

If the issue is not resolved before stage 3, I will be strongly minded to lodge an amendment then. Given the minister's assurance that she will discuss the matter with me and consider the evidence, I am prepared to seek to withdraw amendment 26, although I reserve the right to lodge an amendment on the issue at stage 3.

The Convener: In view of what is stated in the committee's stage 1 report, I ask whether other members of the committee are content for amendment 26 to be withdrawn.

Dr Turner: I agree that something should be done before stage 3, so that the matter is finally decided upon.

Amendment 26, by agreement, withdrawn.

Section 11 agreed to.

Section 12—Arrangements for provision of general dental services

The Convener: Amendment 2, in the name of the deputy minister, is grouped on its own.

16:00

Rhona Brankin: Amendment 2 is a technical amendment. Section 12 is concerned with the expansion of the categories of persons with whom health boards can enter into arrangements to provide general dental services. The amendment will extend the list to include bodies corporate, which are generally referred to in practice as dental corporations.

Amendment 2 is consistent with the policy intention to allow health boards to take a more active role in securing and providing general dental services. The particular intention is to enable health boards to make arrangements with individual dentists or dental corporations to undertake to provide general dental services. Health boards could also themselves provide
general dental services, through salaried NHS staff.

Dental corporations are not new; 26 currently operate in the UK. Amendment 2 will complete amendment of section 25 of the National Health Service (Scotland) Act 1978, and will clarify that a body corporate may provide dental services, in addition to dental practitioners’ being able to do so.

I move amendment 2.

Amendment 2 agreed to.

The Convener: Amendment 3, in the name of the deputy minister, is grouped with amendments 12 to 14.

Rhona Brankin: Amendments 3 and 12 to 14 are technical amendments. Taken together, they will create a single definition of

“carrying on the business of dentistry”

under the terms of the National Health Service (Scotland) Act 1978. Such a definition is necessary because the bill now contains a number of references to

“carrying on the business of dentistry”,

so it makes sense to consolidate them.

Amendments 3 and 12 will remove existing definitions from sections 12(b) and 22(3)(e) of the bill respectively. Those definitions will be replaced by amendment 13, which will insert a single definition of

“carrying on the business of dentistry”

in section 108 of the 1978 act, which is that act’s interpretation section.

Amendment 14 is consequential on amendment 3, which will delete section 12(b) from the bill. Section 12(b) would have the effect of repealing section 25(3) of the 1978 act, which places restrictions on remuneration that is paid to dental practitioners. The deletion of section 12(b) will make it necessary to repeal section 25(3) of the 1978 act through schedule 3 of the bill, which will be achieved by amendment 14.

I move amendment 3.

Amendment 3 agreed to.

Section 12, as amended, agreed to.

Section 13 agreed to.

Section 14—Provision of certain dental services under NHS contracts

The Convener: Amendment 4, in the name of the deputy minister, is grouped with amendment 5.

Rhona Brankin: Amendments 4 and 5 amend section 17AA of the 1978 act, and are consequential on part 3 of the bill, which, through new section 17V of the 1978 act, makes provision as to how contractual arrangements between pharmaceutical care services, contractors and health boards or other health service bodies are to be treated. Existing section 17AA makes provision for certain services to be treated as NHS contracts for certain purposes.

An NHS contract is an arrangement whereby one health service body provides goods or services to another health service body. Although the contract might contain all the usual range of contract terms, it does not give rise to contractual rights and liabilities. Any disputes are settled using internal NHS procedures, rather than the courts.

The services may be provided by community pharmacy contractors, among others.

New section 17V makes provision for the future providers of pharmaceutical care services to be regarded, if they wish, as health service bodies. The contracts between such providers and health boards would be classed as NHS contracts. In effect, the new provision makes the existing section 17AA provision redundant, and amendment 4 removes it.

Amendment 5 is consequential on amendment 4 and removes the definition of a pharmaceutical list from section 17AA.

I move amendment 4.

Amendment 4 agreed to.

Amendment 5 moved—[Rhona Brankin]—and agreed to.

Section 14, as amended, agreed to.

Section 15—Lists of persons undertaking to provide or approved to assist in the provision of general dental services

The Convener: Amendment 6, in the name of the deputy minister, is grouped with amendments 7, 9 and 10.

Rhona Brankin: These are minor amendments that amend sections 25(2A)(a) and 26(2A)(a) as they are inserted into the 1978 act by sections 15 and 17 of the bill respectively. The amendments will allow for regulations to provide for subdivisions in either part of the lists of persons who provide or are approved to assist in the provision of general dental and general ophthalmic services. The Executive’s policy is that all principal and non-principal dentists and optometrists who provide or assist in the provision of general dental services or general ophthalmic services should be listed in each health board area. The reason for providing for further subdivisions of each part of the list is to provide for practitioners who may provide a more limited or specialist type of dental service.
I move amendment 6.

Amendment 6 agreed to.

Amendment 7 moved—[Rhona Brankin]—and agreed to.

The Convener: Amendment 27, in the name of Nanette Milne, is grouped with amendment 28.

Mrs Milne: The amendments are intended to ensure that those who are already providing dental or ophthalmic services are subject to the same disclosure checks, in the same timeframe, as those who are being added to the registered list. In my view, if disclosure checks are necessary for new practitioners before they can be listed, they are necessary for all registered practitioners. That should be made clear on the face of the bill.

I move amendment 27.

The Convener: As I recall, the issue with which the amendment deals was raised at stage 1.

Rhona Brankin: In its consultation paper on improving primary care services, which was published in February 2004, the Executive proposed that all list applicants and those who are already on family health service lists should be subject to disclosure requirements. I make clear that it has always been the Executive’s policy intention that a requirement for disclosure of information should apply equally to people applying to join a list and those who are already on it. Nanette Milne’s amendments 27 and 28 as drafted will not achieve that end and are not required.

Mrs Milne: With the reassurance that the bill addresses the principles behind my concerns, I will ask to withdraw amendment 27.

The Convener: The point arose from the committee’s stage 1 report. Are members content for the amendment to be withdrawn?

Amendment 27, by agreement, withdrawn.

The Convener: Amendment 8, in the name of the deputy minister, is grouped with amendment 11.

Rhona Brankin: Amendments 8 and 11 make it clear that regulations may require providers of general dental or ophthalmic services to be included in a health board’s list. The bill will insert new sections 25(2B) and 26(2B) in the 1978 act, which will make explicit provision that regulations may provide that people may not assist in the provision of general dental or ophthalmic services unless they are on the second part of the list. No similar explicit provision is made that regulations may provide that people may not provide services unless they are on the first part of the list.

The policy intention is to take a belt-and-braces approach to make it clear and explicit that only those who appear on the first part of a board’s list may provide general dental or ophthalmic services. Amendment 8 concerns the providers of general dental services and amendment 11 concerns the providers of general ophthalmic services. The amendments will improve patient protection for health service users by ensuring that all practitioners—whether they provide or assist in providing general dental and ophthalmic services—are included on a board’s list.

I move amendment 8.

Amendment 8 agreed to.

Section 15, as amended, agreed to.

Section 16 agreed to.

Section 17—Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

Amendments 9 and 10 moved—[Rhona Brankin]—and agreed to.

The Convener: Will Nanette Milne move amendment 28, which was debated with amendment 27?

Mrs Milne: As amendment 27 was withdrawn, I will not move amendment 28.

Amendment 28 not moved.

Amendment 11 moved—[Rhona Brankin]—and agreed to.

Section 17, as amended, agreed to.

The Convener: That ends today’s consideration of the bill at stage 2. Before everyone rushes off, I inform members that the target for next week’s meeting is to complete consideration of part 3, which is on pharmaceutical care services, and of part 4, which is on discipline. The deadline for lodging amendments is noon on Thursday 19 May.
I suggest that for subsequent stage 2 meetings, I lodge committee amendments—those that derive directly from recommendations in our stage 1 report—in my name, with a supporting member’s name. The supporting member will deal with the amendment at the meeting, but as it will be in my name, it will be clear that the amendment derives directly from our stage 1 report. Other members would be required to support amendments, as otherwise I would have to vacate the chair every time that a committee amendment arose. Potential committee amendments would be circulated in advance, to ensure that members were content with their drafting. Are members happy to adopt that procedure? This afternoon, Nanette Milne moved not only an amendment that arose from our stage 1 report, but amendments of her own.

Kate Maclean: I was not aware that provision existed for committee amendments. I thought that amendments were the responsibility of individual members.

The Convener: That is the case, but our stage 1 report contained several recommendations and we need to find a way to show that an amendment derives directly from those recommendations and is not an individual member’s proposal.

I have made the suggestion because, this afternoon, one member moved amendments on her party’s behalf and an amendment that derived directly from our stage 1 report. It was difficult to distinguish between the two types of amendment, so an attempt is being made to clarify the situation for future meetings.

Helen Eadie: I am not entirely happy with the proposal. If you are saying that you and other members wish to lodge amendments that derive from our report, that is fair enough. However, you should not tie other members into supporting amendments without their agreement.

The Convener: We would do nothing without members’ agreement. That is par for the course. If committee members are content to continue in the present way, we will do that. However, I ask members who lodge amendments that derive directly from the stage 1 report to say that they are doing that. That information is needed because—with the best will in the world—committee members might have forgotten that they unanimously agreed a position previously. We want to make clear where amendments derive from.

Meeting closed at 16:16.
Smoking, Health and Social Care (Scotland) Bill

2nd Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Section 9 to 36 Schedules 2 and 3
Sections 1 to 5 Schedule 1
Sections 6 to 8 Section 37
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 18

Shona Robison
66 In section 18, page 11, leave out lines 25 and 26

Rhona Brankin
Supported by: Mr Andy Kerr
15 In section 18, page 11, line 37, leave out <a document to be known as>

Section 19

Shona Robison
67 In section 19, page 13, line 9, at end insert—

<( ) consist solely of services supplying stoma appliances and providing support in relation to the use of appliances supplied;

( )>

Shona Robison
68 In section 19, page 13, line 32, at end insert <; or

( ) with a dispensing appliance contractor who is included in any list of an NHS Trust in the United Kingdom, a Health Board in Scotland, a Health Authority in England and Wales or a Health and Social Services Board in Northern Ireland.>

Rhona Brankin
Supported by: Mr Andy Kerr
16 In section 19, page 14, line 18, at end insert—

<( ) The Scottish Ministers must publish directions given by them under subsection (1) in the Drug Tariff or in such other manner as they consider appropriate.>
In section 19, page 14, line 27, at end insert—

( ) provide that the Scottish Ministers may give directions as to the manner in which, and the standards to which, services must be provided;

( ) make provision as to—

( )>

In section 19, page 15, line 16, leave out from <any> to end of line 19 and insert <directions for the time being in force given by the Scottish Ministers under regulations under subsection (1).> After section 19

After section 19, insert—

<Drug Tariff

After section 17V of the 1978 Act (as inserted by section 19 above), insert—

“Drug Tariff

17VA Drug Tariff

(1) The Scottish Ministers must prepare, maintain and publish a document (to be known as the “Drug Tariff”).

(2) The Scottish Ministers—

(a) must include in the Drug Tariff, such information relating to pharmaceutical care services as may be prescribed;

(b) may include in it such other information relating to such services as they consider appropriate.”>  

Section 20

In section 20, page 16, line 2, leave out <17V> and insert <17VA>

In section 20, page 16, line 2, leave out <19> and insert <(Drug Tariff)>
Section 22

Rhona Brankin
Supported by: Mr Andy Kerr
34 In section 22, page 18, line 7, at end insert <or>

Rhona Brankin
Supported by: Mr Andy Kerr
35 In section 22, page 18, line 24, at end insert—

  <( ) in subsection (3)—

    (i) in paragraph (a), after the word “providing,” insert “assisting in providing,”;

    (ii) in paragraph (b), after the word “provision,” insert “assistance in provision,”;>

Rhona Brankin
Supported by: Mr Andy Kerr
12 In section 22, page 18, leave out lines 28 to 30

Section 24

Shona Robison
57 In section 24, page 20, line 28, leave out from <; and> to end of line 29

Shona Robison
58 In section 24, page 20, line 36, after <died> insert <either—

  ( )> 

Shona Robison
59 In section 24, page 20, line 37, after <Scotland;> insert <or

  ( ) the person’s sole or main residence is or was outside the United Kingdom but, immediately before acquiring such sole or main residence, the person’s sole or main residence is or was in Scotland;>

Shona Robison
60 In section 24, page 20, line 40, at end insert—

  <( ) provide for a right of appeal against the determination of such claims>

Shona Robison
61 In section 24, page 20, line 40, at end insert—

  <( ) provide that a claim may be made in respect of a dead person, without such a claim having to have been made prior to that person’s death>
Shona Robison
62 In section 24, page 21, line 6, leave out from <(but) to end of line 8

Section 26

Rhona Brankin
Supported by: Mr Andy Kerr
69 In section 26, page 22, line 6, at end insert—

<( ) In section 37 (right to make representations to Commission under Part 2 as respects conditions), for subsection (2) substitute—

“(2) Where a notice to which this section applies has been given—

(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the local authority to whom the notice was given make such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) the local authority notify the Commission that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.>

After section 26

Rhona Brankin
Supported by: Mr Andy Kerr
1 After section 26, insert—

<Frequency of inspection of care services under the 2001 Act

(1) The 2001 Act is amended as follows.

(2) In section 25 (inspection of registered care services), after subsection (5) insert—

“(5A) The Scottish Ministers may, after consulting the Commission and thereafter such other persons (or groups of persons) as they consider appropriate, by order amend—

(a) subsection (3)(a) above by substituting for “twelve months” in either or both sub-paragraphs (i) and (ii) a different period (being a period which is not less than twelve months);

(b) subsection (5) above by substituting for “twelve months” in either or both paragraphs (a) and (b) a different period (being a period which is not less than twelve months).
(5B) An order under subsection (5A) above may make different provision for different purposes.”.

(3) In section 78 (orders and regulations), in subsection (2)(b), after the word “3” insert “or 25(5A)”.

Section 30

Rhona Brankin
Supported by: Mr Andy Kerr

70 In section 30, page 25, line 19, leave out <a person> and insert <an individual>

Rhona Brankin
Supported by: Mr Andy Kerr

71 In section 30, page 26, line 15, at end insert <;

( ) after subsection (10) insert—

“(11) In subsection (1A)—

“dental practitioner” has the same meaning as in section 108(1) of the National Health Service (Scotland) Act 1978 (c.29);

“ophthalmic optician” means a person registered in either of the registers kept under section 7 of the Opticians Act 1989 (c.44) of ophthalmic opticians.”.

After section 30

Rhona Brankin
Supported by: Mr Andy Kerr

63 After section 30, insert—

<Appeals under Public Health (Scotland) Act 1897

Amendment of Public Health (Scotland) Act 1897: appeal against certain orders etc.

After section 156 of the Public Health (Scotland) Act 1897 (c.38), insert—

“156A Appeal to sheriff or sheriff principal in certain cases: sections 54, 55 and 96

(1) Any person in respect of whom—

(a) an order under section 54(1) (for removal to a hospital) or under section 54(3) (for transfer to another hospital) (referred to in this section and section 156C as a “section 54 order”);

(b) a direction under section 55(1) (for detention in a hospital) or under section 55(3) (for removal to another hospital) (referred to in this section and section 156C as a “section 55 direction”); or

(c) a decision under section 96 (for removal to a hospital) (referred to in this section and sections 156B and 156C as a “section 96 decision”),
is made, or any person having an interest in the welfare of the person in respect of whom the order, the direction or, as the case may be, the decision is made, may appeal under this section against the order, the direction or, as the case may be, the decision.

(2) An appeal under this section against—

(a) a section 54 order or a section 55 direction by a sheriff may be made to the sheriff principal;

(b) a section 54 order or a section 55 direction by a justice may be made to the sheriff principal of either of the sheriffdoms mentioned in subsection (3);

(c) a section 96 decision may be made to the sheriff of either of those sheriffdoms.

(3) The sheriffdoms are—

(a) the sheriffdom in which the person (in respect of whom the section 54 order, section 55 direction or section 96 decision in question is made) is resident immediately before it is made;

(b) the sheriffdom in which the hospital (in which that person is detained pursuant to the section 54 order, section 55 direction or section 96 decision in question) is situated.

(4) An appeal under this section may be made on either or both of the following grounds—

(a) that the section 54 order, section 55 direction or section 96 decision in question was based on an error of law;

(b) that the section 54 order, section 55 direction or section 96 decision in question was not supported by the facts found to be established by the sheriff or justice who made the order or direction or, as the case may be, the local authority who made the decision.

(5) An appeal against a section 54 order, section 55 direction or section 96 decision may be made before the expiry of the period of 21 days beginning with the day on which the order, the direction or, as the case may be, the decision is made.

(6) An appeal against a section 54 order or section 55 direction by a justice or a section 96 decision is to be made by way of summary application.

(7) In an appeal under this section against a section 54 order, section 55 direction or section 96 decision, the sheriff principal or, as the case may be, the sheriff may—

(a) confirm the order, the direction or, as the case may be, the decision;

(b) direct that the order, the direction or, as the case may be, the decision ceases to have effect;

(c) make such other order or direction as the sheriff principal or, as the case may be, the sheriff thinks fit.
156B Further appeal to sheriff principal: section 96 decision

(1) Where, in an appeal under section 156A against a section 96 decision, the sheriff confirms the decision, the person in respect of whom the section 96 decision was made, or any person having an interest in the welfare of that person, may appeal to the sheriff principal against the decision of the sheriff in the appeal on either or both of the grounds mentioned in subsection (2).

(2) The grounds are—

   (a) that the decision of the sheriff in the appeal under section 156A was based on an error of law;

   (b) that that decision was not supported by the facts found to be established by the sheriff in the appeal.

(3) An appeal under this section may be made before the expiry of the period of 21 days beginning with the day on which the decision of the sheriff in the appeal under section 156A is made.

(4) In an appeal under this section, the sheriff principal—

   (a) may allow the appeal and when doing so must direct that the section 96 decision ceases to have effect;

   (b) may refuse the appeal and confirm the decision of the sheriff;

   (c) may make such other order or direction as the sheriff principal thinks fit.

156C Further appeal to Court of Session: sections 54, 55 and 96

(1) Where, in an appeal under section 156A against a section 54 order or section 55 direction, the sheriff principal confirms the order or, as the case may be, the direction, the person in respect of whom the decision in the appeal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

   (a) that the decision of the sheriff principal in the appeal under section 156A was based on an error of law;

   (b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.

(2) Where, in an appeal under section 156B against a decision of the sheriff in an appeal under section 156A, the sheriff principal confirms the decision of the sheriff in the appeal under section 156A, the person in respect of whom the decision of the sheriff principal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

   (a) that the decision of the sheriff principal in the appeal under section 156B was based on an error of law;

   (b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.
156D Effect of appeal in relation to section 54 order, section 55 direction or section 96 decision

A section 54 order, a section 55 direction or a section 96 decision may be given effect notwithstanding that an appeal may be or is made against, or in relation to, it under this Act.”.

Schedule 2

Rhona Brankin
Supported by: Mr Andy Kerr

64* In schedule 2, page 36, line 13, at end insert—

In section 157 of the Public Health (Scotland) Act 1897, for the words “the preceding section” substitute “section 156 or as provided in sections 156A to 156C”.

Rhona Brankin
Supported by: Mr Andy Kerr

29 In schedule 2, page 36, line 15, at end insert—

(1A) In section 2(1) (Health Boards and Special Health Boards), in each of paragraphs (a) and (b), for the words “under this Act” substitute “relating to the health service”.

Rhona Brankin
Supported by: Mr Andy Kerr

36 In schedule 2, page 36, line 15, at end insert—

(a) in subsection (1A)—

(i) in paragraph (a), for the words from the second “to” to “he” substitute “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry to submit to the Board, in relation to treatment which he, or as the case may be, it”;

(ii) in paragraph (b), after the words “a dental practitioner” insert “or such a body corporate”;

(b) in subsection (1B), after the words “dental practitioner” insert “or body corporate”.

Rhona Brankin
Supported by: Mr Andy Kerr

30 In schedule 2, page 36, line 15, at end insert—

(1C) In section 10(3) (Common Services Agency), for the words “under this Act” substitute “relating to the health service”.

8
In schedule 2, page 36, line 23, at end insert—

( ) In section 17C(2A)(b)(ii) (other Part 1 services which may be included in arrangements for the provision of personal dental services), after the word “Part” insert “(but not pharmaceutical care services).”.

In schedule 2, page 36, line 23, at end insert—

( ) In section 17D (persons with whom agreements may be made)—

(a) in subsection (1)(b)(vi), for the words “an individual” substitute “a person”;

(b) in subsection (2)—

(i) in paragraph (b)(v) of the definition of “NHS employee”, for the words “an individual” substitute “a person”;

(ii) in paragraph (c)(i) of that definition, for the words from the beginning to “or” substitute “a dental practitioner or body corporate whose name is included in the first part of a list prepared under section 25(2) of this Act or in a list prepared under”;

(iii) in paragraph (c)(ii) of that definition, after the word “who” insert “, or body corporate which,”;

(iv) in paragraph (b) of the definition of “qualifying body”, for the words “which, in accordance with the provisions of Part IV of the Dentists Act 1984, is entitled to carry on the business of dentistry” substitute “entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(v) in the definition of “section 17C employee”, for the words from “by” to the end substitute “by a person providing services in accordance with the arrangements”.

In schedule 2, page 36, line 28, leave out from “section” to end of line 29 and insert “the words from “has” to the end substitute “means—

(a) the first part of a list prepared under section 25(2);

(b) the first part of a list prepared under section 26(2);”

In schedule 2, page 37, line 11, at end insert—

( ) In section 64(5) (permission for use of facilities in private practice), in paragraph (b), after the word “provide” insert “dental,”.
In schedule 2, page 37, line 29, at beginning insert <in subsection (1)—
( ) after the definition of “dispensing optician”, insert—

“Drug Tariff” means the Drug Tariff required to be prepared,
maintained and published by the Scottish Ministers under section 17VA
of this Act;”;

In schedule 2, page 37, line 41, at end insert—
( ) after that subsection, insert—

“(1A) References in this Act to “carrying on the business of dentistry” are to be
construed in accordance with section 40 of the Dentists Act 1984 (c.24).”;

In Schedule 8, in paragraph 8(2)(b), for the words “disqualification, conditional
disqualification or declaration of unfitness” substitute “disqualification or conditional
disqualification”.

In schedule 2, page 38, line 15, at end insert <;
( ) in subsection (2)(b)—
(i) after the words “dental practitioner” insert “or body corporate entitled, by
virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business
of dentistry”;
(ii) after the word “his” insert “or its”;

National Health Service (Primary Care) Act 1997 (c.46)
(1) The 1997 Act is amended as follows.
(2) In section 1 (pilot schemes)—
(a) in subsection 3(b), after the word “services” insert “nor pharmaceutical care
services”;
(b) in subsection 8—
(i) in the definition of “personal dental services”, after the words “dental
practitioner” insert the words “or body corporate”;

10
(ii) at end, insert “;

“pharmaceutical care services” has the same meaning as for the purposes of Part 1 of the 1978 Act.”.

(3) In section 3(3) (persons with whom pilot schemes for personal dental services may be made)—

(a) in paragraph (b) of the definition of “dental list”—

(i) after the word “Scotland,” insert “the first part of”;

(ii) for the words “section 25(2)(a)” insert “section 25(2)”;

(b) in the definition of “NHS employee”—

(i) in paragraph (b), after the words “dental practitioner” insert “or body corporate”; 

(ii) in paragraph (c), after the word “who” insert “, or body corporate which,”.

(4) In section 17(5) (the Dental Practice Boards)—

(a) after the words “dental practitioner” insert “or body corporate”; 

(b) after the word “he” insert “or it”.

Rhona Brankin
Supported by: Mr Andy Kerr

44 In schedule 2, page 38, leave out lines 20 and 21 and insert—

<) for paragraph (b) substitute—

“(b) dental practitioners or bodies corporate undertaking to provide, and persons approved to assist in providing, general dental services;”;

Rhona Brankin
Supported by: Mr Andy Kerr

45 In schedule 2, page 38, line 32, at end insert—

<The Scottish Public Services Ombudsman Act 2002 (asp 11)

In paragraph 14 of schedule 4 to the Scottish Public Services Ombudsman Act 2002, for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”.

Schedule 3

Rhona Brankin
Supported by: Mr Andy Kerr

46 In schedule 3, page 39, line 5, column 2, at beginning insert—

<In section 17C(6), the words “by a general dental practitioner”.

Rhona Brankin
Supported by: Mr Andy Kerr

14 In schedule 3, page 39, line 5, column 2, leave out <25(4) and> and insert <25(3) to>
Rhona Brankin  
Supported by: Mr Andy Kerr  
47 In schedule 3, page 39, line 6, column 2, at end insert—

<In section 28B(6), the words “Subject to section 25(3),”.

Rhona Brankin  
Supported by: Mr Andy Kerr  
48 In schedule 3, page 39, column 2, leave out line 7 and insert—

<In section 29A, subsection (2) and in subsection (5), the words “(including provision modifying the effect of this Part)”.

Rhona Brankin  
Supported by: Mr Andy Kerr  
49 In schedule 3, page 39, line 29, at end insert—

<Health Services Act 1980 (c.53) Section 20(2).  
In Schedule 6, paragraph 4.  
In Schedule 7, the entry for section 25(3) of the 1978 Act.>

Rhona Brankin  
Supported by: Mr Andy Kerr  
50 In schedule 3, page 39, line 29, at end insert—

<Health and Social Services and Social Security Adjudications Act 1983 (c.41)>

Rhona Brankin  
Supported by: Mr Andy Kerr  
51 In schedule 3, page 39, line 29, at end insert—

<Dentists Act 1984 (c.24) In Schedule 5, paragraph 12.>

Rhona Brankin  
Supported by: Mr Andy Kerr  
52 In schedule 3, page 39, column 2, leave out line 44 and insert—

<Section 40.  
In Schedule 9, paragraph 19(6), (7) and (8).>

Rhona Brankin  
Supported by: Mr Andy Kerr  
53 In schedule 3, page 39, line 45, at end insert—
In section 1(8), the words “by a general dental practitioner”.
Section 27(2).
Section 28(2).
Section 29(2).
In Schedule 2, paragraphs 43, 44 and 45.
In Schedule 3, the entry concerning section 25(2)(c) of the 1978 Act.

Rhona Brankin
Supported by: Mr Andy Kerr

54 In schedule 3, page 39, line 45, at end insert—
<Health Act 1999 (c.8) Section 56(3) and (4).
In Schedule 4, paragraphs 49, 51(d) and (g), 52(c) and 53.
In Schedule 5, in the entry concerning section 32A of the 1978 Act, the words “and, in subsection (6)(a), “prepared under this Part of this Act””.

Rhona Brankin
Supported by: Mr Andy Kerr

55 In schedule 3, page 40, line 5, at end insert—
<Community Care and Health (Scotland) Act 2002 (asp 5) In schedule 2, paragraphs 2(6)(c), (7), (8), (9)(b), (10)(b) and (11).>

Rhona Brankin
Supported by: Mr Andy Kerr

65 In schedule 3, page 40, line 7, at end insert—
<Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) In schedule 2, paragraph 4(3)(b) and (6)(b).>

Rhona Brankin
Supported by: Mr Andy Kerr

56 In schedule 3, page 40, line 7, at end insert—
<Primary Medical Services (Scotland) Act 2004 (asp 1) Section 5(3)(a).
In the schedule, paragraph 1(8), (10), (11)(a), (13) and (16)(a).>
After section 4

Margo MacDonald

33 After section 4, insert—

<No-smoking premises: further provision for licensed premises

(1) This section applies where, by virtue of regulations under section 4(2), licensed premises are no-smoking premises.

(2) The owner of, or person who holds the licence for, the licensed premises may apply to the Licensing Board within whose area the premises are situated for the premises to be treated as if they are not no-smoking premises.

(3) The Licensing Board may grant applications under subsection (2) only exceptionally and in determining such applications must have regard to—

(a) the views of any employees who work in the licensed premises;
(b) the adequacy of ventilation in the licensed premises;
(c) the number and capacity of other licensed premises in the locality in which the licensed premises are situated in respect of which applications under subsection (2) have been granted; and
(d) the level of public demand for licensed premises which are not no-smoking premises.

(4) Where the Licensing Board grants an application under subsection (2), the licensed premises are, for the purposes of sections 1, 2 and 3 and despite any regulations under section 4(2) by virtue of which the premises are no-smoking premises, to be treated as if they are not no-smoking premises.

(5) Licensed premises which are to be treated as if they are not no-smoking premises by virtue of this section may advertise that fact.

(6) The Scottish Ministers may by regulations make further provision about the making and determination of, and the effect of granting, applications under subsection (2).>

Section 37

Rhona Brankin

Supported by: Mr Andy Kerr

31 In section 37, page 32, line 5, leave out <and 35> and insert <, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36>

Rhona Brankin

Supported by: Mr Andy Kerr

32 In section 37, page 32, line 5, after <schedule 1> insert <and paragraph 1(1A) and (1C) of schedule 2>
Smoking, Health and Social Care (Scotland) Bill

Groupings of Amendments for Stage 2 (Day 2)

For debate on Day 2:

Dispensing of appliances
66, 67, 68

Drug tariff
15, 16, 19, 20, 21, 22

Pharmaceutical care service contracts: directions
17, 18

Disqualification by the NHS tribunal
34, 35, 41, 48, 55

For debate on subsequent days (subject to any additional amendments lodged):

Skipton Fund: commencement date
57

Skipton Fund: residency in Scotland
58, 59

Skipton Fund: right of appeal
60

Skipton Fund: posthumous claims
61

Skipton Fund: taking payments into account in other proceedings
62

Right to make representations to care commission
69

Frequency of inspection of care services
1

Technical amendments relating to adults with incapacity certificates
70, 71

Appeal against forcible detention under Public Health (Scotland) Act 1897
63, 64
Ability of Scottish Ministers to confer their health functions on Health Boards and the Common Services Agency
29, 30, 31, 32

Minor and consequential amendments relating to dental services and bodies corporate
36, 38, 40, 42, 43, 44, 46

Exclusion of pharmaceutical care services
37

Consequential amendments and repeals relating to listing provisions
39, 45, 50, 51

Consequential and miscellaneous amendments
47, 49, 52, 53, 54, 56

Removal of age limit on Mental Health Tribunal membership
65

Provision for licensed smoking premises
33

NOTE: THE FOLLOWING AMENDMENTS HAVE ALREADY BEEN DEBATED—
With 3 – 12, 13, 14
AMENDMENT GROUP 2: Pharmaceutical Care Services – the drug tariff
AMENDMENT NOS: 15, 16, 19, 20, 21 and 22

- Collectively these amendments deal with the duty on Scottish Ministers to prepare and maintain the Drug Tariff and what must and may be contained in it. The Drug Tariff already exists and details the fees, allowances and reimbursement details for the current pharmaceutical services contracts.

- These amendments place into primary legislation a requirement on Ministers to publish the Drug Tariff and clarify the status of the document as a vehicle for publishing information relating to pharmaceutical care services. These amendments also allow directions to be published in the document.

AMENDMENT GROUP 3: Pharmaceutical Care Services – PCS contracts
AMENDMENT NOS: 17 and 18

- Amendment 17 inserts a direction making power at 17U(2). This power is wider in scope than the existing provision at 17U(6), which is removed by amendment 18.

- The existing power is limited to the act of dispensing. Under the new PCS contracts Community Pharmacists will be providing a wider range of services under the direction of Scottish Ministers.

- These amendments allow Ministers to prescribe the operational standards for PCS contracts which will apply to all aspects of service provision, i.e. not just dispensing as the current wording effects.

AMENDMENT GROUP 4: Discipline – NHS Tribunal
AMENDMENT NOS: 34, 35, 41, 48 and 55

Amendment 34

- This amendment inserts an “or” between the last two types of list of family health service practitioners in the definition of “list” in the Tribunal provisions in the 1978 Act as amended by the Bill. This makes clear that the references to the different lists of family health service practitioners in that definition are to be read with alternative effect.

Amendment 35

- Amendment 35 provides that, in addition to a practitioner who provides or performs services, a practitioner who assists in the provision of services can be referred to the NHS Tribunal where fraud of the health service is committed or attempted by another person who is acting on their behalf and that practitioner failed to take reasonable
steps to prevent that happening.

**Amendment 41**

- This is a technical amendment consequential on the main provisions of the Bill with respect to the listing of family health service practitioners. In future, all family health service practitioners will be required to be listed before they can perform. The Bill therefore repeals declarations of unfitness in the 1978 Act as this term is no longer necessary. This amendment removes wording in paragraph 8(2)(b) of Schedule 8 of the 1978 Act to this effect.

**Amendment 48**

- This is an amendment to Schedule 3 removing wording in section 29A(5) of the 1978 Act which is no longer required as a result of the new listing provisions.

**Amendment 55**

- This amendment is technical and adds a further consequential repeal to provisions in the Community Care and Health (Scotland) Act 2002 which are redundant as a result of the new provisions on the disqualification of practitioners.
Amendments 66 to 68 in the name of Shona Robison - New arrangements for the provision of stoma appliance supply services

Purpose

This paper explains the background to, and the Executive’s plan for, the future introduction of new arrangements for stoma appliance supply services.

Background

The existing arrangements for the supply of stoma appliances require a prescription (GP10) to be signed by a GP. The prescription is then dispensed either by a community pharmacy or directly by an appliance supplier if on a pharmaceutical list. The assessment of the patient’s requirement is, however, carried out by a specialist stoma nurse, who may be employed by the NHS or sponsored by, or directly employed by, an appliance supplier.

In terms of the current legislation, the dispensing of stoma appliances by appliance suppliers is currently regarded a pharmaceutical service. Under the planned new community pharmacy contract, pharmaceutical services will extend beyond the basic practice of dispensing medicines and appliances and into more clinically based services that require the professional skills of registered pharmacists. The consequence is that appliance suppliers per se will no longer be eligible to hold a pharmaceutical service contract.

It has, therefore, been necessary for the Executive to review and develop new stoma service arrangements for implementation from April 2006. The approach has been informed by a full consultation exercise in June 2003, the responses to which were published in May 2004. In December 2004 the Executive advised key stakeholders, including patient groups, NHS Boards and contractor representatives of its intentions for future stoma service provision.

The Way Forward

The Executive intends to make the provision of stoma services a distinct healthcare service in its own right with national standards for both the assessment and appliance supply processes. It means the discontinuance of appliance suppliers dispensing GP10 prescriptions and its replacement by:

- provision of an enhanced prescription led service exclusively through prescribers expressly trained to assess the requirements of patients with a clinical need for an appliance, with dispensing through a local network of
those community pharmacists, specifically trained and willing to deliver the service, but with no use of agency arrangements; and/or

- provision of a *locally contracted service* with NHS Board staff (stoma nurses) suitably qualified to assess patients’ needs, with products being sourced by the Board and delivered directly to patients from locally let contracts. The “suppliers” could be existing appliance contractors if they meet the NHS Board’s stated needs and laid down standards.

During the consultation stoma patients expressed concern that the new supply arrangements would restrict their choice of appliance. To address this concern NHS Boards are being advised that **existing patients are to continue to be able to use the appliance which, over time, they found to be most appropriate for their condition and that new patients are not disadvantaged by comparison with the previous arrangements.**

The independent assessment of patients’ needs will be at the heart of the new arrangements. The existing network of stoma nurses is considered by NHS Boards to be appropriate to meet patient needs and this level of patient support is to be at least maintained and, as possible under the new arrangements, ideally, improved.

**Action being taken**

The Executive is establishing a National Steering Group to oversee the roll-out of an Action Plan leading to implementation of the new arrangements from April 2006. The matters that the Group will oversee include the establishment of common supply standards, national procurement initiatives and delivery of NHS Board requirements as summarised below. The Group will be chaired by a senior NHS Board Executive and will comprise representatives for patients and all other key stakeholders such as appliance suppliers, stoma nurses, pharmacy representatives and relevant NHS administrators.

The Executive has also written to NHS Boards requiring them to:

- establish local implementation groups, involving patient representatives and stoma nurses, to consider the local service arrangements that will best meet the needs of patients within the Board’s area in the context of an integrated service across the hospital and primary care sectors;

- review, where relevant, whether the status of appliance supplier sponsored or employed nurses continues to be appropriate for the new arrangements;

- prepare local consultation and implementation plans;

- identify and meet any training needs for prescribers and suppliers.

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1 Under these arrangements a dispensing doctor or community pharmacist passes prescriptions to an appliance supplier in return for an introductory commission.
Public Awareness

A more detailed note of the above information has been issued to NHS Boards as a Health Department Letter (HDL) with an action for it to be copied to stoma nurses, all relevant patient groups within their area and all appliance suppliers and community pharmacists on their pharmaceutical lists.

A copy of the HDL is will shortly be available on the Executive’s Scottish Health On the Web (SHOW) page but MSPs may find the attached Q&A material helpful in dealing with enquiries on the issue.

May 2005

NEW STOMA APPLIANCE SUPPLY SERVICES: Q&A

What is changing?

From 2006, NHS Boards will be required to provide a dedicated and inclusive service for those patients who need stoma and ostomy products and support services.

Whilst the supply and fitting services will no longer be classed as a pharmaceutical service, they will become a healthcare service in their own right.

Why the change?

The forthcoming new community pharmacy contract calls for a range of services that appliance suppliers will not be able to provide, so new arrangements for this category of healthcare are required.

Currently there are no national standards for ways in which a patient’s stoma appliance needs are assessed. The changes will introduce minimum standards for both the appliances that are available and the assessment and fitting specifications that NHS Boards must meet.

In some cases, the assessment and supply services are interlinked with appliance suppliers sponsoring or employing stoma nurses. The changes are to ensure full transparency and separation of the processes.

Who will set the standards?

The standards and service specifications will be national. They will be set by the Executive based on advice from health service professionals and following further consultation with other key stakeholders, including patient group representatives, appliance suppliers and their representative bodies.
Limited choice of products?

No – the scope of appliances available will not be reduced. Patients currently on set appliance products will not be asked to switch to other products that do not meet their professionally assessed needs.

Reduced access to suppliers?

No – services will still be provided by a combination of appliance suppliers and community pharmacists.

NHS Boards will be required to honour existing patients’ choice of service providers where it is assessed to be meeting their need.

An end to sponsored nurse arrangements?

NHS Boards are to review their current arrangements and ensure that in future assessments are clinically sound and independent of the supply process.

Funding levels to be maintained?

This is not a cost cutting exercise – the focus is on improving health care standards and maintaining the supply chain whilst ensuring value for money for the NHS.
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

15th Meeting, 2005 (Session 2)

Tuesday 24 May 2005

Present:

Roseanna Cunningham (Convener)   Helen Eadie
Janis Hughes (Deputy Convener)    Kate Maclean
Stewart Maxwell (Committee Substitute)  Mr Duncan McNeil
Mrs Nanette Milne                  Mike Rumbles
Jean Turner

Apologies: Shona Robison.

Smoking, Health and Social Care (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 2).

The following amendments were agreed to (without division): 15, 16, 17, 18, 19, 20, 21, 34, 35 and 12.

Amendment 66 was moved and, with the agreement of the Committee, withdrawn.

Amendments 67 and 68 were not moved.

Sections 18, 19, 20 and 22 were agreed to as amended.

Sections 21 and 23 were agreed to without amendment.

The Committee ended consideration of the Bill for the day, amendment 12 having been disposed of.
Smoking, Health and Social Care (Scotland) Bill: Stage 2

14:02

The Convener: Item 3 is consideration of the Smoking, Health and Social Care (Scotland) Bill at stage 2. I remind members that, as previously agreed, the committee will consider only amendments that relate to parts 3 and 4 of the bill at today's meeting. That means that only the first four groupings, which cover the dispensing of appliances, the drug tariff, directions on pharmaceutical care services contracts, and disqualifications by the national health service tribunal, will be debated today.

Section 18—Health Boards’ functions: provision and planning of pharmaceutical care services

The Convener: The first group of amendments deal with the dispensing of appliances. The amendments are in the name of Shona Robison but, as Shona Robison's committee substitute, Stewart Maxwell will speak to and move them. Amendment 66 is grouped with amendments 67 and 68.

Mr Maxwell: First, I will say why the amendments were lodged. There appears to be confusion on the issue. The bill is unclear and confusing on the implications for the future supply of pharmaceutical care services.

Many stoma patients require a great deal of stoma care from their dispensing appliance contractors—or DACs. I am thinking not just of the supply of colostomy bags and appliances but of at-home fittings, maintenance and personal support by specialist stoma nurses, many of whom are funded by the industry.

The problem is that the bill contains provisions for excluding DACs from entering into further pharmaceutical care services contracts. That will preclude DACs from providing a number of essential services for NHS patients, yet there are no viable alternative providers of those services. The bill reads that any contractor is prohibited from entering into a pharmaceutical care service contract unless they provide what are referred to as “essential services”. As the committee knows, those services will be defined in regulations. However, it appears that the term refers to operations that are considered integral to what a general pharmacist provides. It appears that a company that does not offer the full range of what are considered integral services for a pharmacist—for example, the dispensing of controlled drugs—could not enter into a contract for the supply of any pharmaceutical care services.

To a greater or lesser extent, the purpose of the amendments is to ensure that DACs would not be excluded from pharmaceutical care services contracts. The amendments are drafted to avoid cutting out those specialist providers at this legislative stage. The amendments would leave those measures out of the legislation to avoid unease.

The bill also requires the supply of any kind of pharmaceutical care service to be carried out or supervised by a registered pharmacist. That requirement has only ever been made of contractors who supplied controlled drugs. Given that DACs do not dispense controlled substances, they have never been subject to that requirement. I see no reason why the existing service should require a pharmacist’s supervision. I therefore ask the committee to support the amendments.

I move amendment 66.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): It would be tragic if, because of the new arrangement for pharmaceutical services, the firms that have until now supplied people faced a problem. It would be tragic if in the new arrangements there was any hindrance to people who require stoma care getting a service that is custom designed for them. Stomas are as individual as the people. The type of appliance that the person uses is individual to them. If the person does not get the particular appliances that they are used to using, infection can often be a problem. If they have to make do with a substitute, there can be long-term implications. In this day and age, when we definitely do not want to break the skin and have infection, many of the people affected who were consulted prior to the introduction of the bill said that they were happy with the way things were going and were desperate that things should stay the same. I have had patients who found it extremely difficult to change when it seemed that another appliance was the only one that was available.

Many of these people go and pick up their prescriptions, which are very bulky—it is not a matter of going to get a small packet. Often the appliances are delivered to their house. Some pharmacies can do that, but others cannot. Some companies do it for them.

I seek reassurance from the minister that the changes that are being made in the bill will not disadvantage people who have very special needs. Those people do not want to become housebound or have to attend hospital for treatment because they cannot have the right appliance. They would have to go to hospital if they used the wrong appliances because those appliances might use adhesive to which they are allergic. I welcome the amendments.
Mrs Nanette Milne (North East Scotland) (Con): My concern lies with the network of stoma nurses. The briefing paper from the Executive states:

“The existing network of stoma nurses is considered by NHS boards to be appropriate to meet patient needs.”

I am aware that a number of those nurses are currently funded by the stoma appliance providers. If that is no longer the case, will the health boards be in a position to employ the nurses or will the network become smaller because the boards will not be in a position to employ them?

Janis Hughes (Glasgow Rutherglen) (Lab): I concur with Jean Turner’s point about patients who are used to particular appliances. Having nurses with stomas, I understand the difficulty of getting an appliance that suits the patient. Sometimes that takes a very long time. When the patient is used to an appliance they obviously want to continue to use it. That is important for the quality of life that patients with stomas achieve.

I know that there was a consultation process during which the views of users, among others, were considered, but I seek reassurance from the minister about the on-going care and provision of appliances that patients with stomas can expect under the new proposals.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I would like some confirmation from the minister. The issue is a controversial one. I am surprised that there are no national standards for ways in which a patient’s stoma appliance needs are assessed. Can the minister comment on that? In addition, can she say whether the scope of the appliances that are now available will be reduced or increased by the proposals?

Helen Eadie (Dunfermline East) (Lab): Will the minister give us more details of the timescales for some of the actions that are mentioned in the briefing paper that we have received? The paper talks about the establishment of

“a National Steering Group to oversee the roll-out of an Action Plan leading to implementation of the new arrangements from April 2006.”

People have told the committee of their concerns that existing patients should be able to use the appliance that they have found to be most appropriate for their condition, and that new patients should not be disadvantaged by the new arrangements. Will those requirements come into effect immediately?

The Convener: I think that that exhausts members’ questions and comments.

Rhona Brankin: Amendments 66, 67 and 68 appear to have been founded on a misunderstanding of the intention behind the modernisation of the community pharmacy service.

The bill expands the role of the community pharmacist in the provision of enhanced pharmaceutical care services, including medication review arrangements for patients who have chronic conditions and regularly need repeat prescriptions. The bill will also provide a minor ailments service under which eligible patients will be able go straight to their pharmacist for advice and certain medications, rather than having to go to their general practitioner first.

Services must be delivered to clearly defined standards and by suitably qualified registered pharmacists working from registered premises. As a consequence, the provisions for the delivery of pharmaceutical care services have been developed distinctly. That will not cause any removal, diminution or attenuation of appliance supply services. That is important and it is the key aspect of the new arrangements that I think may have been missed by the appliance supply community.

Through alternative administrative arrangements and directions, the Executive will ensure that stoma services become a dedicated health care service in their own right. Currently, appliance suppliers have no recognised registration body. They work from premises that are not subject to regulation and to standards that have not been nationally agreed. That would lead to a mismatch in trying to define appliance supply services within the constraints of the provisions for pharmaceutical care services.

After a public consultation, we have determined a way forward to ensure that the current availability of services is maintained. Services will then be enhanced with the introduction of nationally agreed service standards. That answers Mr Rumbles’s point.

The Executive has prepared an action plan and established a national steering group to oversee the implementation of the plan. The group comprises representatives of patients, appliance suppliers, stoma nurses and the national health service.

Through a letter from the Health Department, health boards have been instructed to review their current arrangements and establish local implementation groups, with full stakeholder representation, as part of the process leading to the changes that will come into effect from April 2006.

I am aware that the interpretation that some have placed on the new arrangements has given rise to concerns on the part of some patients and stoma nurses. As we have made clear on a number of occasions, patients will still have
access to stoma nurses and will still be able to source their prescribed appliance from their current supplier. It is intended that stoma nurses will continue to be the patient’s champion throughout their stoma care journey from the hospital to the community. That status of nurses is well acknowledged and will be reinforced.

All the new arrangements can be delivered within the legislative framework. Consequently, I invite Mr Maxwell to withdraw amendment 66 and not to move the other amendments in the group.

The Convener: Stewart, would you like to press amendment 66 or seek agreement to withdraw it?

Mr Maxwell: May I first comment on what the minister has said?

The Convener: Yes, of course.

Mr Maxwell: I am reassured to an extent by what the minister has said. It has been extremely helpful and I will not move the amendments at this stage.

The Convener: You have already moved amendment 66.

Mr Maxwell: On the basis of what the minister has said I will not move amendments 67 and 68. Hopefully we can clarify any outstanding issues before stage 3, so that everyone is aware of what the situation is.

The Convener: Do you wish to withdraw amendment 66?

Mr Maxwell: Yes.

Amendment 66, by agreement, withdrawn.

14:15

The Convener: Amendment 15, in the name of the minister, is grouped with amendments 16 and 19 to 22.

Rhona Brankin: The bill makes a number of references to the drug tariff. The drug tariff already exists and specifies the fees, allowances and reimbursement details for the current pharmaceutical services contracts. More particularly, and by way of example, it details the method by which the prices of listed and other drugs are calculated for reimbursement purposes. It defines the standards of quality of drugs that can be dispensed and lists the dental and nurse prescribing formularies. The amendments make it an explicit requirement of primary legislation that Scottish ministers produce such a document. Currently, that is left to regulations. The intention is to make clear the status and purposes for which the drug tariff must or may be used for directions that relate to the provision of pharmaceutical care services. Amendment 19 places into primary legislation a requirement on ministers to publish and maintain the drug tariff. It also clarifies the status of the document as a vehicle in which information relating to pharmaceutical care services must be published and in which relevant directions may be published.

Amendments 15 and 20 to 22 are consequential on amendment 19 and are concerned with amending the definitions and references to the drug tariff elsewhere in the bill. Amendment 16 provides further detail on the way that Scottish ministers will issue directions regarding payments made under pharmaceutical care services contracts.

I move amendment 15.

Amendment 15 agreed to.

Section 18, as amended, agreed to.

Section 19—Pharmaceutical care services contracts

Amendments 67 and 68 not moved.

Amendment 16 moved—[Rhona Brankin]—and agreed to.

The Convener: Amendment 17, in the name of the minister, is grouped with amendment 18.

Rhona Brankin: I move amendment 17.

Amendments 17 and 18 widen the scope of the powers through which ministers can prescribe the manner and standards of the new pharmaceutical care services contracts. The existing power is limited to directing on dispensing. The new PCS contracts will deliver a wider range of services. The services are to be provided to the same standards throughout Scotland, and the bill provides that compliance with the stated standards will be a condition of PCS contracts. That will accord with the committee’s recommendations in its stage 1 report.

I move amendment 17.

Amendment 17 agreed to.

Amendment 18 moved—[Rhona Brankin]—and agreed to.

Section 19, as amended, agreed to.

After section 19

Amendment 19 moved—[Rhona Brankin]—and agreed to.

Section 20—Persons performing pharmaceutical care services

Amendments 20 and 21 moved—[Rhona Brankin]—and agreed to.

Section 20, as amended, agreed to.

Section 21 agreed to.
Section 22—Disqualification by the NHS Tribunal

The Convener: Group 4 is on disqualification by the NHS tribunal. Amendment 34, in the name of the minister, is grouped with amendments 35, 41, 48 and 55.

Rhona Brankin: Amendments 34, 35, 41, 48 and 55 are technical, minor and consequential amendments to the discipline provisions of the bill that relate to the NHS tribunal. Section 22 contains a list of the new lists of persons who are subject to the jurisdiction of the NHS tribunal. To make it clear that a practitioner need be only on, or applying to be on, a list for the services that they perform, provide or assist in providing, amendment 34 follows the legal drafting convention and will insert an “or” between the final two types of list.

Amendment 35 will provide that, in addition to a practitioner who provides or performs services, a practitioner who assists in the provision of services can be referred to the NHS tribunal if fraud of the health service is committed or attempted by another person who is acting on the practitioner’s behalf and the practitioner has failed to take reasonable steps to prevent that from happening.

Amendment 41 is consequential on the main provisions of the bill on the listing of family health service practitioners. In future, all family health service practitioners will be required to be listed before they can perform. The bill therefore repeals the provision on declarations of unfitness in the National Health Service (Scotland) Act 1978, as it is no longer necessary. Amendment 41 will remove a further reference to declarations of unfitness in the 1978 act.

Amendment 48 will insert a repeal in schedule 3—it will remove wording in section 29A(5) of the 1978 act that is no longer required as a consequence of the provisions for new listing arrangements in parts 2 and 3 of the bill. Similarly, amendment 55 will add a further consequential repeal to schedule 3 by removing redundant wording in the Community Care and Health (Scotland) Act 2002.

I move amendment 34.

Amendment 34 agreed to.

Amendments 35 and 12 moved—[Rhona Brankin]—and agreed to.

Section 22, as amended, agreed to.

Section 23 agreed to.

The Convener: That ends today’s consideration of the bill at stage 2, which may be something of a record. The target for next week’s meeting is to complete consideration of sections 24 to 30. The deadline for amendments to those sections has already expired—it was earlier than usual because of the holiday weekend.

That ends our public business for today.

14:24

Meeting continued in private until 14:41.
3rd Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Sections 9 to 36 Schedules 2 and 3
Sections 1 to 5 Schedule 1
Sections 6 to 8 Section 37
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 24

Rhona Brankin
Supported by: Mr Andy Kerr

74 In section 24, page 20, line 24, after second <of> insert—
<(ya)>

Shona Robison

57 In section 24, page 20, line 28, leave out from <; and> to end of line 29

Rhona Brankin
Supported by: Mr Andy Kerr

75 In section 24, page 20, line 29, at end insert <;
(za) persons who—
(i) became infected with the hepatitis C virus by transmission of the virus by means specified in the scheme from a person who before 1st September 1991 was treated anywhere in the United Kingdom under the National Health Service by way of the receipt of blood, tissue or a blood product and as a result of that treatment became infected with the hepatitis C virus;
(ii) were at the time of transmission in a relationship mentioned in subsection (1A) with the person from whom the virus was transmitted; and
(iii) did not die before 29th August 2003>

Rhona Brankin
Supported by: Mr Andy Kerr

76 In section 24, page 20, line 29, at end insert—
<(1A) The relationships referred to in subsection (1)(za)(ii) are—
(a) spouse or civil partner;>
(b) person who was living with the person from whom the virus was transmitted as husband or wife or in a relationship which had the characteristics of the relationship between civil partners (or if the person from whom the virus was transmitted was in hospital immediately before death, had been so living when that person was admitted to hospital);

(c) other cohabitant (whether or not of the same sex as the person from whom the virus was transmitted);

(d) where the person from whom the virus was transmitted was a mother, a son or daughter of the mother;

(e) such other relationship as the scheme may specify; and the scheme may specify or elaborate the meaning of relationship for this purpose.

Rhona Brankin
Supported by: Mr Andy Kerr

77 In section 24, page 20, line 31, leave out <question> and insert <questions>

Rhona Brankin
Supported by: Mr Andy Kerr

78 In section 24, page 20, line 33, leave out <is> and insert <; and

( ) a person became infected with the virus by transmission of it by means specified in the scheme from a person who became infected as mentioned in sub-paragraph (i),

are

Shona Robison

58 In section 24, page 20, line 36, after <died> insert <either—

( )>

Shona Robison

59 In section 24, page 20, line 37, after <Scotland;> insert <or

( ) the person’s sole or main residence is or was outside the United Kingdom but, immediately before acquiring such sole or main residence, the person’s sole or main residence is or was in Scotland;>

Dr Jean Turner

79 In section 24, page 20, line 37, after <Scotland;> insert <or

( ) the person’s sole or main residence is or was outside the United Kingdom but, before acquiring such sole or main residence, the person had at some time had a sole or main residence in Scotland;>

Shona Robison

60 In section 24, page 20, line 40, at end insert—

<( ) provide for a right of appeal against the determination of such claims>
Shona Robison
61 In section 24, page 20, line 40, at end insert—

<( ) provide that a claim may be made in respect of a dead person, without such a claim having to have been made prior to that person’s death>

Rhona Brankin
Supported by: Mr Andy Kerr
80 In section 24, page 21, line 1, at end insert—

<( ) specify conditions for eligibility for the making of a claim by another person under the scheme in respect of a person falling within subsection (1)(za) who has died without having made a claim under the scheme;>

Shona Robison
62 In section 24, page 21, line 6, leave out from <(but> to end of line 8

Section 26

Rhona Brankin
Supported by: Mr Andy Kerr
69 In section 26, page 22, line 6, at end insert—

<( ) In section 37 (right to make representations to Commission under Part 2 as respects conditions), for subsection (2) substitute—

“(2) Where a notice to which this section applies has been given—

(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the local authority to whom the notice was given make such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) the local authority notify the Commission that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.>
After section 26

Rhona Brankin  
Supported by: Mr Andy Kerr

1 After section 26, insert—

 Fresquency of inspection of care services under the 2001 Act

(1) The 2001 Act is amended as follows.

(2) In section 25 (inspection of registered care services), after subsection (5) insert—

“(5A) The Scottish Ministers may, after consulting the Commission and thereafter such other persons (or groups of persons) as they consider appropriate, by order amend—

(a) subsection (3)(a) above by substituting for “twelve months” in either or both sub-paragraphs (i) and (ii) a different period (being a period which is not less than twelve months);

(b) subsection (5) above by substituting for “twelve months” in either or both paragraphs (a) and (b) a different period (being a period which is not less than twelve months).

(5B) An order under subsection (5A) above may make different provision for different purposes.”.

(3) In section 78 (orders and regulations), in subsection (2)(b), after the word “3” insert “or 25(5A)”.”

Section 30

Rhona Brankin  
Supported by: Mr Andy Kerr

70 In section 30, page 25, line 19, leave out <a person> and insert <an individual>

Rhona Brankin  
Supported by: Mr Andy Kerr

72 In section 30, page 25, line 20, leave out from <who> to end of line 21

Rhona Brankin  
Supported by: Mr Andy Kerr

73 In section 30, page 25, line 22, at beginning insert <who satisfies such requirements as may be so prescribed>

Mrs Nanette Milne

81 In section 30, page 25, line 40, leave out from beginning to end of line 5 on page 26

Mrs Nanette Milne

82 In section 30, page 26, leave out lines 9 to 15
In section 30, page 26, line 15, at end insert <;

( ) after subsection (10) insert—

“(11) In subsection (1A)—

“dental practitioner” has the same meaning as in section 108(1) of the National Health Service (Scotland) Act 1978 (c.29);

“ophthalmic optician” means a person registered in either of the registers kept under section 7 of the Opticians Act 1989 (c.44) of ophthalmic opticians.”.

After section 30

After section 30, insert—

<Appeals under Public Health (Scotland) Act 1897

Amendment of Public Health (Scotland) Act 1897: appeal against certain orders etc.

After section 156 of the Public Health (Scotland) Act 1897 (c.38), insert—

“156A Appeal to sheriff or sheriff principal in certain cases: sections 54, 55 and 96

(1) Any person in respect of whom—

(a) an order under section 54(1) (for removal to a hospital) or under section 54(3) (for transfer to another hospital) (referred to in this section and section 156C as a “section 54 order”);

(b) a direction under section 55(1) (for detention in a hospital) or under section 55(3) (for removal to another hospital) (referred to in this section and section 156C as a “section 55 direction”); or

(c) a decision under section 96 (for removal to a hospital) (referred to in this section and sections 156B and 156C as a “section 96 decision”),

is made, or any person having an interest in the welfare of the person in respect of whom the order, the direction or, as the case may be, the decision is made, may appeal under this section against the order, the direction or, as the case may be, the decision.

(2) An appeal under this section against—

(a) a section 54 order or a section 55 direction by a sheriff may be made to the sheriff principal;

(b) a section 54 order or a section 55 direction by a justice may be made to the sheriff principal of either of the sherifffdoms mentioned in subsection (3);

(c) a section 96 decision may be made to the sheriff of either of those sherifffdoms.
The sheriffdoms are—

(a) the sheriffdom in which the person (in respect of whom the section 54 order, section 55 direction or section 96 decision in question is made) is resident immediately before it is made;

(b) the sheriffdom in which the hospital (in which that person is detained pursuant to the section 54 order, section 55 direction or section 96 decision in question) is situated.

An appeal under this section may be made on either or both of the following grounds—

(a) that the section 54 order, section 55 direction or section 96 decision in question was based on an error of law;

(b) that the section 54 order, section 55 direction or section 96 decision in question was not supported by the facts found to be established by the sheriff or justice who made the order or direction or, as the case may be, the local authority who made the decision.

An appeal against a section 54 order, section 55 direction or section 96 decision may be made before the expiry of the period of 21 days beginning with the day on which the order, the direction or, as the case may be, the decision is made.

An appeal against a section 54 order or section 55 direction by a justice or a section 96 decision is to be made by way of summary application.

In an appeal under this section against a section 54 order, section 55 direction or section 96 decision, the sheriff principal or, as the case may be, the sheriff may—

(a) confirm the order, the direction or, as the case may be, the decision;

(b) direct that the order, the direction or, as the case may be, the decision ceases to have effect;

(c) make such other order or direction as the sheriff principal or, as the case may be, the sheriff thinks fit.

Where, in an appeal under section 156A against a section 96 decision, the sheriff confirms the decision, the person in respect of whom the section 96 decision was made, or any person having an interest in the welfare of that person, may appeal to the sheriff principal against the decision of the sheriff in the appeal on either or both of the grounds mentioned in subsection (2).

The grounds are—

(a) that the decision of the sheriff in the appeal under section 156A was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff in the appeal.

An appeal under this section may be made before the expiry of the period of 21 days beginning with the day on which the decision of the sheriff in the appeal under section 156A is made.
In an appeal under this section, the sheriff principal—

(a) may allow the appeal and when doing so must direct that the section 96 decision ceases to have effect;

(b) may refuse the appeal and confirm the decision of the sheriff;

(c) may make such other order or direction as the sheriff principal thinks fit.

156C Further appeal to Court of Session: sections 54, 55 and 96

(1) Where, in an appeal under section 156A against a section 54 order or section 55 direction, the sheriff principal confirms the order or, as the case may be, the direction, the person in respect of whom the decision in the appeal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

(a) that the decision of the sheriff principal in the appeal under section 156A was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.

(2) Where, in an appeal under section 156B against a decision of the sheriff in an appeal under section 156A, the sheriff principal confirms the decision of the sheriff in the appeal under section 156A, the person in respect of whom the decision of the sheriff principal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

(a) that the decision of the sheriff principal in the appeal under section 156B was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.

156D Effect of appeal in relation to section 54 order, section 55 direction or section 96 decision

A section 54 order, a section 55 direction or a section 96 decision may be given effect notwithstanding that an appeal may be or is made against, or in relation to, it under this Act.”.>

Schedule 2

Rhona Brankin  
Supported by: Mr Andy Kerr

64 In schedule 2, page 36, line 13, at end insert—

<Public Health (Scotland) Act 1897 (c.38)>

In section 157 of the Public Health (Scotland) Act 1897, for the words “the preceding section” substitute “section 156 or as provided in sections 156A to 156C”.

7
29 In schedule 2, page 36, line 15, at end insert—
   <(1A) In section 2(1) (Health Boards and Special Health Boards), in each of paragraphs (a) and (b), for the words “under this Act” substitute “relating to the health service”.
>
36 In schedule 2, page 36, line 15, at end insert—
   <( ) In section 4 (Scottish Dental Practice Board)—
      (a) in subsection (1A)—
         (i) in paragraph (a), for the words from the second “to” to “he” substitute “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry to submit to the Board, in relation to treatment which he, or as the case may be, it”;
         (ii) in paragraph (b), after the words “a dental practitioner” insert “or such a body corporate”;  
      (b) in subsection (1B), after the words “dental practitioner” insert “or body corporate”.
>
30 In schedule 2, page 36, line 15, at end insert—
   <(1C) In section 10(3) (Common Services Agency), for the words “under this Act” substitute “relating to the health service”.
>
37 In schedule 2, page 36, line 23, at end insert—
   <( ) In section 17C(2A)(b)(ii) (other Part 1 services which may be included in arrangements for the provision of personal dental services), after the word “Part” insert “(but not pharmaceutical care services)”.
>
38 In schedule 2, page 36, line 23, at end insert—
   <( ) In section 17D (persons with whom agreements may be made)—
      (a) in subsection (1)(b)(vi), for the words “an individual” substitute “a person”;  
      (b) in subsection (2)—
         (i) in paragraph (b)(v) of the definition of “NHS employee”, for the words “an individual” substitute “a person”;
(ii) in paragraph (c)(i) of that definition, for the words from the beginning to “or” substitute “a dental practitioner or body corporate whose name is included in the first part of a list prepared under section 25(2) of this Act or in a list prepared under”; 

(iii) in paragraph (c)(ii) of that definition, after the word “who” insert “, or body corporate which,”;

(iv) in paragraph (b) of the definition of “qualifying body”, for the words “which, in accordance with the provisions of Part IV of the Dentists Act 1984, is entitled to carry on the business of dentistry” substitute “entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(v) in the definition of “section 17C employee”, for the words from “by” to the end substitute “by a person providing services in accordance with the arrangements”.

Rhona Brankin  
Supported by: Mr Andy Kerr

39 In schedule 2, page 36, line 28, leave out from “section” to end of line 29 and insert “the words from “has” to the end substitute “means—

(a) the first part of a list prepared under section 25(2);

(b) the first part of a list prepared under section 26(2);”.

Rhona Brankin  
Supported by: Mr Andy Kerr

40 In schedule 2, page 37, line 11, at end insert—

<(  ) In section 64(5) (permission for use of facilities in private practice), in paragraph (b), after the word “provide” insert “dental,”.>

Rhona Brankin  
Supported by: Mr Andy Kerr

22 In schedule 2, page 37, line 29, at beginning insert “in subsection (1)—

(  ) after the definition of “dispensing optician”, insert—

“Drug Tariff” means the Drug Tariff required to be prepared, maintained and published by the Scottish Ministers under section 17VA of this Act;”.

Rhona Brankin  
Supported by: Mr Andy Kerr

13 In schedule 2, page 37, line 41, at end insert—

<(  ) after that subsection, insert—

“(1A) References in this Act to “carrying on the business of dentistry” are to be construed in accordance with section 40 of the Dentists Act 1984 (c.24).”>
In schedule 2, page 37, line 41, at end insert—

<(  ) In Schedule 8, in paragraph 8(2)(b), for the words “disqualification, conditional disqualification or declaration of unfitness” substitute “disqualification or conditional disqualification”>.

In schedule 2, page 38, line 15, at end insert <;

(  ) in subsection (2)(b)—

(i) after the words “dental practitioner” insert “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(ii) after the word “his” insert “or its”>

In schedule 2, page 38, line 15, at end insert—

National Health Service (Primary Care) Act 1997 (c.46)

(1) The 1997 Act is amended as follows.

(2) In section 1 (pilot schemes)—

(a) in subsection (3)(b), after the word “services” insert “nor pharmaceutical care services”;

(b) in subsection (8)—

(i) in the definition of “personal dental services”, after the words “dental practitioner” insert the words “or body corporate”;

(ii) at end, insert “;”;

““pharmaceutical care services” has the same meaning as for the purposes of Part 1 of the 1978 Act.”.

(3) In section 3(3) (persons with whom pilot schemes for personal dental services may be made)—

(a) in paragraph (b) of the definition of “dental list”—

(i) after the word “Scotland,” insert “the first part of”;

(ii) for the words “section 25(2)(a)” insert “section 25(2)”;

(b) in the definition of “NHS employee”—

(i) in paragraph (b), after the words “dental practitioner” insert “or body corporate”;

(ii) in paragraph (c), after the word “who” insert “, or body corporate which,.”.

(4) In section 17(5) (the Dental Practice Boards)—
(a) after the words “dental practitioner” insert “or body corporate”;

(b) after the word “he” insert “or it”.

Rhona Brankin
Supported by: Mr Andy Kerr

44 In schedule 2, page 38, leave out lines 20 and 21 and insert—

<( ) for paragraph (b) substitute—

“(b) dental practitioners or bodies corporate undertaking to provide, and persons approved to assist in providing, general dental services;”;

Rhona Brankin
Supported by: Mr Andy Kerr

45 In schedule 2, page 38, line 32, at end insert—

<The Scottish Public Services Ombudsman Act 2002 (asp 11)

In paragraph 14 of schedule 4 to the Scottish Public Services Ombudsman Act 2002, for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”.

Schedule 3

Rhona Brankin
Supported by: Mr Andy Kerr

46 In schedule 3, page 39, line 5, column 2, at beginning insert—

<In section 17C(6), the words “by a general dental practitioner”.

Rhona Brankin
Supported by: Mr Andy Kerr

14 In schedule 3, page 39, line 5, column 2, leave out <25(4) and> and insert <25(3) to>

Rhona Brankin
Supported by: Mr Andy Kerr

47 In schedule 3, page 39, line 6, column 2, at end insert—

<In section 28B(6), the words “Subject to section 25(3),”.

Rhona Brankin
Supported by: Mr Andy Kerr

48 In schedule 3, page 39, column 2, leave out line 7 and insert—

<In section 29A, subsection (2) and in subsection (5), the words “(including provision modifying the effect of this Part)”.

11
In schedule 3, page 39, line 29, at end insert—

Section 20(2).

In Schedule 6, paragraph 4.

In Schedule 7, the entry for section 25(3) of the 1978 Act.

In schedule 3, page 39, line 29, at end insert—

Section 16(a).

In Schedule 5, paragraph 12.

In schedule 3, page 39, column 2, leave out line 44 and insert—

Section 40.

In Schedule 9, paragraph 19(6), (7) and (8).

In schedule 3, page 39, line 45, at end insert—

Section 1(8), the words “by a general dental practitioner”.

Section 27(2).

Section 28(2).

Section 29(2).

In Schedule 2, paragraphs 43, 44 and 45.

In Schedule 3, the entry concerning section 25(2)(c) of the 1978 Act.
Rhona Brankin
Supported by: Mr Andy Kerr

55 In schedule 3, page 40, line 5, at end insert—

<Health Act 1999 (c.8) Section 56(3) and (4).
In Schedule 4, paragraphs 49, 51(d) and (g), 52(c) and 53.
In Schedule 5, in the entry concerning section 32A of the 1978 Act, the words “and, in subsection (6)(a), “prepared under this Part of this Act””.>

Rhona Brankin
Supported by: Mr Andy Kerr

65 In schedule 3, page 40, line 7, at end insert—

<Community Care and Health (Scotland) Act 2002 (asp 5)
In schedule 2, paragraphs 2(6)(c), (7), (8), (9)(b), (10)(b) and (11).>

Rhona Brankin
Supported by: Mr Andy Kerr

56 In schedule 3, page 40, line 7, at end insert—

<Primary Medical Services (Scotland) Act 2004 (asp 1)
Section 5(3)(a).
In the schedule, paragraph 1(8), (10), (11)(a), (13) and (16)(a).>

Margo MacDonald

33 After section 4, insert—

<No-smoking premises: further provision for licensed premises

(1) This section applies where, by virtue of regulations under section 4(2), licensed premises are no-smoking premises.

(2) The owner of, or person who holds the licence for, the licensed premises may apply to the Licensing Board within whose area the premises are situated for the premises to be treated as if they are not no-smoking premises.

(3) The Licensing Board may grant applications under subsection (2) only exceptionally and in determining such applications must have regard to—

(a) the views of any employees who work in the licensed premises;
(b) the adequacy of ventilation in the licensed premises;>
(c) the number and capacity of other licensed premises in the locality in which the licensed premises are situated in respect of which applications under subsection (2) have been granted; and

(d) the level of public demand for licensed premises which are not no-smoking premises.

(4) Where the Licensing Board grants an application under subsection (2), the licensed premises are, for the purposes of sections 1, 2 and 3 and despite any regulations under section 4(2) by virtue of which the premises are no-smoking premises, to be treated as if they are not no-smoking premises.

(5) Licensed premises which are to be treated as if they are not no-smoking premises by virtue of this section may advertise that fact.

(6) The Scottish Ministers may by regulations make further provision about the making and determination of, and the effect of granting, applications under subsection (2).

Section 37

Rhona Brankin
Supported by: Mr Andy Kerr

31 In section 37, page 32, line 5, leave out <and 35> and insert <, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36>

Rhona Brankin
Supported by: Mr Andy Kerr

32 In section 37, page 32, line 5, after <schedule 1> insert <and paragraph 1(1A) and (1C) of schedule 2>
Smoking, Health and Social Care (Scotland) Bill

Groupings of Amendments for Stage 2 (Day 3)

For debate on Day 3:

Skipton Fund: infection by secondary transmission
74, 75, 76, 77, 78

Skipton Fund: commencement date
57

Skipton Fund: residency in Scotland
58, 59, 79

Skipton Fund: right of appeal
60

Skipton Fund: posthumous claims and eligibility requirements
61, 80

Skipton Fund: taking payments into account in other proceedings
62

Right to make representations to care commission
69

Frequency of inspection of care services
1

Persons who can authorise medical treatment for adults with incapacity
70, 72, 73, 71

Extension of mental incapacity certificates to 3 year duration
81, 82

Appeal against forcible detention under Public Health (Scotland) Act 1897
63, 64

For debate on subsequent days (subject to any additional amendments lodged):

Ability of Scottish Ministers to confer their health functions on Health Boards and the Common Services Agency
29, 30, 31, 32

Minor and consequential amendments relating to dental services and bodies corporate
36, 38, 40, 42, 43, 44, 46
Exclusion of pharmaceutical care services
37

Consequential amendments and repeals relating to listing provisions
39, 45, 50, 51

Consequential and miscellaneous amendments
47, 49, 52, 53, 54, 56

Removal of age limit on Mental Health Tribunal membership
65

Provision for licensed smoking premises
33

NOTE: THE FOLLOWING AMENDMENTS HAVE ALREADY BEEN DEBATED—
With 3 – 13, 14
With 15 – 22
With 34 – 41, 48, 55
AMENDMENT GROUP 1: Skipton fund: infection by secondary transmission

AMENDMENT NOS: 74, 75, 76, 77, 78 (amendment 80 also refers but is not in this group)

- These amendments will allow claims to Skipton fund from Scottish claimants in respect of individuals (secondary infectees) infected by contact with an individual infected with hepatitis C as a result of NHS treatment (the primary infectee). A number of conditions must be satisfied in order to permit such claims and these amendments set out what these conditions are.
  
  o Amendment 74 is a technical drafting amendment;
  o Amendment 75 provides a statutory basis for Scottish Ministers to make payments through the Skipton Fund Scheme to secondary infectees;
  o Amendment 76 sets out who is eligible to claim and specifies which relationships are recognised;
  o Amendment 77 is a technical amendment required to introduce amendment 75;
  o Amendment 78 establishes two key requirements. Firstly, that the secondary infectee must have become infected with the hepatitis C virus and, secondly, that the person from whom they have acquired the infection, must have themselves acquired it through NHS treatment prior to 1 September 1991; and,
  o Amendment 80 clarifies that a claim must be submitted when a person is alive.

AMENDMENT GROUP 7: Right to make representations to care commission [see further background to amendment at annex A]

AMENDMENT NO: 69

- The purpose of this amendment is to bring section 37(2) of the Regulation of Care (Scotland) Act 2001 (“the Act”) into line with the existing amendments made by the Bill to Section 16(2) of the Act.

- Under Part 2 of the Act, local authorities who seek to provide certain care services must apply to the Care Commission to register that service. The Care Commission may impose certain conditions on local authorities on registration of such services. It is open to the local authority concerned to make representations to the Care Commission regarding the imposition of those conditions and to apply to the Care Commission for variation or removal of any conditions imposed.

- As with the amendments already made in the Bill to section 16 of the Act, the amendment to section 37 will make clear that the Care Commission requires to consider any representations made by the care service provider, in this case.
instance the local authority, in relation to conditions placed on care service registrations under Part 2 of the Act before deciding whether to impose, vary or remove them (as the case may be).

**AMENDMENT GROUP 9: Persons who can authorise medical treatment for adults with incapacity [see background to section 30 amendments at annex B]**

AMENDMENT NOS: 70, 71, 72 and 73

**Amendment 70**

- New section 47(1A) as inserted by the Bill defines the categories of persons who may issue section 47 certificates and authorise medical treatment. Amendment 70 ensures that people who are prescribed by Scottish Ministers in regulations made under new section 47(1A) must be individuals and so bodies corporate or partnerships may not do so.

**Amendment 71**

- This is a technical amendment which clarifies some of the categories of additional healthcare professionals who will be able to issue certificates of incapacity under section 47 of the Act. It does this by inserting a definition of ‘dental practitioner’ and ‘ophthalmic optician’ into section 47 of the Act. This amendment clarifies the existing policy intention.

**Amendments 72 & 73**

- These amendments ensure that of the specified groups of healthcare professionals, only those who have undergone prescribed training will be able to issue certificates of incapacity under section 47 of the Adults with Incapacity Act 2000 (“The Act”). The Bill at present does not insert into section 47 a requirement for the specified groups of health professionals (dental practitioners, ophthalmic opticians and registered nurses) to have undergone training on the assessment of incapacity. These amendments will ensure that the requirement for training, which is to be prescribed as a requirement under regulations, will apply to all of those health professionals.

**AMENDMENT GROUP 11: Appeal against forcible detention under Public Health (Scotland) Act 1897**

Amendments 63 and 64 – see background to amendments to the 1897 Act at Annex C.
ANNEX A

REGULATION OF CARE (SCOTLAND) ACT 2001

Purpose of Amendment

The purpose of the amendment is to enable the Care Commission to move to a more proportional, targeted and risk-based system of regulation of care services.

Effect of Amendment

The effect of the amendment is to enable Ministers by order to vary (below but not above the current statutory levels) the minimum frequency of Care Commission inspection of care services. Particular details of the amendment are:-

- The power is capable of being exercised in different ways in respect of different care services. It would be possible to make an order for one or more particular care services whilst leaving the others unaffected.

- The statutory arrangements distinguish between the number of inspections to be carried out in the first 12 months after registration and subsequent 12 month periods: the power is capable of being used in different ways in respect of those 2 periods. It would thus be possible to leave unaffected the inspection frequency for a newly registered service whilst varying the frequency for established ones.

- The power can only be exercised after consultation first with the Care Commission and subsequently with appropriate persons or groups of persons.

- Any order made under the power is subject to affirmative resolution procedure.

Background to Amendment

The Executive’s vision for care service regulation is continuous improvement in users’ experience of care services through transparent, proportional, accountable, targeted and consistent regulation. The current statutory requirements (in the Regulation of Care (Scotland) Act 2001) place constraints on the Care Commission’s ability to move to a more proportionate, targeted and risk-based inspection regime capable of delivering that vision. The Commission is statutorily obliged to inspect all care services at least once a year (or twice a year, in the case of certain services) regardless of whether or not the Commission has any grounds for concern about the service. Within any given level of resources, this restricts the Commission’s ability to target regulatory effort on to those services where the need for improvement is greatest. It also places an unnecessary burden on good quality providers receiving inspection visits which may not be needed. In relation to costs, it establishes an unavoidable minimum amount of regulatory activity which has to be paid for through fees paid by providers and grant-in-aid from the Executive.
The amendment will enable Ministers, after consultation and with the approval of the Scottish Parliament, to vary the minimum frequency for particular specified services so as to enable the Commission’s resources to be more effectively deployed.
ANNEX B

BRIEFING ON SECTION 30 – AUTHORISATION OF MEDICAL TREATMENT

Background

1. Part 5 of the 2000 Act came into operation on 1 July 2002. It gives a general authority to medical practitioners to treat patients who are incapable of consenting to the treatment in question. The authority is conferred by a certificate of incapacity, which can only be issued by a registered medical practitioner.

3. A Code of Practice, which had been the subject of extensive consultation, also came into effect on 1 July 2002.

4. The Code gives guidance on the operation of Part 5. It sets out the assessment process, which should be undertaken before a certificate of incapacity is issued. It makes clear that adults must not be labelled as incapable because of some other circumstance or condition. Rather, the assessment of capacity must be made in relation to the particular matter or matters about which a decision or action is required. Thus doctors, in assessing capacity, should bear in mind that they are assessing capacity in relation to a decision about the medical treatment in question. In assessing capacity, it is a statutory requirement to take account of the present and past wishes of the adult, so far as this can be ascertained by any means appropriate to the adult, including communication by human communication or by mechanical aid. It would be reasonable, in this regard, to use the help of the adult’s relatives, friends, social work, clergy or others, who may be in a position to assist. The practitioner’s own knowledge of the patient will also be relevant to the assessment process, as will the experiences of other health professionals - in particular nurses from their (often) close ongoing contact with the patient. The doctor should also ascertain whether it would be reasonable and practicable to seek the views of any existing proxy with welfare powers.

5. The Act currently provides for certificates of incapacity to last for a maximum of 1 year, from the date of examination on which it is based.

6. The Code was due for revision in July 2003, but, in the light of concerns expressed about the operation of Part 5, the Executive agreed to advance the review. In particular, general practitioners were concerned about the workload implications of the procedure recommended to be followed in the Code of Practice, especially the processes connected with the completion of certificates under Section 47. Dental practitioners were concerned that treatment for an adult with incapacity presenting at their surgeries could be delayed until a certificate of incapacity could be issued by a doctor. This is especially frustrating in the community dental service, where patients – and their capacity to consent or refuse – are often already well known to the dental practitioner.

7. A consultation exercise on the implementation of Part 5 was accordingly launched on 31 March 2003. This sought the views of a wide range of stakeholders on changes or improvements that might be made to the Code of Practice, and whether consideration ought to be given to amending the terms of Part 5 to assist its
effective operation including (a) whether health professionals other than registered medical practitioners should be allowed to sign certificates of incapacity and (b) whether the maximum duration of certificates of incapacity should be extended.

8. A qualitative study of the implementation and early operation of Part 5 was also commissioned by the Executive in July 2003. A 3-stage process of data collection was employed across four case study areas of Scotland to focus on the experiences of those who had come into contact with Part 5. This process included a postal questionnaire with health and social care practitioners; 52 interviews with practitioners and representatives of relevant stakeholder organisations; and 4 interviews with carers of adults who had experienced the operation of Part 5 of the Act.

9. An analysis of the responses to these 2 initiatives was placed in the Scottish Parliament Reference Centre, with Bib.Nos.31350 and 32709 respectively. In addition, Executive officials met key stakeholders in February 2004, including the British Medical Association, Alzheimer’s Scotland, the Law Society of Scotland, the Scottish General Practitioners Committee, ENABLE, the Mental Welfare Commission, the Association of Directors of Social Work, CARE, the Society for the Protection of Unborn Child and the Scottish Council on Human Bioethics.

Extending the Range of Health Professionals Who Can Issue Certificates of Incapacity

10. As the analysis of written submissions to the consultation records, the general consensus among respondents was that health professionals other than registered medical practitioners should be allowed to sign certificates of incapacity, subject to various qualifications including the need to ensure that health professionals are equipped with sufficient skills. This was also the view of the meeting with stakeholders in February 2004.

11. Accordingly, the Bill provides that, in addition to the medical practitioner primarily responsible for the medical treatment of the adult, the following may issue certificates of incapacity:

A person who is;

- a dental practitioner
- an ophthalmic optician
- a registered nurse
- or a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfy such requirements as may be so prescribed,

and who is primarily responsible for medical treatment of the kind in question.

12. It is envisaged that the Code of Practice will set out the circumstances in which it would be appropriate for nurses and other proposed signatories to issue certificates.
13. It is important to note that these additional categories of potential signatories could only authorise treatment within their specialism. Thus, a dentist could only authorise dental treatment and a nurse could only authorise or carry out treatment, which was within his or her professional competence. Before issuing a certificate of incapacity, they would need to carry out the assessment procedure set out in the Act and the accompanying Code of Practice.

Extending Duration of Certificates of Incapacity

14. The general consensus among respondents to the consultation was that the maximum length of certificates of incapacity could be extended, subject to various qualifications. For example, a number of respondents expressed reservations about extending the duration for adults, where capacity might fluctuate.

15. Accordingly, it will only be appropriate to issue a three year certificate for those patients who come within the conditions or circumstances prescribed by Scottish Ministers. Healthcare professionals will not have discretion to widen the conditions or circumstance. Any proposed changes to the conditions or circumstances will have to be subject to consultation, agreed by Scottish ministers and approved by the Parliament, by secondary legislation subject to negative resolution.

16. The Quality & Outcomes Framework of the new GP contract seeks to reward GPs who review their patient’s medication on an annual basis as part of improving the quality of the service. In the revised Code of Practice to Part 5 of the 2000 Act, which will be subject to consultation, the Executive plans to inform healthcare professionals that, in line with best practice, patients with a 3 year certificate should have their medication reviewed on an annual basis. A record confirming the review and outcome should be placed in the patients records, which is where the certificate of incapacity should also be retained. In that way patients living at home or in care homes should not suffer a reduction in patient care, and this will be carried out in a way that is not overly bureaucratic for GPs. We expect a similar review to be carried out by Consultants or, where appropriate, by doctors within their team for patients in long term hospital care.

17. In addition, the new Pharmacy contract will include chronic medication service as part of the core contract. This will allow patients to have their medication supplied, monitored and reviewed regularly as part of the shared care arrangement between the community pharmacist and the general medical practitioner. This will, in turn, add to the regular monitoring of patient on repeat medication.

Conclusion

18. It is important to note that none of those bodies representing patients who would be covered by the provisions of the bill object to it. Alzheimer Scotland is content to support the proposals, Enable has no objection to it, and the Scottish Association for Mental Health is not opposed to the main provisions, subject to some conditions.
19. The professional bodies affected by the proposals are all supportive of them. These include the Royal College of General Practitioners, the Royal College of Nursing, the British Dental Association, and Optometry Scotland.

20. In proposing these amendments to the 2000 Act, the Executive’s aim has been to find ways to help improve the operation of this important legislation, while at the same time maintaining its principles and ensuring the continuing benefits and protection it provides for this vulnerable group of adults.

May 2005
PUBLIC HEALTH (SCOTLAND) ACT 1897

Purpose of Amendment

To provide a right of appeal against removal to hospital, detention in, or continuing detention in, hospital, for persons suffering from an infectious disease, as set out in sections 54, 55, and 96 of the 1897 Act. There is currently no appeal provision; indeed section 157 of the Act has the effect of denying any appeal or review of orders, directions or actions taken under the sections listed above.

Effect of Amendment

The provision of the right of appeal will mean that these sections of the Act are compatible with the European Convention on Human Rights. This in turn should ensure that where it is necessary to use powers under these sections in order to protect the public health, it is easier to do so because the judicial system is aware that safeguards are in place and individuals have a right of appeal.

Background to amendment

The Act dates from 1897, and various provisions have been amended over the years, but provision is clearly now required to provide for a right of appeal in respect of decisions made under sections 54, 55 or 96 in order to ensure compatibility with the European Convention on Human Rights.

There have been problems in recent years in enforcing the 1897 Act powers to isolate people who knowingly put other people’s health at risk from life-threatening infections. In Glasgow, for instance, on at least two occasions, people with highly infectious cases of tuberculosis have refused to co-operate with treatment plans and despite having been advised of the risk they present to the community, have gone on to infect others. In these cases it has been necessary to seek orders for compulsory detention in hospital under sections 54 and 55 of the Act, to protect their families, households and the wider community. However, it has proved difficult to secure such orders, not least because there is no right of appeal. A similar problem arises with section 96 which allows a local authority to remove a person suffering from an infectious disease in a lodging house to hospital, on the certificate of a designated medical officer.

In the light of the threats from infectious diseases such as pandemic influenza, ensuring compatibility with ECHR should assist in the use of the relevant sections of the Act, when necessary, to safeguard public health.
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

16th Meeting, 2005 (Session 2)

Tuesday 31 May 2005

Present:

Helen Eadie  
Kate Maclean  
Mr Duncan McNeil  
Shona Robison  
Jean Turner  
Janis Hughes (Deputy Convener)  
Stewart Maxwell (Committee Substitute)  
Mrs Nanette Milne  
Mike Rumbles

Apologies: Roseanna Cunningham (Convener).

Smoking, Health and Social Care (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 3).

The following amendments were agreed to (without division): 74, 75, 76, 77, 78, 58, 59, 80, 62, 69, 1, 70, 72, 73, 71 and 63.

The following amendments were agreed to (by division):  
  57 (For 5, Against 2, Abstentions 1)  
  61 (For 5, Against 2, Abstentions 1)

The following amendment was disagreed to (by division):  
  79 (For 1, Against 5, Abstentions 2)

Amendments 60 and 81 were moved and, with the agreement of the Committee, withdrawn.

Amendment 82 was not moved.

Sections 24, 26, and 30 were agreed to as amended.

Sections 25, 27, 28, 29 were agreed to without amendment.

In relation to amendment 57, the Deputy Minister agreed to provide additional information in advance of Stage 3 on the number of individuals infected with Hepatitis C as a result of NHS treatment who died before 29 August 2003 and the cost of extending the ex-gratia payment scheme to the families or dependants of these individuals.

The Committee ended consideration of the Bill for the day, amendment 63 having been disposed of.
Smoking, Health and Social Care (Scotland) Bill: Stage 2

14:04

The Deputy Convener: Item 2 is consideration of the Smoking, Health and Social Care (Scotland) Bill at stage 2. I remind members that, as previously agreed, at today’s meeting we will consider only those amendments relating to sections 24 to 30, in part 5 of the bill. That means that the first 11 groupings on the groupings lists will be debated today.

Section 24—Payments to certain persons infected with hepatitis C as a result of NHS treatment

The Deputy Convener: Amendment 74, in the name of the minister, is grouped with amendments 75 to 78.

Rhona Brankin: The amendments will allow claims against the Scottish ministers from claimants in respect of individuals who were infected through contact with an individual who was infected with hepatitis C as a result of NHS treatment. The Skipton Fund scheme was set up to alleviate the hardship of people who are alive and were infected with hepatitis C as a result of NHS treatment through blood, tissue or blood products. In some cases, the infection might have been passed from mother to baby or from partner to partner; and they will not have died before 29 August 2003.

Amendment 76 sets out who is eligible to claim and specifies the relationships that will confer eligibility to claim from the scheme. Amendment 77 is a technical amendment that is required to introduce amendment 78. Amendment 78 will establish two key requirements: the secondary infectee must be infected with the hepatitis C virus; and the person from whom the secondary infectee acquired the virus must have acquired the virus through NHS treatment prior to 1 September 1991.

I move amendment 74.

The Deputy Convener: We have been joined by Stewart Maxwell MSP. Will you indicate whether you are here as an observer or as a committee substitute?

Mr Stewart Maxwell (West of Scotland) (SNP): I am here as a committee substitute for Roseanna Cunningham.

The Deputy Convener: Thank you.

I am an observer.

Shona Robison: I do not believe that amending the bill by removing the date to create a level playing field for everyone would have huge financial consequences. As we heard in evidence from stakeholders, amendments 74 to 78 will correct that position. If the amendments are not agreed to, the Scottish ministers will be unable to pay eligible secondary infectees who claim under the scheme. That is clearly unacceptable.

The amendments will allow claims against the Scottish ministers from claimants in respect of individuals who were infected through contact with an individual who was infected with hepatitis C as a result of NHS treatment. The Skipton Fund scheme was set up to alleviate the hardship of people who are alive and were infected with hepatitis C as a result of NHS treatment through blood, tissue or blood products. In some cases, the infection might have been transferred to a partner or close family member and the scheme makes provision for ex gratia payments to secondary infectees who meet the eligibility criteria.

However, we believe that provision for that important group of people should be enshrined in the bill. The bill as introduced does not make provision for secondary infectees and amendments 74 to 78 will correct that position. If the amendments are not agreed to, the Scottish ministers will be unable to pay eligible secondary infectees who claim under the scheme. That is clearly unacceptable.

Rhona Brankin: I emphasise that the amendments are required to enable the Skipton Fund scheme to meet the policy objective of ensuring that ex gratia payments can be made to all eligible people to help to alleviate their suffering. I do not think that any member of the committee will disagree with that objective.

Amendment 74 agreed to.

The Deputy Convener: Amendment 57, in the name of Shona Robison, is in a group on its own.

Shona Robison: Amendment 57 would remove the arbitrary start date for claims, to allow the dependants of people who died before 29 August 2003 to make a claim. Currently, the family and dependants of a person who died on 29 August 2003 can make a claim, whereas the dependants of someone who died 24 hours earlier cannot do so. That is unfair and unjust.

I do not believe that amending the bill by removing the date to create a level playing field for everyone would have huge financial consequences. As we heard in evidence from stakeholders,
Frank Maguire and others, the number involved would be very small. I remind members that the Skipton Fund has an underspend because fewer claims than expected have been lodged to date.

Deaths from hepatitis C must be referred to the procurator fiscal, so the minister and her officials may well have the figures and will be able to determine the number of people who would be affected should the date be removed from the bill. I am confident that only a small number of people are involved and that the change would not have a huge financial impact on the Skipton Fund.

The amendment would right a wrong. We cannot have an arbitrary date that discriminates against the dependants of some people who are deceased. That is unjust. The amendment would remove that injustice.

I move amendment 57.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I agree with Shona Robison. We are dealing with a matter of conscience. The date does not really matter. The issue comes down to where and how someone acquired the infection. A considerable time can elapse between someone acquiring an infection and showing signs and symptoms of it, so it might be very difficult for them to make themselves known to the authorities in time to comply with a date.

The most important issues are where someone got the infection and how they got it. If they can prove all the things that are required, I do not think that the date is necessary. I have spoken to people who have acquired the infection and those connected with them and I know that not a large number of people would be affected. We would not be opening the floodgates, because, to be able to apply, people would have to be in the appropriate category.

Helen Eadie (Dunfermline East) (Lab): I am not inclined to support amendment 57, although I will listen to the points of view of other members. I am persuaded by the minister’s argument that the fund is intended for people who are alive as opposed to the families of people who have died. It was always intended that the money should make life easier for people who were living with hepatitis C. It was on that basis that the money was passed on.

My other reason for taking the view that I have arrived at is that throughout the discussion, both in formal meetings of the committee and in our informal discussions round the table, we have been at pains to try to establish the exact number of people involved. Responsible politicians must always ensure when they take decisions that the resources will be available to make payment to the people concerned.

One intention behind the amendment is to expand the number of people who will receive money from the fund, but it is not clear to me that we can take such a decision today, as we do not have sufficient information. The best guesstimate that I have heard is that we could face a fivefold increase in the number of people who would be paid. I would like to get firm information from the minister before we take a decision. I am not in the business of writing a blank cheque that might place an intolerable strain on other parts of the health service. I must be sure that money will come to my area to deliver all the key services that are needed.

I am not unsympathetic to the families of people who have died, but the fundamental point that the ministers have made throughout is that the payments are intended to make the lives of people who are suffering from hepatitis C much easier. There is no doubt that the disease has care implications. However, if the amendment were agreed to, people might argue that we were switching to a compensation scheme, although that is not what the amendment says.

14:15

Kate Maclean (Dundee West) (Lab): I will agree with one of Helen Eadie’s points and disagree with another. I disagree that the fund will be used only for people who are alive, because, if people died between 29 August 2003 and 5 July 2004, their estate will receive compensation. The Executive is already saying that money will be given to the estate or the families of a certain number of people who have died. The problem is that the date that has been set is arbitrary—it was set according to the announcement of the scheme. I have difficulty with that inconsistency.

Although I am sympathetic to Shona Robison’s amendment 57, I agree with Helen Eadie that we do not have enough information about what the costs would be. I hope that the minister will be able to give us more details about how many people we are talking about, how that figure has been arrived at and what the cost implications are. I am interested in that information.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I, too, would like more information, so perhaps the minister can give us some today. If we agreed to amendment 57, would the Skipton Fund or the NHS in Scotland pay? If it was the Skipton Fund, would we be running a risk that, in effect, other victims would have to pay? I am interested in the extent of the liability, which has not been described clearly. In our evidence sessions on the issue, we requested information from witnesses on the number of people who are, if you like, in the queue, but I do not think that that was followed up, although perhaps we could check.
The minister may or may not be able to assist us with another issue in which I am interested. Would amendment 57 change the Skipton Fund payments fundamentally? The payments come with the assurance that they are ex gratia. Many of the people who will receive the payments will be on benefits, but there is the assurance that those benefits will be unaffected by the ex gratia payment and that there will be no tax liabilities. If we accept amendment 57, would that change the fundamental principle? If we moved to something outwith the Skipton Fund, the system could perhaps be defined as more akin to a compensation fund, which would raise questions about tax and benefits.

My final question is for my fellow committee members who support amendment 57. If the current date is changed, what date would apply? It is important that, as legislators, we try to set a date so that we can make calculations about the overall costs and impact of the amendment on either the Skipton Fund or the NHS.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Amendment 57 is the most important amendment to the bill that we will consider. It affects real people deeply—we do not know exactly how many people it affects, but it certainly affects people. Shona Robison outlined a moral case; she said that the current proposals are unfair and unjust and that the amendment would be about justice for all. As Jean Turner mentioned, the amendment is about a matter of conscience.

I listened carefully to Helen Eadie, who said that the scheme was always intended to help people who are alive, which I accept. However, if that is the case, what about those people who died between 29 August 2003 and the start of the operation of the Skipton Fund on 5 July 2004? As it stands, the bill is neither just nor fair.

Duncan McNeil asked what date should apply. Amendment 57 would remove the reference to 29 August 2003, so ex gratia payments would be available to those who were infected before 1 September 1991. The date is quite clear. Alternatively, the Executive could have come forward with another date. For example, the start date for ex gratia payments could have been 5 July 2004, which would have made it clear that the Executive’s intention was to benefit only those who are alive.

Unfortunately, we have several criteria in the bill. It is only right that we amend the commencement date of the ex gratia payment, but how best should we do that? Should we accept Shona Robison’s amendment 57? My preference is for the minister to make it clear in her summing up that she will take the issue to stage 3. If she commits to re-examining the issue, I hope that Shona Robison will withdraw her amendment. One thing is sure: the date in the bill is not the right one. Unless the minister makes a commitment to review the matter, I am minded to support Shona Robison’s amendment 57, on the basis that that will ensure that the issue is considered again at stage 3.

Mr Maxwell: Most of the issues have been covered by other members, so my comments will be brief. Helen Eadie and Duncan McNeil made valid points, but the issue is relatively straightforward—it is a matter of justice for all those who have suffered. It is particularly unjust to exclude some dependants on the basis of an arbitrary date in the bill.

Helen Eadie made the point that the scheme is for those who are alive, but I hope that she accepts that there is an inconsistency in her argument, given that the dependants of those who died between the two dates in 2003 and 2004 can benefit.

I hope that members will support amendment 57, because, if the Parliament is about anything, it should be about justice and compassion. Amendment 57 is an example of what we are here to do.

Mrs Milne: I reserve judgment. I fully accept Shona Robison’s point about unfairness. My concern is the number of people involved. The number of those who were infected with blood products must be finite, but we do not have that number. If the minister also does not have it, I would be happier not to take a decision today, but instead to address the issue at stage 3, when I hope that the information will be available to us to enable us make a reasoned judgment.

Rhona Brankin: I cannot support amendment 57 without further consideration of the costs that could be involved. I have listened to members’ comments and I agree with many of them. I begin by pointing out, as members have done, that payments from the Skipton Fund are not compensation, but ex gratia payments to relieve the hardship and suffering of those alive today who contracted hepatitis C through NHS treatment with blood, tissue or blood products.

Of course, we all have great sympathy with those who have been infected with hepatitis C through NHS treatment. That is not under debate. However, the amendment would allow relatives to make claims in respect of individuals who died before the scheme was announced on 29 August 2003. That date was agreed by all four United Kingdom Administrations as the start date.

As has been said, the amendment would open up the scheme to a much wider group of people who died prior to that date. That would be costly, but it would also change the nature of the scheme. The cost estimates for the scheme do not make any provision for those who died before 29 August
2003. We and the other UK Administrations would have to find major extra resources to meet any further costs and that could be at the expense of patients and the delivery of health services generally.

The scheme that we propose was carefully costed to offer a fair package for those who contracted hepatitis C from NHS treatment and to balance that with the wider interests of NHS patients. To depart from it could give rise to serious additional costs and difficulties. It would involve changing key aspects of a scheme that is already in operation and is benefiting large numbers of people in Scotland and throughout the UK.

As has also been pointed out, changing the system to a compensation scheme could put at risk the social security derogation, so Skipton Fund payments in future could be means tested. In the present scheme, Skipton Fund payments do not affect social security payments. I am concerned about anything that would damage or undermine the operation of the existing scheme.

As I said, meeting claims in respect of those who have died would not reflect the main purpose of the scheme, which is to help those who are alive today with the extra difficulties and expenses that they face. It would also mean significant additional costs to the Executive. Along with the other three UK Administrations, we developed a scheme that we believe is fair and affordable. It makes payments to relieve the suffering and hardship of the individuals involved, but it does not impact on the NHS’s ability to deliver on its other obligations.

The scheme has been successful in helping more than 400 people in Scotland. To date, more than £10 million has been paid out to Scottish claimants. The work that was carried out by Lord Ross’s expert group in 2002 suggested that 4,000 people in Scotland had been infected with hepatitis C through blood products or blood transfusion. It was estimated that about 1,200 of those people were still living at that time. That indicates the large scale of the cost increases that we might face if the scheme was extended. It is clear that there would not be claims in respect of all the deceased people who would be eligible, but there could be a large number of additional claims.

If the committee supports amendment 57, that will mean additional costs at the expense of the delivery of health services to the people of Scotland today. We do not believe that that would represent the best use of the limited resources that are available in the health budget, which have to meet many important priorities throughout Scotland.

In view of the lack of information at this stage, and having heard the arguments, I invite Shona Robison to withdraw amendment 57. That would enable us to look further into what could be difficult cost issues and to return to the matter at stage 3.

14:30

Shona Robison: There are a number of questions that I would like to ask the minister, but I do not know whether I am in a position to do so. She cited the figure of 1,200, but I do not know where that comes from or what the breakdown is. I find it surprising, because the figures that are cited by those who are involved with the relatives are nowhere near that figure. I would certainly like to see more detail on the figure that she gave.

I would have liked to have heard more of a commitment from the minister that she is genuinely prepared to look at the date again. However, her comments suggest that she does not want to do that. She seems already to have decided that cost would be a barrier in that respect. I should also add that changing the date would not put the scheme of financial assistance at risk by somehow transforming it into a compensation scheme.

The minister was also inconsistent when she said—three times—that the scheme is for those who are living, not for their dependants. However, the scheme is for dependants of a relative who died between 29 August 2003 and 5 July 2004. We need some consistency on the matter. If the minister really believes what she said, no relatives would be allowed to claim under the scheme. That is not the case. Her comments are inconsistent and unfair to the relatives who cannot claim.

I am prepared to acknowledge that more work needs to be done on the numbers. I am also prepared to meet the minister halfway if she can give a genuine commitment to reconsider the date instead of simply coming up with evidence on why she will not support amendment 57.

The Deputy Convener: Shona, will you indicate whether you intend to press or withdraw amendment 57?

Shona Robison: Well, if the minister is not prepared to come back—

The Deputy Convener: I do not think that at this stage in the debate there is scope to ask the minister any further questions. I am afraid that that opportunity has gone.

Shona Robison: That is a pity, because I think that there is room for negotiation. I am afraid that, given the minister’s comments, I will have to press amendment 57.

The Deputy Convener: The question is, that amendment 57 be agreed to. Are we agreed?

Members: No.
The Deputy Convener: There will be a division.

FOR
Maclean, Kate (Dundee West) (Lab)
Maxwell, Mr Stewart (West of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)

ABSTENTIONS
Milne, Mrs Nanette (North East Scotland) (Con)

The Deputy Convener: The result of the division is: For 5, Against 2, Abstentions 1.

Amendment 57 agreed to.

Amendments 75 to 78 moved—[Rhona Brankin]—and agreed to.

The Deputy Convener: We move to group 3. Amendment 58, in the name of Shona Robison, is grouped with amendments 59 and 79.

Shona Robison: Amendments 58 and 59 would make it possible for people who now live outwith the UK, but who lived in Scotland immediately before they left, to claim under the Skipton Fund. As the bill stands, a person has to be resident in Scotland to claim under the fund, which means that someone who was infected with hepatitis C as a result of NHS treatment in Scotland and then went to live abroad would be denied any financial assistance. Surely that cannot be right and is adding insult to injury. As only a small number of people will be in that position, I do not think that such a move will have major financial implications.

I move amendment 58.

Dr Turner: Shona Robison has explained her amendments clearly but amendment 79 goes a bit further. If someone has lived in Scotland and then gone on to live anywhere else outside Scotland or the UK they should be able to apply to the Skipton Fund, because they could have been in hospital in Scotland when they got their infection and then gone off to wherever. As I said earlier, what is important is where someone is when they get their infection and how they get it. The fact that someone can say that they got an infection in an NHS establishment in Scotland means that where they live thereafter is almost irrelevant. They should be able to apply. I therefore support amendments 58, 59 and 79.

Helen Eadie: I am not minded to support amendment 79 but I am persuaded by Shona Robison’s amendments.

I am not minded to support Jean Turner’s amendment because it could cover anyone who has lived in Scotland at any time irrespective of their nationality—the amendment does not make that clear—and I wonder if Jean has thought that through. It could open up all sorts of possibilities so I am not happy to support amendment 79.

Rhona Brankin: I support Shona Robison’s amendments 58 and 59. They will ensure that in terms of Scottish residency requirements, people who contracted hepatitis C from NHS treatment and then left the UK to live abroad will be eligible to claim from the Skipton Fund, provided they were resident in Scotland before they left the UK. The amendments will clarify the residency qualification aspects of the scheme and will provide useful transparency for applicants. The committee brought to our attention the need to extend the residency qualification to include that group and we believe that amendments 58 and 59 will achieve that.

I cannot support Jean Turner’s amendment 79 as it goes further than amendments 58 and 59. It would permit claims to be made of the Skipton Fund if a person had ever resided in Scotland. That could give rise to an anomalous situation where an individual would be entitled to claim payments from Scottish ministers and another UK Administration simultaneously and that would be illogical. It would extend the scope of the scheme beyond what is necessary to ensure that all those who are entitled to payments under the scheme are eligible to receive them. Amendments 58 and 59 are clearer about who qualifies for the scheme and that is why I cannot support amendment 79. I ask Jean Turner not to move it.

Shona Robison: I am pleased that the minister supports my amendments. They are just common sense.

Amendment 58 agreed to.

Amendment 59 moved—[Shona Robison]—and agreed to.

The Deputy Convener: I ask Jean Turner if she wishes to move amendment 79.

Dr Turner: Amendment 79 moved—[Dr Jean Turner]. I will move the amendment because I feel strongly about it. In all conscience, if someone was living in Scotland when they got their infection that is the important thing. It should not have anything to do with where they eventually live. I think that the amendment is very clear but it might well be that it could be improved upon legally.

Amendment 79 moved—[Dr Jean Turner].

The Deputy Convener: The question is, that amendment 79 be agreed to. Are we agreed?

Members: No.

The Deputy Convener: There will be a division.
The result of the division is: For 1, Against 5, Abstentions 2.

Amendment 79 disagreed to.

Amendment 60 is very general, and it could allow for appeals to be made on grounds that are not intended under the scope of the Skipton Fund scheme. For example, one dependent could appeal against a payment being made to another dependent of an eligible person who had died. I understand why the minister would seek to place an additional hurdle before the relatives of those who died after 5 July 2004. I cannot understand why the minister would seek to place an additional hurdle before the relatives of those who died after 5 July 2004. That is yet another arbitrary date to preclude claims for those who have died. The rule states that, if the person who is affected with hepatitis C died after 5 July 2004 but did not make a claim while alive, their dependents will not benefit. That is inconsistent with the fact that the relatives of someone who died between the dates of 29 August 2003 and 5 July 2004 can claim against the scheme, irrespective of when the case was lodged. I cannot understand why the minister would seek to place an additional hurdle before the relatives of those who died after 5 July 2004.

I move amendment 60.

Rhona Brankin: I support the principle of having a right of appeal, and I believe that Shona Robison’s amendment 60 is well intended. The details of an appeals process are currently being developed by all the United Kingdom Administrations. The policy intention has always been for the scheme to include a right of appeal. The right of appeal will allow those whose claim is rejected by the Skipton Fund to appeal against a decision that that is in line with natural justice. I move amendment 60.

Shona Robison: Amendment 60 would mean that the Skipton Fund would have an appeals procedure. It is important that anyone who is refused assistance by the fund at any stage of their illness, whether it is for the initial claim or for the higher-rate claim, should be entitled to appeal that decision. That is in line with natural justice.

I move amendment 60.

Rhona Brankin: Amendment 80 clarifies that a claim must be submitted when a person is alive. That is intended to reinforce the basic principle of the scheme that the fund exists to help those alive and suffering. The only exception to that is the period between 29 August 2003 and 5 July 2004 when the mechanics of the scheme were being developed. As I said previously, payments from the Skipton Fund are not compensation but ex gratia payments to relieve the hardship and suffering of those living today who contracted hepatitis C through NHS treatment with blood, tissue or blood products.

I believe that our approach strikes a fair balance between helping to alleviate the suffering of those who have been infected by hepatitis C through NHS treatment and meeting the wider needs of health care in Scotland today. I do not believe that Shona Robison’s amendment 61 achieves that balance. Extending the scope of the scheme in the manner that she proposes will not alleviate hardship for current sufferers of hepatitis C;
instead it will add to the costs of the scheme. The additional costs will have to be met from the existing health budget and will be at the expense of services and patient care in Scotland. I cannot support an amendment that would cause a fundamental conflict in the way that the UK-agreed Skipton Fund scheme is operated in Scotland. I invite Shona Robison to withdraw amendment 61.

Mike Rumbles: I am not happy with what I have just heard. As far as I am concerned, if a wrong is done to one person because of the bill, a wrong is done to one person. It seems that it is for administrative convenience that all the four Administrations of the United Kingdom use the same date, rather than doing what is the right thing to do. For that reason I am minded to support amendment 61, because it is in line with amendment 57, which we agreed to earlier.

Shona Robison: There might be a good reason why someone did not make an application before they died. They might not have known about the fund, they might not have been in a fit state to make an application or they might have died suddenly. One can think of a host of scenarios. It is about fairness and consistency. The arbitrary dates are not fair or consistent. Surely it is up to us to ensure that the scheme, as it is administered in Scotland, is fair and just and does not discriminate against anyone because of arbitrary dates that are used for one reason or another. I will press amendment 61.

The Deputy Convener: The question is, that amendment 61 be agreed to. Are we agreed?

The Deputy Convener: There will be a division.

FOR
Maclean, Kate (Dundee West) (Lab)
Maxwell, Mr Stewart (West of Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Eadie, Helen (Dunfermline East) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)

ABSTENTIONS
Milne, Mrs Nanette (North East Scotland) (Con)

The Deputy Convener: The result of the division is: For 5, Against 2, Abstentions 1.

Amendment 61 agreed to.

Amendment 80 moved—[Rhona Brankin]—and agreed to.

The Deputy Convener: Amendment 62, in the name of Shona Robison, is in a group on its own.

Shona Robison: Amendment 62 would remove the provision that Skipton Fund payments may be taken into account in awards made under other proceedings. As the bill stands, if someone claims under the Skipton Fund they could de facto be prevented from taking legal action for compensation, as the Skipton Fund financial assistance could be put at risk. That runs counter to assurances given by the minister that that would not be the case. If the provision is not removed it will be a barrier to some claiming under the Skipton Fund who believe that they have yet to receive true justice for being infected with hepatitis C while undergoing NHS treatment and might wish to seek recourse elsewhere. We should not be putting barriers in the way of people who want to do that. Amendment 62 would ensure that that does not happen.

I move amendment 62.

Rhona Brankin: I am aware that the Health Committee raised the issue during its stage 1 deliberations. I support the principle that ex gratia payments made to a person under the Skipton Fund scheme should not affect compensation or other payments that that person receives. Therefore, I support amendment 62.

Shona Robison: I thank the minister for supporting the amendment.

Amendment 62 agreed to.

Section 24, as amended, agreed to.

Section 25 agreed to.

Section 26—Implementation of certain decisions under the 2001 Act

The Deputy Convener: Amendment 69, in the name of the minister, is in a group on its own.

Rhona Brankin: Amendment 69 is one of a number of technical amendments to the Regulation of Care (Scotland) Act 2001 that have been identified as necessary following implementation of that act. Under part 2 of the act, local authorities that seek to provide certain care services must apply to the Scottish Commission for the Regulation of Care to register those services and the care commission may impose certain conditions on a local authority’s registration of such services. It is open to the local authority to make representations to the care commission regarding the imposition of conditions and to apply to the commission for variation or removal of any conditions.

Amendment 69 is similar to the amendments that the bill already makes to section 16 of the 2001 act. The change that it would make to section 37 of the act would make it clear that the care commission is required to consider any representation that the care service provider—in this case, the local authority—makes on conditions that are placed on the registration of care services
before it decides whether to impose, vary or remove those conditions. The current wording of section 37(2) of the 2001 act does not allow the care commission to take account of representations that the local authority makes. Amendment 69 will rectify that and ensure that the act accurately and consistently reflects the Executive’s policy intention.

I move amendment 69.

Amendment 69 agreed to.

Section 26, as amended, agreed to.

After section 26

The Deputy Convener: Amendment 1, in the name of the minister, is in a group on its own.

Rhona Brankin: Amendment 1 will give the Scottish ministers the power to vary the minimum frequency of the care commission’s inspection of care services. The Executive’s vision for care service regulation is continuous improvement in users’ experience of care services through transparent, proportional, accountable, targeted and consistent regulation. I stress the word “users” as the amendment is ultimately about them.

The current statutory arrangements make it difficult to fulfil that user-centred vision, as they require the care commission to inspect care services at a specified minimum frequency and the commission has no scope for inspecting at a lower frequency regardless of the circumstances. That means that the commission’s resources are not being used to best effect to drive up the quality of care.

The powers in amendment 1 would apply to the whole range of care services that the care commission regulates. I am aware that the committee was particularly interested in the amendment’s effect on services that currently receive a minimum of two annual inspections—in particular, care homes—and I am happy to repeat that we have no plans to change the minimum inspection frequency for care homes. However, it is worth remembering that the services that are inspected twice a year represent less than 14 per cent of the total number of care services that the commission regulates. The remaining 86 per cent covers a wide range of other care services, such as nurseries and childminders, care at home, adult day care services, child care and nurse agencies. At present, those services are all subject to the same minimum requirement of one inspection a year, despite the wide diversity of provision that they represent. It would be surprising if the current one-size-fits-all approach was the right one for all the services concerned.

The proposed new power will enable ministers to give the care commission the flexibility to target its regulatory activities on the areas of greatest concern. It is capable of being exercised for particular types of care services where it can be demonstrated that the quality of care will not be affected by a change in the level of inspections. It will also enable the care commission to redirect resources committed to inspections to other things, such as consulting service users and advising and supporting providers. That will help to drive improvements in care services.

We are not proposing to do away with the concept of a statutory minimum for the frequency of inspections but want to enable ministers to specify new, lower minimum frequencies for specified categories of care services. That would enable the regulatory framework to move away from the one-size-fits-all model. The statutory minimum frequencies could be tailored to suit the particular circumstances of the wide range of care services that the care commission regulates.

Before making an order under the proposed new power, ministers would be required to consult the care commission in order to ensure that they had an informed, risk-based assessment of the needs of the care services in question. Before proceeding to consult, we would take into account, for example, the vulnerability of the client group, the type of service, the number of complaints and their outcomes across a particular care service sector, and workforce-related issues such as staff turnover or levels of qualified staff across the relevant sector. If we were satisfied that there was enough evidence to support a change to the inspection frequency, ministers would be required to go out to public consultation, which would, of course, include users and providers of the services concerned. Finally, any order that was made by ministers would be subject to the affirmative resolution procedure. That means that Parliament would, rightly, have the last word. If ministers cannot persuade Parliament to approve a proposed change, it will not happen.

The new regulatory framework for care services is settling down. The care commission has gained valuable experience of the operation of the framework and is developing a good understanding of the balance of risks that are inherent in the many services that it regulates. The current requirements, however, constrain the care commission from capitalising fully on that experience. Now is the time to introduce a useful measure of flexibility that will benefit service users and providers.

I move amendment 1.

Shona Robison: I am pleased that the minister has, again, put on the record the fact that it is not the Executive’s intention to reduce the frequency of inspections for care homes, which was a matter of concern to me, and that any changes would
have to be approved by the Scottish Parliament. On that basis, I am happy to support the amendment.

Mrs Milne: I agree with Shona Robison and think that the safeguards that have been included are sufficient.

Amendment 1 agreed to.

Sections 27, 28 and 29 agreed to.

Section 30—Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

The Convener: Amendment 70, in the name of the minister, is grouped with amendments 72, 73 and 71.

Rhona Brankin: Amendment 70 is a technical amendment to new section 47(1A) of the Adults with Incapacity (Scotland) Act 2000, as it will be amended by the bill. That section defines the categories of persons who may issue section 47 certificates and authorise medical treatment. Amendment 70 will ensure that those who are prescribed by Scottish ministers in regulations that are made under new section 47(1A) must be individuals; therefore bodies corporate or partnerships may not issue section 47 certificates and authorise medical treatment.

Amendment 70 clarifies some of the categories of additional health care professionals who will be able to issue certificates of incapacity under section 47 of the 2000 act by inserting definitions for dental practitioner and ophthalmic optician into section 47 of the act. The amendment clarifies the existing policy intention.

Amendments 72 and 73 will ensure that only relevant health care professionals who have undergone prescribed training will be able to issue certificates of incapacity under section 47 of the 2000 act. Members of the committee noted their concerns during stage 1, and the committee’s stage 1 report recommended that the bill be amended to ensure that the extended range of health care professionals who will be allowed to issue certificates of incapacity must have undergone relevant training in assessment of capacity. The Executive agrees with the recommendation and would like to thank the committee for highlighting the issue. Amendments 72 and 73 will therefore amend the wording of section 30 of the bill to the effect that only additional health care professionals in the specified groups who have undergone such training as may be prescribed will be able to sign certificates of incapacity under section 47 of the 2000 act. I move amendment 70.

Amendment 70 agreed to.

Amendments 72 and 73 moved—[Rhona Brankin]—and agreed to.

The Deputy Convener: Amendment 81, in the name of Nanette Milne, is grouped with amendment 82.

Mrs Milne: Amendments 81 and 82 would remove the provision to extend the maximum length of mental incapacity certificates from one year to three years. The extension of the maximum duration of an incapacity certificate was supported by the professional bodies that gave evidence to the committee; however, the patient representative bodies that gave evidence had a number of concerns about the provision. The committee felt that any proposed extension could diminish the importance of regular and comprehensive reassessment of ongoing treatment and that lengthening the period of certification might be seen to encourage long-term use of medication without review.

The British Medical Association believes that regular reviews of treatment should continue, irrespective of the duration of incapacity or the duration of a certificate. It agrees with the committee that it is the individual’s level of capacity that is being assessed and not the need for treatment. However, Alzheimer Scotland was concerned that extension of a certificate’s duration would diminish the importance of regular and comprehensive reassessment of ongoing treatment.

There is also significant concern about inappropriate prescribing of psychotropic medication to people with dementia in care homes. Those people might well be subject to longer-term incapacity certificates. The fear is that to lengthen the period of certification might encourage very long-term use of medication without review, which is why the committee agreed—I think we were unanimous—that changes in legislation should be governed by patient welfare. The committee felt that even with tight regulation there is a real risk that a three-year certificate would be used more extensively than intended, with a consequent reduction in patient care. We felt that if good practice points to an annual review, assessment of capacity and resulting certification should remain part of that annual review.

I move amendment 81.

Dr Turner: I have changed my mind since the committee’s scrutiny of the bill at stage 1. I was one of the people who were concerned about care and incapacity being lumped together. However, it is incapacity that is being assessed, and that should not interfere with regular care of a patient. I have been reassured by what I have read that
they are two separate things and that if checks and balances are in place, that should mean that no patient should be worried about the three-year certificate.

**Rhona Brankin:** It is the Executive’s policy to make sure that the patient has the focus of health care provision, in order to ensure that the patient obtains the best and most appropriate treatment. During the early operation of part 5 of the Adults with Incapacity (Scotland) Act 2000, which is concerned with authorisation of medical treatment, it became clear that improvements could be made. I am pleased that the committee is minded to support the Executive’s proposal to widen the range of health professionals who can authorise medical treatment by completing a section 47 certificate, and I hope to be able to persuade the committee that the Executive’s proposal to extend the duration of a certificate for up to three years, and then only for certain prescribed conditions and circumstances, will be of benefit to that group of adults with incapacity.

The general consensus among respondents to the Executive’s consultation in March 2004 was that the maximum lengths of certificates of incapacity could be extended subject to various qualifications. For example, it was felt that extended certificates should not be used when it is likely that the adult might regain capacity or when an adult has, or might have, fluctuating capacity. In addition, it must be clear that vulnerable patients should have their clinical needs reviewed annually and that the maximum duration of the certificate should be extended only for certain conditions.

The evidence that was provided to the committee at stage 1 did not oppose the issue of certificates for up to three years, provided that they would apply to people whose conditions were not going to improve, and that the clinical needs of those patients would be subject to regular review. The regulations that we will introduce and the best practice guidance for general practitioners, which will be reflected in a revised code of practice, will address the points that were raised in evidence on those issues. The regulations and the code of practice will be fully consulted on with key stakeholders, including patient representative groups, carers and professionals.

The final regulations will make clear the specific conditions and circumstances for which it will be appropriate to issue a certificate of incapacity for up to three years. Health care professionals will not have discretion to widen the conditions or circumstances. Any proposed changes to the regulations will be subject to consultation, agreement by Scottish ministers and approval by Parliament.

A certificate of incapacity is the culmination of a process that assesses whether or not a patient is capable of understanding the intervention that a health care professional intends or proposes to carry out—it is not in and of itself a course of treatment. The benefits of an extended certificate of incapacity are that patients who have permanent incapacity will not have their health care delayed by having to undergo assessment for incapacity every year. For some patients, the process can be distressing; indeed, two responses to the Executive’s consultation made the point that recertification might actually be harmful to the adult with incapacity, so reduction of frequency will benefit that group of patients. I stress that that will not mean a reduction in care for those patients.

Health care professionals will not be required to assess annually the capacity of patients who have permanent incapacity. They will therefore be able to commit more time to meeting the clinical needs of such adults with incapacity and of other patients. The requirement for all health care professionals to comply with all existing requirements for relevant, appropriate and timely interventions remains. The code of practice will explain the need for GPs to review their patients’ medication annually in line with best practice. In addition, the new pharmaceutical care services contract will allow patients to have their medication supplied, monitored and reviewed regularly as part of the shared care arrangements between community pharmacists and GPs. That will add to the regular monitoring of patients on repeat medication.

Health care professionals care about their patients. Our proposals will certainly not lessen patient care, but will help to ensure that those professionals continue to deliver the best possible service to their patients. I therefore ask Nanette Milne to withdraw amendment 81 and not to move amendment 82.

**The Deputy Convener:** I invite Nanette Milne to wind up and to say whether she wishes to press her amendments.

**Mrs Milne:** I find myself in a slightly difficult situation because I can follow what the minister is saying and the intention behind the extension of the period of certification, but I am concerned that there are still imponderables. Jean Turner said that if the checks and balances are in place there should be no worries about the matter. The minister said that there were no regulations yet, but there will be a code of practice. I am concerned that there are still a lot of grey areas. I am reluctant to withdraw amendment 81 without having received more concrete assurances.

**The Deputy Convener:** I am afraid that I have to ask you for a decision. You must either press the amendment or seek leave to withdraw it.
Mrs Milne: If further information is likely to be forthcoming before stage 3, I will withdraw the amendment with the proviso that I could raise the issue again at stage 3. I would prefer to do that.

The Deputy Convener: So—you wish to ask for the committee’s agreement to withdraw the amendment.

Mrs Milne: Yes. I seek to withdraw amendment 81. If the committee agrees, I might raise the matter again at stage 3.

Amendment 81, by agreement, withdrawn.
Amendment 82 not moved.
Amendment 71 moved—[Rhona Brankin]—and agreed to.

Section 30, as amended, agreed to.

After Section 30

The Deputy Convener: Amendment 63, in the name of the minister, is grouped with amendment 64.

Rhona Brankin: Amendments 63 and 64 provide for a right of appeal against removal to hospital, detention in hospital or continuing detention in hospital for anyone who suffers from an infectious disease, under powers that are contained in the Public Health (Scotland) Act 1897. The provision of a right of appeal against the use of those powers will ensure that the relevant provisions comply with paragraph 4 of article 5 of the European convention on human rights, which provides that

“Everyone who is deprived of his”

or her

“liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”

Without the provision of a right of appeal, the powers may be difficult to enforce in some cases, with a consequent risk to public health. Provision of a right of appeal will ensure that public health may be protected where necessary while the human rights of the individuals concerned would still be protected. That is because courts, knowing that a right of appeal exists, would be more willing to countenance detention orders for people who have infectious diseases when the detention can be overturned if it is inappropriate; for example, if an individual who is thought to have an infectious disease that poses a risk is found on further testing not to be suffering from that disease.

I move amendment 63.

Amendment 63 agreed to.

The Deputy Convener: That ends today’s business. I thank members for their co-operation.

Meeting closed at 15:13.
SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL: SECTION 24: PAYMENTS TO THOSE WHO HAVE CONTRACTED HEPATITIS C FROM NHS TREATMENT

I was concerned to hear that the Committee had voted to support amendments to the provisions of the Smoking, Health and Social Care (Scotland) Bill which will extend to relatives and dependants of those who have died eligibility to claim ex gratia payments in relation to those who contracted Hepatitis C from NHS treatment with blood or blood products.

I want to ensure that the Committee is aware of the full implications of taking this step. I am aware that a number of members spoke in terms of the fairness and justice of extending eligibility to relatives and dependants of the deceased. There were also suggestions that the existing provisions lacked clarity and consistency.

I believe the Executive has demonstrated its sympathy and compassion for those who have contracted Hepatitis C through NHS treatment in very practical terms through the lead it has taken in establishing a UK scheme to make ex gratia payments to this group of people. We have sought to approach this in a fair, principled and consistent way, but we have had to set certain criteria and priorities for the operation of the scheme. The amendments agreed to by the Committee risk undermining this approach.

A key foundation of the scheme is that the payments are ex gratia payments. They do not represent compensation, or involve any admission of legal liability. The purpose of the scheme is to relieve the hardship and suffering which claimants experience from living with Hepatitis C. I am concerned that if we move away from this principle, we change the essential nature and purpose of the scheme.
This is a common UK policy and approach, and the Skipton Fund is being operated jointly on behalf of the four UK administrations. If we in Scotland are to change our approach as a result of this Bill, this will mean either that the Scottish Executive will have to opt out of the Skipton arrangements – which have already made payments to over 400 people in Scotland – or we would need to ask the other UK administrations to agree to a different approach and extra costs. I believe opting out of Skipton would create considerable difficulties for us. In particular it would involve extra administrative time and cost, would disrupt arrangements that are already in place and would raise issues as to the treatment of a Scottish scheme within the national social security system.

It is suggested that we have been somehow inconsistent or arbitrary in our approach because our scheme allows for payments to relatives or dependants of the deceased in certain circumstances. I do not accept this is the case. The scheme provides for payments to be made in respect of people who died between 29 August 2003 and 5 July 2004. This is a very limited group of people, and covers the period between the announcement of the Skipton Fund scheme and the date when the fund opened to accept applications.

Following the announcement on 29 August 2003, we believe that people who had contracted the Hepatitis C virus through NHS treatment had a reasonable expectation that they would receive an ex-gratia payment. We therefore considered it right to make payments in respect of these individuals, even where they had died. People who died before 29 August had no expectation of such a payment, while those who died later than 5 July 2004 would have had the opportunity to make a claim.

I would be concerned that there could be considerable difficulties in terms of evaluating evidence for any claims made in respect of people who died before 29 August 2003. It may be necessary to rely on medical evidence that is up to 12 years old, and may not necessarily indicate very clearly the grounds of eligibility for a payment, or the degree of progression of disease.

An important aspect of the practical working of the scheme is that payments are not taken into account for the purpose of assessing social security entitlement. This is achieved through regulations which are made by the UK government specifically for this purpose – included in the Social Security (Miscellaneous Amendments) (No 2) and (No 3) Regulations 2004. Social security is, of course, a reserved function. If significant changes are made to the Skipton Fund which in effect create a different scheme in Scotland I would be concerned that the existing regulations would no longer apply, and there would be no guarantee that new regulations could be made to apply to Scotland only. This would have the potential to significantly disadvantage all claimants.

There are also potentially major cost considerations involved in extending the scheme to cover claims in respect of the deceased. It is estimated that 4,000 people may have been infected with the Hepatitis C virus through NHS treatment, of whom around 1,200 may still be alive and 2,800 deceased. These figures were published in the report of the Lord Ross Expert Group.

It is difficult to estimate what the costs of extending the scheme to cover the deceased might be. We recognise that many of the deceased are people who received blood transfusions when they were already elderly or seriously ill, and may have died before they developed symptoms of Hepatitis C. Take-up from this group, however, does have the potential to add significantly to the costs of the scheme at the expense of the overall health budget. The current scheme is expected to cost some £15 million. If there were a take-up rate of 25% from relatives or dependants of the deceased, the costs of the scheme could more than double, with additional expenditure of some £20 million. I do not believe this is a financial risk which we can afford to accept.
I would be grateful if the Committee could reflect on these matters further. I would intend to press at Stage 3 to restore the position that claims cannot be made in respect of people who died before 29 August 2003, and that individuals - with the exception of the period 29 August 2003 to 5 July 2004 – can claim only while alive.

All the best

Andy

ANDY KERR
4th Marshalled List of Amendments for Stage 2

The Bill will be considered in the following order—

Section 9 to 36  Schedules 2 and 3
Sections 1 to 5  Schedule 1
Sections 6 to 8  Section 37
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 31

Dr Jean Turner

89 In section 31, page 27, line 25, after <may> insert <as the majority share-holder>

Dr Jean Turner

90 In section 31, page 27, line 37, at end insert—

<( ) The Scottish Ministers shall produce, and from time to time publish, a code of practice on companies established under subsection (1), including—

(a) guidance as to the form and content of the memorandum and articles of association establishing a company;

(b) guidance as to the form and content of contracts let by a company;

(c) arrangements for making copies of such memorandum and articles of association and contracts available for public inspection;

(d) arrangements for appointing a company director or board of directors;

(e) arrangements for making details of the director or board of directors available for public inspection; and

(f) arrangements for independent reviews of a company.

( ) Before publishing a such code, the Scottish Ministers shall consult health boards, local authorities, and any other persons, or groups of persons, that appear to them to have an interest in companies established under subsection (1).

( ) The Scottish Ministers shall give a copy of the code of practice to any person who requests such a copy.>

Dr Jean Turner

91 In section 31, page 28, line 10, at end insert <as the majority share-holder>
Caroline Leckie

83 Leave out section 31

Schedule 2

Rhona Brankin
Supported by: Mr Andy Kerr

64 In schedule 2, page 36, line 13, at end insert—
Public Health (Scotland) Act 1897 (c.38)

In section 157 of the Public Health (Scotland) Act 1897, for the words “the preceding section” substitute “section 156 or as provided in sections 156A to 156C”.

Rhona Brankin
Supported by: Mr Andy Kerr

29 In schedule 2, page 36, line 15, at end insert—

(1A) In section 2(1) (Health Boards and Special Health Boards), in each of paragraphs (a) and (b), for the words “under this Act” substitute “relating to the health service”.

Rhona Brankin
Supported by: Mr Andy Kerr

36 In schedule 2, page 36, line 15, at end insert—

( ) In section 4 (Scottish Dental Practice Board)—
(a) in subsection (1A)—
(i) in paragraph (a), for the words from the second “to” to “he” substitute “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry to submit to the Board, in relation to treatment which he, or as the case may be, it”;
(ii) in paragraph (b), after the words “a dental practitioner” insert “or such a body corporate”;
(b) in subsection (1B), after the words “dental practitioner” insert “or body corporate”.

Rhona Brankin
Supported by: Mr Andy Kerr

30 In schedule 2, page 36, line 15, at end insert—

(1C) In section 10(3) (Common Services Agency), for the words “under this Act” substitute “relating to the health service”.

Rhona Brankin
Supported by: Mr Andy Kerr

37 In schedule 2, page 36, line 23, at end insert—
In section 17C(2A)(b)(ii) (other Part 1 services which may be included in arrangements for the provision of personal dental services), after the word “Part” insert “(but not pharmaceutical care services).”

Rhona Brankin
Supported by: Mr Andy Kerr
38 In schedule 2, page 36, line 23, at end insert—

<( ) In section 17D (persons with whom agreements may be made)—

(a) in subsection (1)(b)(vi), for the words “an individual” substitute “a person”;

(b) in subsection (2)—

(i) in paragraph (b)(v) of the definition of “NHS employee”, for the words “an individual” substitute “a person”;

(ii) in paragraph (c)(i) of that definition, for the words from the beginning to “or” substitute “a dental practitioner or body corporate whose name is included in the first part of a list prepared under section 25(2) of this Act or in a list prepared under”;

(iii) in paragraph (c)(ii) of that definition, after the word “who” insert “, or body corporate which,”;

(iv) in paragraph (b) of the definition of “qualifying body”, for the words “which, in accordance with the provisions of Part IV of the Dentists Act 1984, is entitled to carry on the business of dentistry” substitute “entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(v) in the definition of “section 17C employee”, for the words from “by” to the end substitute “by a person providing services in accordance with the arrangements”.

Rhona Brankin
Supported by: Mr Andy Kerr
39 In schedule 2, page 36, line 28, leave out from <“section” to end of line 29 and insert <the words from “has” to the end substitute “means”—

(a) the first part of a list prepared under section 25(2);

(b) the first part of a list prepared under section 26(2);”

Rhona Brankin
Supported by: Mr Andy Kerr
40 In schedule 2, page 37, line 11, at end insert—

<( ) In section 64(5) (permission for use of facilities in private practice), in paragraph (b), after the word “provide” insert “dental,”

Rhona Brankin
Supported by: Mr Andy Kerr
22 In schedule 2, page 37, line 29, at beginning insert <in subsection (1)—
( ) after the definition of “dispensing optician”, insert—

“Drug Tariff” means the Drug Tariff required to be prepared, maintained and published by the Scottish Ministers under section 17VA of this Act;”

Rhona Brankin
Supported by: Mr Andy Kerr

13 In schedule 2, page 37, line 41, at end insert—

(1A) References in this Act to “carrying on the business of dentistry” are to be construed in accordance with section 40 of the Dentists Act 1984 (c.24).”

Rhona Brankin
Supported by: Mr Andy Kerr

41 In schedule 2, page 37, line 41, at end insert—

( ) in Schedule 8, in paragraph 8(2)(b), for the words “disqualification, conditional disqualification or declaration of unfitness” substitute “disqualification or conditional disqualification”.

Rhona Brankin
Supported by: Mr Andy Kerr

42 In schedule 2, page 38, line 15, at end insert <;

( ) in subsection (2)(b)—

(i) after the words “dental practitioner” insert “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(ii) after the word “his” insert “or its”;

Rhona Brankin
Supported by: Mr Andy Kerr

43* In schedule 2, page 38, line 15, at end insert—

National Health Service (Primary Care) Act 1997 (c.46)

(1) The 1997 Act is amended as follows.

(2) In section 1 (pilot schemes)—

(a) in subsection (3)(b), after the word “services” insert “nor pharmaceutical care services”;

(b) in subsection (8) insert <;

“pharmaceutical care services” has the same meaning as for the purposes of Part 1 of the 1978 Act.”

(3) In section 3(3) (persons with whom pilot schemes for personal dental services may be made)—

(a) in paragraph (b) of the definition of “dental list”—
(i) after the word “Scotland,” insert “the first part of”;
(ii) for the words “section 25(2)(a)” insert “section 25(2)”;  
(b) in the definition of “NHS employee”—  
(i) in paragraph (b), after the words “dental practitioner” insert “or body corporate”;
(ii) in paragraph (c), after the word “who” insert “, or body corporate which,”.

(4) In section 17(5) (the Dental Practice Boards)—  
(a) after the words “dental practitioner” insert “or body corporate”;
(b) after the word “he” insert “or it”.

Rhona Brankin  
Supported by: Mr Andy Kerr

44 In schedule 2, page 38, leave out lines 20 and 21 and insert—  
< ( ) for paragraph (b) substitute—  
“(b) dental practitioners or bodies corporate undertaking to provide, and persons approved to assist in providing, general dental services;”;

Rhona Brankin  
Supported by: Mr Andy Kerr

45 In schedule 2, page 38, line 32, at end insert—  
< The Scottish Public Services Ombudsman Act 2002 (asp 11)  
In paragraph 14 of schedule 4 to the Scottish Public Services Ombudsman Act 2002, for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”.

Schedule 3

Rhona Brankin  
Supported by: Mr Andy Kerr

46 In schedule 3, page 39, line 5, column 2, at beginning insert—  
< In section 17C(6), the words “by a general dental practitioner”.

Rhona Brankin  
Supported by: Mr Andy Kerr

47 In schedule 3, page 39, line 6, column 2, at end insert—  
< In section 28B(6), the words “Subject to section 25(3),”.

5
Rhona Brankin  
Supported by: Mr Andy Kerr

48 In schedule 3, page 39, column 2, leave out line 7 and insert—
<In section 29A, subsection (2) and in subsection (5), the words “(including provision modifying the effect of this Part)”.

Rhona Brankin  
Supported by: Mr Andy Kerr

49 In schedule 3, page 39, line 29, at end insert—
<Health Services Act 1980 (c.53) Section 20(2). In Schedule 6, paragraph 4. In Schedule 7, the entry for section 25(3) of the 1978 Act.>

Rhona Brankin  
Supported by: Mr Andy Kerr

50 In schedule 3, page 39, line 29, at end insert—
<Health and Social Services and Social Security Adjudications Act 1983 (c.41)>

Rhona Brankin  
Supported by: Mr Andy Kerr

51 In schedule 3, page 39, line 29, at end insert—
<Dentists Act 1984 (c.24) In Schedule 5, paragraph 12.>

Rhona Brankin  
Supported by: Mr Andy Kerr

52 In schedule 3, page 39, column 2, leave out line 44 and insert—
<Section 40. In Schedule 9, paragraph 19(6), (7) and (8).>

Rhona Brankin  
Supported by: Mr Andy Kerr

53 In schedule 3, page 39, line 45, at end insert—
<National Health Service (Primary Care) Act 1997 (c.46) In section 1(8), the words “by a general dental practitioner”. Section 27(2). Section 28(2). Section 29(2). In Schedule 2, paragraphs 43, 44 and 45.>
In Schedule 3, the entry concerning section 25(2)(c) of the 1978 Act.

**Rhona Brinkin**  
**Supported by: Mr Andy Kerr**

54 In schedule 3, page 39, line 45, at end insert—

*Health Act 1999 (c.8)*  
Section 56(3) and (4).  
In Schedule 4, paragraphs 49, 51(d) and (g), 52(c) and 53.  
In Schedule 5, in the entry concerning section 32A of the 1978 Act, the words “and, in subsection (6)(a), “prepared under this Part of this Act”.”.

**Rhona Brinkin**  
**Supported by: Mr Andy Kerr**

55 In schedule 3, page 40, line 5, at end insert—

*Community Care and Health (Scotland) Act 2002 (asp 5)*  
In schedule 2, paragraphs 2(6)(c), (7), (8), (9)(b), (10)(b) and (11).

**Rhona Brinkin**  
**Supported by: Mr Andy Kerr**

65 In schedule 3, page 40, line 7, at end insert—

*Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)*  
In schedule 2, paragraph 4(3)(b) and (6)(b).

**Rhona Brinkin**  
**Supported by: Mr Andy Kerr**

56 In schedule 3, page 40, line 7, at end insert—

*Primary Medical Services (Scotland) Act 2004 (asp 1)*  
Section 5(3)(a).  
In the schedule, paragraph 1(8), (10), (11)(a), (13) and (16)(a).

**Section 2**

**Mike Rumbles**

84 In section 2, page 2, line 8, leave out *<an>* and insert *<a second or subsequent>*

**Section 4**

**Mr Stewart Maxwell**

85 In section 4, page 2, line 25, leave out *<tobacco or>* and insert *<tobacco,>*
After section 4

Margo MacDonald

33 After section 4, insert—

<No-smoking premises: further provision for licensed premises

(1) This section applies where, by virtue of regulations under section 4(2), licensed premises are no-smoking premises.

(2) The owner of, or person who holds the licence for, the licensed premises may apply to the Licensing Board within whose area the premises are situated for the premises to be treated as if they are not no-smoking premises.

(3) The Licensing Board may grant applications under subsection (2) only exceptionally and in determining such applications must have regard to—

(a) the views of any employees who work in the licensed premises;
(b) the adequacy of ventilation in the licensed premises;
(c) the number and capacity of other licensed premises in the locality in which the licensed premises are situated in respect of which applications under subsection (2) have been granted; and
(d) the level of public demand for licensed premises which are not no-smoking premises.

(4) Where the Licensing Board grants an application under subsection (2), the licensed premises are, for the purposes of sections 1, 2 and 3 and despite any regulations under section 4(2) by virtue of which the premises are no-smoking premises, to be treated as if they are not no-smoking premises.

(5) Licensed premises which are to be treated as if they are not no-smoking premises by virtue of this section may advertise that fact.

(6) The Scottish Ministers may by regulations make further provision about the making and determination of, and the effect of granting, applications under subsection (2).>
Rhona Brankin
Supported by: Mr Andy Kerr

31 In section 37, page 32, line 5, leave out <and 35> and insert <, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36>

Rhona Brankin
Supported by: Mr Andy Kerr

32 In section 37, page 32, line 5, after <schedule 1> insert <and paragraph 1(1A) and (1C) of schedule 2>
Groupings of Amendments for Stage 2 (Day 4)

For debate on Day 4:

*Joint ventures: governance arrangements*
89, 90, 91

*Removal of power to participate in joint ventures*
83

*Ability of Scottish Ministers to confer their health functions on Health Boards and the Common Services Agency*
29, 30, 31, 32

*Minor and consequential amendments relating to dental services and bodies corporate*
36, 38, 40, 42, 43, 44, 46

*Exclusion of pharmaceutical care services*
37

*Consequential amendments and repeals relating to listing provisions*
39, 45, 50, 51

*Consequential and miscellaneous amendments*
47, 49, 52, 53, 54, 56

*Removal of age limit on Mental Health Tribunal membership*
65

For debate on subsequent days (subject to any additional amendments lodged):

*Penalties for smoking offences*
84

*The meaning of ‘smoke’*
85, 86, 87, 88

*Provision for licensed smoking premises*
33

**NOTE: THE FOLLOWING AMENDMENTS HAVE ALREADY BEEN DEBATED—**
With 3 – 13, 14
With 15 – 22
With 34 – 41, 48, 55
With 63 – 64
AMENDMENT GROUP 2: Ability of Scottish Ministers to confer their health functions on Health Boards and the Common Services Agency

AMENDMENT NOS: 29, 30, 31, 32

- These amendments clarify existing legislation by providing that Scottish Ministers may confer on Health Boards, Special Health Boards and the Common Services Agency, by order any of their functions relating to the health service, rather than any of their functions under the National Health Service (Scotland) Act 1978 Act (“the 1978 Act”).
  
  o Amendment 29 amends section 2(1) of the 1978 Act to provide that the reference to Scottish Ministers’ functions is changed to refer instead to their functions relating to the health service.

  o Amendment 30 amends section 10(3) of the 1978 Act to provide that the reference to Scottish Ministers’ functions is changed to refer instead to their functions relating to the health service.

  o Amendments 31 and 32 provide that changes to the 1978 Act made by amendments 29 and 30, come into operation on the day after Royal Assent.

AMENDMENT GROUP 3: Minor and consequential amendments relating to dental services and bodies corporate

AMENDMENT NOS: 36, 38, 40, 42, 43, 44, 46

- These amendments are minor and consequential amendments relating primarily to Part 2 of the Bill.

  o Amendment 36 amends section 4(1A) and (1B) of the National Health Service (Scotland) Act 1978 (“the 1978 Act”) to allow regulations to provide that the Scottish Dental Practice Board (SDPB) may direct a body corporate, in addition to dental practitioners to submit specific treatment information and/or not to carry out specific treatment without their prior approval.

  o Amendment 38 updates the provisions in section 17D of the 1978 Act which sets out the persons with whom a section 17C agreement can be made.

  o Amendment 40 amends section 64(5)(b) of the 1978 Act so that dental corporations may apply for permission to use premises and facilities
which they have been authorised to use for the purposes of Part II of the 1978 Act, for providing services to private patients.

- Amendment 42 amends section 17 of the Health and Medicines Act 1988 to provide that the sanctions that may be provided for in regulations relating to prior approval of treatment, may apply to a dental corporation as well as a dental practitioner.

- Amendment 43 inserts a number of minor and consequential amendments to the National Health Service (Primary Care) Act 1997 in so far as it relates to Parts 2 and 3 of the Bill.

- Amendment 44 amends section 115(6C) of the Police Act 1997 to clarify the description of a list of persons undertaking to provide or assist in the provision of GDS in respect of which enhanced criminal records certificates may be obtained. This is updated to include bodies corporate as well as dental practitioners.

- Amendment 46 is a technical amendment to simplify the definition of personal dental services in the 1978 Act as it relates to section 17C agreements (persons with whom a Health Board can enter into arrangements to provide PDS).

**AMENDMENT GROUP 4: Exclusion of pharmaceutical care services**

**AMENDMENT NO: 37**

- This is a minor and consequential amendment arising from the Part 3 provisions in the Bill (Pharmaceutical Care Services, etc).

- It provides that section 17C arrangements for personal dental services under the National Health Services (Scotland) Act 1978 cannot include arrangements for the provision of pharmaceutical care services.

- The areas of personal dental services and pharmaceutical care services are distinct and this amendment ensures that will continue to be the case within the legislation.

**AMENDMENT GROUP 5: Consequential amendments and repeals relating to listing provisions**

**AMENDMENT NOS: 39, 45, 50, 51**

- Amendments 39, 45, 50 and 51 are minor and consequential amendments arising from Part 2 (general dental services etc.) and Part 3 (pharmaceutical care services) of the Bill.
Amendment 39 provides that regulations may require dental and ophthalmic practitioners on the first part of the list to hold approved indemnity cover to provide general dental services (GDS) and general ophthalmic services (GOS).

Amendment 45 excludes from the investigation of the Ombudsman, action taken by a Health Board in the exercise of certain of its functions relating to investigation and disciplinary matters under regulations made in respect of persons on lists of persons performing personal dental services, or pharmaceutical care services.

Amendment 50 is consequential upon section 15 of the Bill and repeals section 16(a) of the Health and Social Services and Social Security Adjudications Act 1983 which is now spent.

Amendment 51 repeals provisions in the Dentists Act 1984, which amend provisions in the 1978 Act and which are now spent.

AMENDMENT GROUP 6: Consequential amendments and miscellaneous amendments

AMENDMENT NOS: 47, 49, 52, 53, 54, 56

- These amendments are consequential and miscellaneous repeals relating to Parts 2, 3 and 4 of the Bill.

  o Amendment 47 repeals redundant wording at the opening of subsection 28B(6) of the National Health Service (Scotland) Act 1978, which refers to section 25(3).

  o Amendment 49 repeals redundant wording in the Health Services Act 1980 in section 20(2), paragraph 4 of schedule 6 and schedule 7 in respect of the entry for section 25(3) of the 1978 Act.

  o Amendment 52 repeals spent provisions in the National Health Service and Community Care Act 1990, which amended the 1978 Act.

  o Amendment 53 repeals spent provisions in the National Health Service (Primary Care) Act 1997 and simplifies the definition of personal dental services that may be provided under pilot schemes.

  o Amendment 54 repeals provisions in the Health Act 1999 that are spent as a result of the provisions in this Bill.

  o Amendment 56 repeals provisions in the Primary Medical Services (Scotland) Act 2004 which amend the 1978 Act and which are now spent as a result of this Bill.
AMENDMENT GROUP 7: Removal of age limit on Mental Health Tribunal membership

AMENDMENT NO: 65

- Amendment 65 removes the age limit at which members of the Mental Health Tribunal for Scotland must retire.

- This amendment provides Scottish Ministers with the opportunity to offer appointments to persons with the necessary qualifications, training and experience who would otherwise have been excluded from being offered such appointments due to their age and to retain in service those who reach age 70.

- It is expected that age discrimination legislation, which will implement EU obligations under EU Council Directive 2000/78/EC, will come into force around October 2006. Removing the age limit at this stage will also ensure that the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 will not be potentially incompatible with the Directive when it comes into force.
MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003

Purpose of Amendment

The purpose of this amendment is the removal of the upper age limit for members of the Mental Health Tribunal for Scotland.

Effect of Amendment

The amendment will delete paragraphs 4(3)(b) and 4(6)(b) of Schedule 2 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (‘the 2003 Act’). This will result in the removal of both the requirement that a Tribunal member must vacate office on attaining the age of 70 and the provision that a member of a Tribunal whose appointment comes to an end after the appointment period of 5 years may not be reappointed where that member is 69 or over.

Background on Amendment

The recruitment of 100 of each of the legal, medical and general members is required in order for the Tribunal to successfully carry out its functions. The recruitment process is underway and the response has been very positive with offers of appointment made to successful candidates.

The 2003 Act provides that Tribunal members must demit office once over 69. Although the majority of the provisions of the 2003 Act are not due to come into force until October 2005 the provisions concerned with the members’ age limit have already been commenced along with other provisions of the 2003 Act required to enable the Tribunal to be established and appoint members. The recruitment process has identified a small number of candidates who have the necessary qualifications, training and experience but unfortunately cannot be offered an appointment due to the age limit.

Removal of the age limit would allow for an increase in the number of offers of appointment made for all members but is particularly relevant for medical members. The removal of the age limit will not impact on the remaining provisions of the 2003 Act setting out the circumstances when a member would not be appointed, or reappointed; or the provisions setting out the circumstances when a member may be removed from office by order of a disciplinary committee.
Due to a general shortage of psychiatrists in Scotland it appears likely that the appointment of 100 medical members will not be achieved. As each Tribunal panel must have a medical member we consider that it would be very difficult for the Tribunal to operate successfully with a small number of medical members. Increasing the number of medical members (and in particular those who are not in current employment and could therefore potentially undertake more than 2 days work each month) would greatly assist the Tribunal to operate efficiently and effectively and to deliver its functions without unduly impacting on a workforce currently operating under capacity.

NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

Purpose of Amendment

To clarify the functions that Scottish Ministers may provide to be exercisable by Health Boards, Special Health Boards and the Common Services Agency.

Effect of Amendment

The amendments to sections 2(1)(a) and (b) and Section 10(3) of the National Health Service (Scotland) Act 1978 (‘the 1978 Act’) provide that the reference there to Scottish Ministers’ functions under the 1978 Act is changed to refer instead to their functions relating to the health service. This clarifies the functions that Scottish Ministers may provide for Health Boards, Special Health Boards and the Common Services Agency to exercise. The effect will be that the amendment restates the existing law in a clearer way. It does not affect the functions that are conferred on and exercisable by Health Boards, Special Health Boards and the Agency by order at the moment. However it makes provision so that greater clarity can be brought as to what functions may be carried out by these bodies in the health sphere in Scotland.

Background to Amendment

The National Health Service (Scotland) Act (“the 1978 Act”) gives Scottish Ministers a range of functions relating to the health service which in terms of existing legislation may be exercisable by them, or by order, Health Boards, Special Health Boards or the Common Services Agency.

There is however overlap between some of Ministers functions relating to the health service under the 1978 Act and under other Acts, and activities which may equally be done under both. An example is functions given to Ministers under section 63 of the Health Services and Public Health Act 1968 in relation to providing instruction for those employed in the health service which overlaps with functions given to Ministers in the 1978 Act itself.

Because of this overlap the Executive does not consider that this makes for clarity in the functions that may be conferred on and are exercisable by Health Boards, Special Health Boards and the Agency.
In particular, in the course of consideration of payments made by a Special Health Board, it was noted that the payments could be made in exercise of Ministers functions under the 1978 Act or in exercise of their functions relating to the health service under another Act. This is not very satisfactory in providing for clarity. Although there is no legislative gap or deficiency, these amendments will clarify the situation.
HEALTH COMMITTEE

EXTRACT FROM THE MINUTES

17th Meeting, 2005 (Session 2)

Tuesday 7 June 2005

Present:
Roseanna Cunningham (Convener)  Janis Hughes (Deputy Convener)
Kate Maclean  Paul Martin (Substitute)
Mr Duncan McNeil  Mrs Nanette Milne
Shona Robison  Mike Rumbles
Jean Turner

Also present: Carolyn Leckie

Apologies: Helen Eadie

**Smoking, Health and Social Care (Scotland) Bill:** The Committee considered the Bill at Stage 2 (Day 4).

The following amendments were agreed to (without division): 64, 29, 36, 30, 37, 38, 39, 40, 22, 13, 41, 42, 43, 44, 45, 46, 14, 47, 48, 49, 50, 51, 52, 53, 54, 55, 65 and 56.

The following amendment was disagreed to (by division):

83 (For 0, Against 9, Abstentions 0)

Amendment 89 was moved and, with the agreement of the Committee, withdrawn.

Amendments 90 and 91 were not moved.

Sections 31, 32, 33, 34, 35 and 36 were agreed to without amendment.

Schedules 2 and 3 were agreed to as amended.

The Committee ended consideration of the Bill for the day, amendment 56 having been disposed of.
Smoking, Health and Social Care (Scotland) Bill: Stage 2

14:09

The Convener: Item 4 is further consideration of the Smoking, Health and Social Care (Scotland) Bill at stage 2. I remind members that, as we agreed previously, the committee will consider at today’s meeting amendments that relate to sections 31 and 32 in part 5, sections 33 to 36 in part 6 and schedules 2 and 3. That means that we will debate only the first eight groupings in the list of groupings.

Section 31—Joint ventures

The Convener: Group 1 is on the governance arrangements for joint ventures. Amendment 89, in the name of Dr Jean Turner, is grouped with amendments 90 and 91.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): In lodging the amendments in the group, I am trying to achieve better governance, transparency and accountability and to ensure that the national health service in Scotland is “the majority share-holder” in all joint ventures.

From the evidence that the committee took, we know that the Royal College of Nursing Scotland was unconvinced by the experience in England and that the Scottish Trades Union Congress and Unison Scotland oppose the policy of joint ventures and question whether it represents value for money for the public. The Convention of Scottish Local Authorities agreed to it in principle, but raised concerns about its practical application. I, too, agree in principle, but I have doubts about how things will work in practice.

For example, I worked in an NHS health centre, which, although it was large, was never large enough for the work that had to be done. The pharmacy, which was the only part of the centre to rent its space, also did not have enough space. It would certainly need to expand to make full use of the new contract. I cannot see how a joint venture company could have solved our problems. Perhaps it could do so in the short term, but I am not sure how a commercial company would expand to allow the flexibility that all NHS departments require if they are to expand or reshape themselves, as they have had to do regularly over many years. The NHS needs to be a major shareholder if it is to have security, especially if outside contractors come into the NHS working space, as happens in England.

The local improvement finance trust—or LIFT—joint venture model was put before the committee and was much favoured by the private companies
that gave evidence. We heard that, out of the 42 projects that have gone ahead, the oldest is only 18 months old. None of those trusts has been going long enough to throw up problems. We probably need more pilots—let us remember NHS 24.

There is one such joint venture in my constituency, which is in the form of a private company limited by guarantee. There are three partners: the NHS primary care trust, East Dunbartonshire Council and Scottish Enterprise. The model was chosen to help to regenerate a village after the closure of Lennox Castle hospital and the sale of land to build houses.

There are downsides to the LIFT model. Once board members have been appointed, they can reappoint themselves at the end of their term, if they wish to do so. That means that no one from the local community has a chance to stand for office. The community also has no voting powers or input at the annual general meeting. Once set, terms are fixed by the company limited by guarantee.

Many constituents say that the model is not fair and that they would have no involvement. They feel that the model is not transparent and that such companies would be accountable to no one but themselves. Because they lack information, people are even asking about the vested interests of board members and whether there is a possible conflict of interest. For example, if a local builder is on the board, how do people know that he does not have a vested interest?

The amendments in the group would introduce the transparency and accountability that are needed to protect board members and the Scottish Executive and to dispel public fears. The minister has said that a joint venture company would perform its obligations without recourse to Government or public funds. In the case that I have described, a private company limited by guarantee is made up of organisations that are publicly funded. What happens if they fail or have problems? Who will pick up the pieces?

We have not had time to give section 31 the full scrutiny that it deserves. Even the minister’s own words implied that although it might be possible to develop alternative models, there would be local and national cost and time implications in doing so. The section requires the public and the private to perform their obligations in a joint venture that is without recourse to Government or public funds. We should not rush into commitments that involve public money without first making use of pilots. As I mentioned, we need only think of NHS 24.

I move amendment 89.

14:15

Shona Robison (Dundee East) (SNP): Like Jean Turner, I share a number of concerns about the provisions in the bill. Scrutiny is one such concern and another is the lack of alternative models. I recall Helen Eadie saying that she would have liked alternative models to have been put before the committee, which we could perhaps have explored had we had more time.

Jean Turner’s amendments 89 to 91 try to introduce more transparency and accountability without throwing the baby out with the bath water. Given the lack of experience of such projects, we should support that aim, as we do not know much about how they will work on the ground. If nothing else, amendments 89 to 91 seek to put in place safeguards in case anything should go wrong.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I do not agree. Giving the powers that the amendments suggest to Scottish ministers would perhaps give them too much power, and would not allow the joint ventures to develop in all the ways that are outlined in the bill. Amendments 89 to 91 are too restrictive.

Mrs Nanette Milne (North East Scotland) (Con): I do not agree. Giving the powers that the amendments suggest to Scottish ministers would perhaps give them too much power, and would not allow the joint ventures to develop in all the ways that are outlined in the bill. Amendments 89 to 91 are too restrictive.

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Mrs Nanette Milne (North East Scotland) (Con): I do not agree. Giving the powers that the amendments suggest to Scottish ministers would perhaps give them too much power, and would not allow the joint ventures to develop in all the ways that are outlined in the bill. Amendments 89 to 91 are too restrictive.

Rhona Brankin: I will address amendments 89 and 91 first. Requiring ministers or health bodies to be majority shareholders would have a number of implications and would present practical difficulties, so I cannot support amendments 89 and 91. The powers that we seek are generic. We want to maintain a position in which alternative models are available. Indeed, the committee raised the importance of having alternate models in its stage 1 report, as Shona Robison said.

Under these restrictive amendments, only models involving a majority shareholding by Scottish ministers or health bodies would be possible. That would prevent the use of mutuals, companies limited by guarantee or contractual joint ventures. For example, it would not be possible for a health body to enter into a joint venture with three public sector partners, such as coterminal local authorities, on an equal partnership basis, because each partner would be able to have only a 25 per cent shareholding.

There would also be serious implications for the sharing of risk. The balance of equity risk would rest with the public sector as the majority shareholder. In the case of the exploitation of novel technologies, the public sector would assume the risk that we want to avoid and the
possibility of further commercial investment would be limited.

While I support the member's motives in seeking openness and sound governance of joint venture companies, I believe that amendment 90 is flawed and unnecessary.

The amendment is flawed because it makes blanket assumptions about the form that joint venture companies will take. As I have pointed out, the provisions have been drafted to ensure that there is the flexibility that already exists in other parts of the public sector. It would be illogical to have in primary legislation provisions that cover only some of the possible joint venture options.

The amendment is unnecessary because there is already adequate provision in relation to suitable governance arrangements and disclosure requirements for public sector bodies. I reassure the committee that the Scottish Executive is fully committed to openness. Within NHS Scotland, there is already mandatory guidance covering the disclosure of business cases and contracts. Joint ventures would be no different in that regard.

The Executive is committed to the preparation and publication of guidance on the appointment and conduct of public sector officials who act as directors on the boards of joint venture companies. Companies that are established as joint ventures will also be subject to statutory requirements on the disclosure of information, such as the publishing of accounts. Scottish ministers and NHS boards are also required to make information available under the Freedom of Information (Scotland) Act 2002.

For those reasons, I invite Jean Turner to withdraw amendment 89 and not to move amendments 90 and 91.

**The Convener:** I invite Jean Turner to wind up and to indicate whether she wants to press or withdraw amendment 89.

**Dr Turner:** I would like to think that the minister might consider the matter, because there are loopholes and the bill does not protect the Scottish Executive, the public or those who will be involved in joint venture companies. I will withdraw amendment 89 and see what the minister brings to the Parliament at stage 3.

*Amendment 89, by agreement, withdrawn.*

*Amendments 90 and 91 not moved.*

**The Convener:** Amendment 83, in the name of Carolyn Leckie, is in a group on its own.

**Carolyn Leckie (Central Scotland) (SSP):** I participated in many of the stage 1 evidence-taking sessions at which the committee discussed section 31. I am sure that members expect me to disagree in principle with the increased marketisation of health care and health care premises, as that is where I come from politically. However, even by the other parties' political compass, the evidence that Executive representatives and Partnerships UK gave in support of the assertion that the LIFT model demonstrates value for money and of its impact on service delivery was flimsy. The committee agreed that the evidence that was presented was not robust; indeed, it referred to that in its stage 1 report.

In comparison with the lack of robust evidence in support of section 31, the credible case that Dave Watson of Unison, the STUC and the Royal College of Nursing made should set off alarm bells. Given that the witnesses from the public bodies did not expect that they would rush to exercise the powers that are contained in section 31, there is an argument, from whatever political perspective, for taking the powers out of the bill and separating them from the high-profile debate about a ban on smoking in public places in order to scrutinise them on their own and to give us the chance to explore alternative models from all political perspectives. I would include in that exploration a model that is based on public funding, public buildings and public service delivery.

Many concerns were expressed about conflict of interest—Jean Turner made reference to that in speaking to her amendments 89 to 91. The Executive cannot escape from the experience of the private finance initiative, nor can it escape from Allyson Pollock's research on PFI or her dismantling of the case for it. Under companies legislation, it is impossible to reconcile the public service ethos and the obligation on a company that is comprised of shareholders, regardless of the mix of shareholders, to meet the bottom line. Therefore, there is bound to be a conflict of interest for directors who are appointed from public bodies.

I repeat that section 31 at least requires exclusive and robust investigation and a thorough debate. By all accounts, even by the standards of the Executive and of the public bodies who participated in gathering evidence in support of the provisions, enough evidence has not been given. The private companies involved were not able to answer many questions about the impact of LIFT schemes in England and were not able to reassure us about where they would end up in the long term.

I suggest that, in the interests of democracy, the Executive should be making its proposals in the context of a debate that centres on such issues, rather than through high-profile legislation that should be focusing on the pro-health agenda.

I move amendment 83.
Mike Rumbles: Carolyn Leckie ignores the fact that, throughout Scotland, many NHS facilities are currently private. Up and down the country, general practitioner services are provided privately. The fact that the bill provides for ministers to form companies to provide and upgrade facilities and services throughout Scotland is to be welcomed. As far as I can see, the provisions in section 31 are positive, and it would be a mistake to remove the section from the bill, especially if we want to improve NHS services for patients, wherever they are in Scotland.

Mrs Milne: Carolyn Leckie will not expect me to agree with her amendment. The much denigrated PFI about which Carolyn Leckie spoke has provided several very good facilities for the NHS in Scotland that would not exist without it. Like Mike Rumbles, I believe that joint ventures are a positive way forward for the NHS.

The logic of what Carolyn Leckie said about taking section 31 out of the bill and dealing with it in a stand-alone piece of legislation could apply to every section. Some of us said that at the stage 1 debate but I think that we have moved beyond that. I support the inclusion of section 31 and am not in favour of amendment 83.

Rhona Brankin: I reject amendment 83. It seeks to remove the provisions that would allow Scottish ministers and health bodies to form and participate in the formation of companies for the provision of health services or to exploit intellectual property. The removal of the joint venture provisions from the bill was the subject of a motion lodged by Carolyn Leckie during the stage 1 debate on 28 April. The Parliament was given the opportunity to vote on the matter and the member’s motion was soundly defeated.

The provisions have been the subject of much debate during the past three years including in a formal consultation exercise from February to May 2004. The Health Committee has considered the provisions closely and has taken evidence from a range of interested parties. The committee’s stage 1 report raised several issues on which the Executive has responded.

On joint ventures for the provision of facilities and services, the Executive continues to carry out through the joint premises project board a programme of work to support the development of an appropriate model for Scotland. The NHS, COSLA and Unison are progressing that work. Although the powers that are sought are generic and allow flexibility with regard to the types of commercial model that could be employed, much discussion has focussed on the NHS LIFT model that was implemented in England. Ms Leckie has referred to it again today.

The committee’s report expressed the concern that it is too soon to make an objective judgment about the performance of that model. To an extent, it is relatively early days, but Scotland benefits from not starting with a blank sheet of paper or having to reinvent the wheel.

During the stage 1 evidence sessions, and in ministers’ response to the committee, reference was made to the impending release of a report by the National Audit Office on the development of NHS LIFT in England. Unfortunately, the publication of the report was delayed until 19 May, due to the general election. In the NAO press release, Sir John Bourn, the Comptroller and Auditor General, said:

“I welcome LIFT as an attractive new way of improving primary health and social care facilities. This is an excellent example of a department doing something different and new to come up with an effective solution to an established problem. I fully support this kind of innovation and the department must carefully evaluate this initiative so that all of government, and especially Building Schools for the Future, a similar initiative, can benefit from the lessons that arise.”

We continue to maintain close links with developments in England and with the Department of Health’s response to the NAO’s recommendations.

It is clear that in Scotland we can learn lessons from experiences in England, but we must also work with stakeholders to ensure that we develop a model that is appropriate to the needs of Scotland. The joint premises project board is undertaking that task.

On intellectual property, credulity would be stretched to the limit if anyone believed that Scotland and the world would be better off if innovations and novel technologies were allowed to gather dust on the shelf instead of bringing benefits to people by delivering better health care through more effective treatments and care regimes, while earning returns that could be reinvested in further improvements to the NHS in Scotland.

Therefore, I invite Carolyn Leckie to withdraw amendment 83.

14:30

Carolyn Leckie: I will press amendment 83. Members of the committee will not be surprised to hear that I reject much of the minister’s response, which is just wishful thinking that takes us no further forward from the position that we were in after hearing the evidence at stage 1.

Mike Rumbles said that the effect of the provisions in section 31 would be good as far as he could see, which demonstrates the problem. None of us can see very far, because not much
evidence has been presented. Paragraph 233 of the committee’s stage 1 report says:

“it was apparent to the Committee that representatives from COSLA and the NHS Confederation had only limited knowledge of existing NHS LIFT projects in England.”

As far as I can see, we are no further forward, and I do not accept that there is a need for urgency in pushing through the provisions without further scrutiny and debate.

It is interesting to learn that the Liberal Democrats are ditching the attempt to pitch their party’s policy to the left of Labour. A consensus on privatisation is appearing fast. Indeed, privatisation is the only game in town, because that is the ideological agenda that the Executive and the Westminster Government are driving forward. If the political will to do so exists, it is perfectly possible to build primary care services on a public model and to protect intellectual property and ensure that its benefits are enjoyed throughout the NHS and internationally without creating a company to own the intellectual property.

During the committee’s evidence-taking session on intellectual property, I envisaged a horrific situation in which a company that owned a piece of intellectual property that was attached to a specific NHS board or primary care service would in effect sell that intellectual property back to the NHS. Currently, innovations that are developed in the NHS are owned by the entire NHS on the public service model and by all the patients who can benefit from them. It would be abhorrent and unethical if an advance or invention that under the current system would automatically benefit patients throughout the country had to be sold to patients in a transaction between different parts of the NHS. Such an approach would create inequalities.

I hope that the committee will support amendment 83.

The Convener: The question is, that amendment 83 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division. I remind those present that only members of the committee may vote.

Against
Cunningham, Roseanna (Perth) (SNP)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Milne, Mrs Nanette (North East Scotland) (Con)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 0, Against 9, Abstentions 0.

Amendment 83 disagreed to.

Section 31 agreed to.

Sections 32 to 36 agreed to.

Schedule 2

MINOR AND CONSEQUENTIAL AMENDMENTS

Amendment 64 moved—[Rhona Brankin]—and agreed to.

The Convener: Group 3 is on the ability of Scottish ministers to confer their health functions on health boards and the Common Services Agency. Amendment 29, in the name of the minister, is grouped with amendments 30 to 32.

Rhona Brankin: Amendments 29 to 32 are minor amendments that seek to clarify existing legislation by providing that Scottish ministers may by order confer on health boards, special health boards and the Common Services Agency any of their functions that relate to the health service.

Under the National Health Service (Scotland) Act 1978, ministers have a range of functions in relation to the health service. Ministers may by order provide for those functions to be exercisable by health boards and special health boards. However, there is some overlap between ministers’ functions under the 1978 act and their functions under other acts. For example, the functions that are given to ministers under section 63 of the Health Services and Public Health Act 1968, on the provision of instruction for those who are employed in the health service, overlap with their functions under the 1978 act. The Executive does not consider that such overlap makes for clarity in the functions that ministers may confer on health boards and special health boards.

Amendment 29 seeks to clarify the existing legislative position in relation to those overlaps by making it clear that under the powers of the 1978 act any functions that relate to the health service in any legislation can be conferred on health boards or special health boards by Scottish ministers. Amendment 30 does likewise in relation to the Common Services Agency. As amendments 29 and 30 essentially seek to restate existing law, it is considered appropriate for them to come into force without the need for a commencement order. Amendments 31 and 32 therefore provide for amendments 29 and 30 to come into operation on the day after royal assent.

I move amendment 29.

Amendment 29 agreed to.

The Convener: Group 4 comprises a variety of minor and consequential amendments in respect of dental services and bodies corporate. Amendment 36, in the name of the minister, is
grouped with amendments 38, 40, 42 to 44 and 46.

Rhona Brankin: These minor and consequential amendments relate primarily to part 2 of the bill and the provision of dental services. Amendments 36, 38, 40, 42 and 46 seek to amend the National Health Service (Scotland) Act 1978.

Amendment 36 seeks to amend the 1978 act to provide that regulations may allow the Scottish Dental Practice Board to issue directions to bodies corporate as well as to dental practitioners.

Amendment 38 seeks to update the list of those with whom a health board can enter into section 17C agreements for the provision of personal dental services or primary medical services to include dental corporations or their employees.

Amendment 40 seeks to provide that bodies corporate that provide general dental services, like dental practitioners who provide general dental services, may apply for permission to use NHS premises and facilities for providing services to private patients.

Amendment 42 seeks to amend section 17 of the Health and Medicines Act 1988 to ensure that dental corporations are covered by the sanctions that may be provided for with regard to prior approval of treatment.

Amendment 43 seeks to insert a number of minor and consequential amendments to the National Health Service (Primary Care) Act 1997 in relation to the provision of pilot personal dental services.

Amendment 44 seeks to amend the list of persons in respect of whom enhanced criminal record certificates may be obtained under the Police Act 1997 in relation to general dental services, and amendment 46 seeks to simplify the definition of personal dental services in the 1978 act.

I move amendment 36.

Amendment 36 agreed to.

Amendment 30 moved—[Rhona Brankin]—and agreed to.

The Convener: Group 5 concerns exclusion of pharmaceutical care services. Amendment 37, in the name of the minister, is in a group on its own.

Rhona Brankin: Amendment 37 is a minor and consequential amendment that arises from part 3 of the bill. At the moment, pharmaceutical services cannot be included within arrangements for personal dental services under section 17(c) of the National Health Service (Scotland) Act 1978. By providing that pharmaceutical care services remain excluded from such arrangements, the amendment seeks to ensure that the changes that part 3 will introduce to the 1978 act will not alter the current position.

I move amendment 37.

Amendment 37 agreed to.

Amendment 38 moved—[Rhona Brankin]—and agreed to.

The Convener: Group 6 concerns consequential amendments and repeals relating to listing provisions. Amendment 39, in the name of the minister, is grouped with amendments 45, 50 and 51.

Rhona Brankin: Amendments 39, 45, 50 and 51 are consequential amendments and repeals that relate to the listing provisions in parts 2 and 3.

Amendment 39 seeks to provide that dental and ophthalmic practitioners in the first part of the list might be required to have indemnity cover and amendment 45 seeks to update the Scottish public services ombudsman’s investigatory remit.

Amendments 50 and 51 are technical amendments from part 2. Amendment 50 seeks to repeal a spent provision in the Health and Social Services and Social Security Adjudications Act 1983 and amendment 51 seeks to repeal a spent amendment to the 1978 act that was made by the Dentists Act 1984.

I move amendment 39.

Amendment 39 agreed to.

Amendments 40, 22, 13 and 41 to 45 moved—[Rhona Brankin]—and agreed to.

Schedule 2, as amended, agreed to.

Schedule 3

REPEALS

Amendments 46 and 14 moved—[Rhona Brankin]—and agreed to.

14:45

The Convener: Group 7 is consequential and miscellaneous amendments. Amendment 47, in the name of the minister, is grouped with amendments 49, 52 to 54 and 56.

Rhona Brankin: These are technical and consequential amendments to schedule 3. They repeal certain provisions in other acts that are spent as a result of the provisions in parts 2, 3 and 4 of the bill.

Amendment 47 repeals wording in the National Health Service (Scotland) Act 1978. Amendment 49 repeals provision in the Health Services Act 1980. Amendment 52 repeals certain provisions in the National Health Service and Community Care Act 1990, which are now redundant. Amendment
53 repeals certain provisions in the National Health Service (Primary Care) Act 1997 and also simplifies the definition of personal dental services in that act. Amendment 54 repeals provisions in the Health Act 1999. Finally, amendment 56 repeals certain provisions in the Primary Medical Services (Scotland) Act 2004, which are spent as a result of this bill.

I move amendment 47.

Amendment 47 agreed to.

Amendments 48 to 55 moved—[Rhona Brankin]—and agreed to.

The Convener: Group 8 is on the removal of the age limit on membership of the Mental Health Tribunal for Scotland. Amendment 65, in the name of the minister, is in a group on its own.

Rhona Brankin: Amendment 65 removes the upper age limit of 69 for the members of the Mental Health Tribunal for Scotland. The limit is currently laid down in the Mental Health (Care and Treatment) (Scotland) Act 2003 and is common practice for tribunals.

Each Mental Health Tribunal for Scotland tribunal must have a medical member and it would be very difficult for the body to operate successfully without a sufficient number of medical members. Removal of the age limit will assist in the recruitment and retention of all members but is particularly relevant for medical members. Amendment 65 will help us not to overload tribunal members who are also working psychiatrists; it will enable us to retain retired psychiatrists who are performing effectively as tribunal members. Removing the age limit will increase the pool of medical members and allow us to retain those who reach 70. Having even a small number of additional members who can work three or more days a month will ensure that members’ availability does not delay hearings and will therefore help the tribunal to operate more efficiently and effectively.

I move amendment 65.

Mike Rumbles: Amendment 65 deals with blatant age discrimination and wherever we find such discrimination we should get rid of it. I therefore support what the Executive is proposing.

Amendment 65 agreed to.

Amendment 56 moved—[Rhona Brankin]—and agreed to.

Schedule 3, as amended, agreed to.

The Convener: That ends today’s stage 2 consideration of the bill. The target for next week’s meeting is to complete consideration of part 1, schedule 1, section 37 of part 6, and the long title. The deadline for lodging amendments to those sections and schedules is noon on Thursday 9 June.

I thank the minister and her officials for their attendance.
Before section 1

Mr Brian Monteith
Supported by: Mrs Nanette Milne

115 Before section 1, insert—

<Meaning of “smoke” and “enclosed public place”

(1) In this Part “smoke” means to hold or otherwise be in possession or control of a lit cigar, cigarette, pipe or any other matter or substance which contains tobacco.

(2) In this Part, “enclosed public place” means so much of any place, including a workplace, as is designed to be wholly enclosed while the place is open to the public but does not include exempt places as listed in schedule (Exempt places).

(3) The Scottish Ministers may, by regulations, modify schedule (Exempt places) so as—

(a) to add a kind of premises to; or

(b) remove a kind of premises from,

those in that schedule.>

Before schedule 1

Mr Brian Monteith
Supported by: Mrs Nanette Milne

116* Before schedule 1, insert—

<SCHEDULE

(introduced by section (Meaning of “smoke” and “enclosed public place”))

EXEMPT PLACES

Domestic premises.

Short and long-term adult residential care premises and hospices.

Psychiatric hospitals and psychiatric units.

Any offshore installation.
Such hotel bedrooms as are designated by the person having the management or control of the hotel as being bedrooms in which smoking is permitted.

Any interview room, detention room or cell accommodation within a police station.

Any legalised police cell within the meaning of section 14 of the Prisons (Scotland) Act 1989 (c.45) or prison cell.

Any retail establishment dedicated to or predominantly for the sale of tobacco or tobacco products.

The stage area of any enclosed theatrical production site, where smoking is an integral part of the production.

Any club premises to which the public does not have access as of right.

Medical research and treatment sites forming part of any educational establishment or healthcare facility, where smoking is integral to the research being conducted.

Those parts of the premises of a tobacco retailer where smoking is integral to the operations being conducted.

Places where religious ceremonies involving the use of tobacco are taking place.

Private vehicles.

Section 1

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

117 In section 1, page 1, line 21, at beginning insert <Subject to subsection (1A),>

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

118 In section 1, page 1, line 21, leave out <no-smoking premises> and insert <an enclosed public place>

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

119 In section 1, page 1, line 21, leave out <knowingly>

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

120 In section 1, page 1, line 22, at end insert—

<(1A) This section shall not apply to a person who has the management or control of a theatre or other venue where a bona fide performance or organised rehearsal of a dramatic or lyric theatrical production is taking place.>

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

121* In section 1, page 1, line 23, leave out subsection (2)
In section 1, page 1, line 24, leave out <no-smoking premises> and insert <an enclosed public place>

In section 1, page 1, line 26, leave out from beginning to <that> in line 27 and insert—

<(3) An accused charged with an offence under this section is not guilty of an offence if—

(za) the accused did not know, and could not reasonably have been expected to know, that the other person was smoking in the premises;

(a)>
In section 2, page 2, line 5, leave out from beginning to <that> and insert <An accused charged with an offence under this section is not guilty of an offence if>

In section 2, page 2, line 7, leave out <no-smoking premises> and insert <an enclosed public place>

In section 2, page 2, line 8, leave out <an> and insert <a second or subsequent>

Section 3

In section 3, page 2, line 11, at beginning insert <Subject to subsection (1A),>

In section 3, page 2, leave out line 12 and insert—

<( ) in, on, or near no-smoking premises so as to be visible to and legible by persons in and persons approaching the premises; and>

In section 3, page 2, line 12, leave out <no-smoking premises> and insert <an enclosed public place>

In section 3, page 2, line 14, leave out <no-smoking premises> and insert <an enclosed public place>

In section 3, page 2, line 16, at end insert—

<( ) A person who removes, covers, defaces or alters any notice required under this section commits an offence.>
Mr Brian Monteith
Supported by: Mrs Nanette Milne

135 In section 3, page 2, line 16, at end insert—
   <(1A) Nothing in subsection (1) requires a notice to be displayed in a theatre or other venue
   being used for a dramatic or lyric theatre production in a location where the notice
   would detract from the performance of the production or the artistic integrity of the set.>

Mr Brian Monteith
Supported by: Mrs Nanette Milne

136 In section 3, page 2, line 17, leave out from beginning to <that> and insert <An accused charged
   with an offence under this section is not guilty of an offence if>

Mr Duncan McNeil

92 In section 3, page 2, line 20, after <may,> insert <after consulting such persons as they consider
   appropriate,>

Rhona Brankin
Supported by: Mr Andy Kerr

96 In section 3, page 2, line 21, at end insert <and that any such provision is to be treated, for the
   purposes of that subsection, as if incorporated in it>

After section 3

Mrs Nanette Milne
Supported by: Mr Brian Monteith

137 After section 3, insert—
   <Exclusions from offences committed under sections 1 to 3
   The Scottish Ministers may, by regulations, provide that no offence is committed under
   sections 1 to 3 if the place in or in relation to which the offence would, but for this
   section, be committed complies with such requirements in respect of air quality as may
   be specified in the regulations.>

Section 4

Mr Stewart Maxwell

85 In section 4, page 2, line 25, leave out <tobacco or> and insert <tobacco,>

Mr Stewart Maxwell

86 In section 4, page 2, line 26, after <it> insert <or any other substance or mixture>

Mr Stewart Maxwell

87 In section 4, page 2, line 27, leave out second <or> and insert <, of>
Mr Stewart Maxwell

88 In section 4, page 2, line 28, at end insert <or of any other lit substance or mixture which is in a form or in a receptacle in which it can be smoked>

Mr Duncan McNeil

93 In section 4, page 2, line 31, at end insert <after consulting such persons as they consider appropriate on a draft of the regulations>

Rhona Brankin
Supported by: Mr Andy Kerr

97 In section 4, page 2, line 35, after <wholly> insert <or substantially>

Rhona Brankin
Supported by: Mr Andy Kerr

98 In section 4, page 2, line 38, leave out <by persons who are employees>

Rhona Brankin
Supported by: Mr Andy Kerr

99 In section 4, page 3, line 4, at end insert—

<( ) In subsection (4)(b), the reference to work includes work undertaken for no financial advantage.>

Mr Brian Monteith
Supported by: Mrs Nanette Milne

138* In section 4, page 3, line 5, leave out subsection (5) and insert—

<( ) In this Part—

“premises” means a building;

“wholly enclosed” means, in respect of premises, having a ceiling or roof and except for doors, windows and passageways, wholly enclosed whether permanently or temporarily and does not include an outdoor part of premises of a place covered by a fixed or movable roof, provided that at least one side is not surrounded by one or more walls or similar structures (inclusive of windows, doors, gates or other means of access or egress from that part) whether permanently or temporarily and that this area does not incorporate any part of the main enclosed floor space;

“the public” means the public generally, any section of the public, or individual selected members of the public; and

“has access” means has access as of right, whether on payment or otherwise.>

Rhona Brankin
Supported by: Mr Andy Kerr

100 In section 4, page 3, line 8, after <“wholly”> insert <or substantially>
Mr Duncan McNeil

94 In section 4, page 3, line 15, after <regulations,> insert <after consulting such persons as they consider appropriate on a draft of the regulations,>

Mr Brian Monteith
Supported by: Mrs Nanette Milne

139 Leave out section 4

After section 4

Rhona Brankin
Supported by: Mr Andy Kerr

101 After section 4, insert—

<Proceeding for offences under sections 1 to 3

(1) Summary proceedings in pursuance of section 1, 2 or 3 may be commenced at any time within the period of 6 months from the date on which evidence sufficient in the opinion of the Lord Advocate to justify the proceedings comes to the Lord Advocate’s knowledge.

(2) Subsection (3) of section 136 of the Criminal Procedure (Scotland) Act 1995 (c.46) (date of commencement of summary proceedings) has effect for the purposes of subsection (1) as it has effect for the purposes of that section.

(3) For the purposes of subsection (1), a certificate of the Lord Advocate as to the date on which the evidence in question came to the Lord Advocate’s knowledge is conclusive evidence of the date on which it did so.>

Margo MacDonald

33 After section 4, insert—

<No-smoking premises: further provision for licensed premises

(1) This section applies where, by virtue of regulations under section 4(2), licensed premises are no-smoking premises.

(2) The owner of, or person who holds the licence for, the licensed premises may apply to the Licensing Board within whose area the premises are situated for the premises to be treated as if they are not no-smoking premises.

(3) The Licensing Board may grant applications under subsection (2) only exceptionally and in determining such applications must have regard to—

(a) the views of any employees who work in the licensed premises;

(b) the adequacy of ventilation in the licensed premises;

(c) the number and capacity of other licensed premises in the locality in which the licensed premises are situated in respect of which applications under subsection (2) have been granted; and

(d) the level of public demand for licensed premises which are not no-smoking premises.
(4) Where the Licensing Board grants an application under subsection (2), the licensed premises are, for the purposes of sections 1, 2 and 3 and despite any regulations under section 4(2) by virtue of which the premises are no-smoking premises, to be treated as if they are not no-smoking premises.

(5) Licensed premises which are to be treated as if they are not no-smoking premises by virtue of this section may advertise that fact.

(6) The Scottish Ministers may by regulations make further provision about the making and determination of, and the effect of granting, applications under subsection (2).

Mrs Nanette Milne
Supported by: Mr Brian Monteith

140 After section 4, insert—

<Enforcement

(1) It is the duty of the appropriate council to enforce the provisions of this Part.

(2) In this section and in section 6 “the appropriate council” means, in relation to no-smoking premises, the council of the area in which those premises are.>

Schedule 1

Mr Brian Monteith
Supported by: Mrs Nanette Milne

141 In schedule 1, page 33, line 6, leave out <no-smoking premises> and insert <an enclosed public place>

Rhona Brankin
Supported by: Mr Andy Kerr

102 In schedule 1, page 36, line 6, at beginning insert—

< ( ) Fixed penalty notices may not be given in such circumstances as may be prescribed.

( ) The method or methods by which fixed penalties may be paid may be prescribed.

( )>

Rhona Brankin
Supported by: Mr Andy Kerr

103 In schedule 1, page 36, leave out line 7

Rhona Brankin
Supported by: Mr Andy Kerr

104 In schedule 1, page 36, leave out line 10
Section 6

Mrs Nanette Milne
Supported by: Mr Brian Monteith

142 In section 6, page 3, line 28, after <may> insert <(on producing, if requested, written evidence of his or her authority)>.

Mrs Nanette Milne
Supported by: Mr Brian Monteith

143 In section 6, page 3, line 28, leave out <search> and insert <inspect>.

Mr Brian Monteith
Supported by: Mrs Nanette Milne

144 In section 6, page 3, line 28, leave out <no-smoking premises> and insert <enclosed public place>.

Mrs Nanette Milne
Supported by: Mr Brian Monteith

145 In section 6, page 3, line 29, leave out from <in> to end of line 30 and insert <at any reasonable time, if the officer considers this necessary in pursuance of the officer’s responsibilities under this Part.>.

Mrs Nanette Milne
Supported by: Mr Brian Monteith

146 In section 6, page 3, line 30, at end insert—

<(1A) In exercising the power mentioned in subsection (1), the officer may require any person to provide such information, facilities or assistance as the officer considers necessary for that purpose.

(1B) But a person is not obliged by subsection (1A) to answer any question or produce any document which the person would be entitled to refuse to answer or to produce in or for the purposes of proceedings in, a court in Scotland.>.

Mrs Nanette Milne
Supported by: Mr Brian Monteith

147 In section 6, page 3, line 30, at end insert—

<( ) In exercising the power mentioned in subsection (1), the officer may be accompanied by such other persons as the officer considers necessary.>.

Mrs Nanette Milne
Supported by: Mr Brian Monteith

148 In section 6, page 3, line 31, leave out subsection (2) and insert—

<(2) The power under subsection (1) may not be exercised by force unless a warrant has been obtained under subsection (2A).>.
(2A) A sheriff may grant a warrant for the exercise of the power in subsection (1) if satisfied, by evidence on oath, that there are reasonable grounds for the exercise of the power in relation to any specified no-smoking premises (other than a private dwelling house) and that any of the following conditions is satisfied—

(a) that the exercise of the power in relation to the premises has been refused;
(b) that such refusal is reasonably anticipated; or
(c) that a notice of intention to exercise the power in relation to the premises would defeat the object of the exercise of the power.

(2B) A warrant under subsection (2A) continues in force until one month after the date on which the sheriff signed it.

Mrs Nanette Milne  
Supported by: Mr Brian Monteith

149 In section 6, page 3, leave out lines 33 to 38 and insert—

<(a) intentionally obstructs an authorised officer of the appropriate council who is acting in the proper exercise of his or her functions under this section;
(b) without reasonable cause, fails to comply with any requirement made of the person by such an officer who is so acting; or
(c) in giving information which is properly requested of that person by the officer makes a statement which is false in a material particular, commits an offence.

( ) But a person does not commit an offence under subsection (3)(c) if the person—

(a) did not know the material particular was false; and
(b) had reasonable grounds to believe that it was true.>

Mrs Nanette Milne  
Supported by: Mr Brian Monteith

150 In section 6, page 4, leave out lines 6 and 7

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

151 In section 6, page 4, line 6, leave out from <no-smoking> to end of line 7 and insert <an enclosed public place, the council of the area in which that enclosed public place is.>

After section 6

Mr Brian Monteith  
Supported by: Mrs Nanette Milne

152 After section 6, insert—

<Defences: burden of proof

(1) This section applies where an accused charged with an offence under this Part relies on a defence under any of sections 1(3)(a) to (b), 2(2) and 3(2).>
(2) Where evidence is adduced which is sufficient to raise an issue with respect to that defence, the court or jury is to assume that the defence is satisfied unless the prosecution proves beyond reasonable doubt that it is not.

After section 7

Mr Duncan McNeil

153 After section 7, insert—

<Sale of tobacco to under-age persons: variation of age limit

(1) The Scottish Ministers may, by order, modify section 18 of the Children and Young Persons (Scotland) Act 1937 (c.37) (offence of selling tobacco etc. to under-age persons and other preventative measures) so as to substitute for the age specified in any of its provisions (at the passing of this Act, 16) such other age or ages as they consider appropriate.

(2) The Scottish Ministers may make an order under this section only after consulting such persons as they consider appropriate on a draft of the order.>

Section 37

Rhona Brankin

Supported by: Mr Andy Kerr

105 In section 37, page 32, line 5, leave out <1 to 8,>

Rhona Brankin

Supported by: Mr Andy Kerr

31 In section 37, page 32, line 5, leave out <and 35> and insert <, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36>

Rhona Brankin

Supported by: Mr Andy Kerr

106 In section 37, page 32, line 5, leave out <and schedule 1>

Rhona Brankin

Supported by: Mr Andy Kerr

32 In section 37, page 32, line 5, after <schedule 1> insert <and paragraph 1(1A) and (1C) of schedule 2>

Rhona Brankin

Supported by: Mr Andy Kerr

107 In section 37, page 32, line 8, at end insert <, and an order under this section appointing a day for sections 1 to 8 or schedule 1 may specify the time in the day for the commencement of those provisions>
Long Title

Rhona Brankin
Supported by: Mr Andy Kerr

108 In the long title, page 1, line 1, after <wholly> insert <or substantially>

Rhona Brankin
Supported by: Mr Andy Kerr

109 In the long title, page 1, line 5, after <treatment> insert <and to certain persons infected with the virus by transmission of it from a person infected with it as a result of such treatment>

Rhona Brankin
Supported by: Mr Andy Kerr

110 In the long title, page 1, line 8, leave out <Council and> and insert <Council,>

Rhona Brankin
Supported by: Mr Andy Kerr

111 In the long title, page 1, line 8, after second <Council> insert <and the minimum frequency of inspection of care services by the Commission>

Rhona Brankin
Supported by: Mr Andy Kerr

112 In the long title, page 1, line 13, after <treatment;> insert <to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act;>

Rhona Brankin
Supported by: Mr Andy Kerr

113 In the long title, page 1, line 16, leave out first <and>

Rhona Brankin
Supported by: Mr Andy Kerr

114 In the long title, page 1, line 17, at end insert <; and for connected purposes>
Groupings of Amendments for Stage 2 (Day 5)

Places covered by smoking prohibition
115, 116, 118, 122, 125, 127, 130, 132, 133, 139, 141, 144, 151

Exclusion of theatre performances and rehearsals
117, 120, 126, 128, 131, 135

Defences
119, 121, 123, 124, 129, 136, 152

Offence of smoking in no-smoking premises: penalty
84

Warning notices
95, 134, 96

Procedures for modifying regulations: no-smoking premises
92, 93, 94

Exemptions for certain places
137, 33

Meaning of “smoke”: substances not including tobacco
85, 86, 87, 88

Meaning of “no-smoking premises”
97, 138, 100

Premises used as a place of work – extension of definition
98, 99

Proceedings for offences under section 1 to 3 – securing not time-barred
101

Local authority enforcement
140, 142, 143, 145, 146, 147, 148, 149, 150

Fixed penalties – general and supplementary – extent of regulation making power
102, 103, 104

Sale of tobacco to under-age persons
153

Commencement
105, 106, 107

Long title
108, 109, 110, 111, 112, 113, 114
NOTE: THE FOLLOWING AMENDMENTS HAVE ALREADY BEEN DEBATED—
With 29 – 31, 32
HEALTH COMMITTEE
EXTRACT FROM THE MINUTES
18th Meeting, 2005 (Session 2)
Tuesday 14 June 2005

Present:

Roseanna Cunningham (Convener) Janis Hughes (Deputy Convener)
Paul Martin (Substitute) Mr Duncan McNeil
Mrs Nanette Milne Mike Rumbles
Shona Robison Jean Turner

Also present: Mr Brian Monteith, Margo MacDonald, Mr Stewart Maxwell

Apologies: Helen Eadie, Kate Maclean

Smoking, Health and Social Care (Scotland) Bill: The Committee considered the Bill at Stage 2 (Day 5).

The following amendments were agreed to (without division): 95, 92, 96, 93, 97, 98, 99, 100, 94, 101, 102, 103, 104, 105, 31, 106, 32, 107, 108, 109, 110, 111, 112, 113, and 114.

The following amendments were agreed to (by division):
85 (For 6, Against 1, Abstentions 0)
86 (For 6, Against 1, Abstentions 0)
87 (For 6, Against 1, Abstentions 0)
88 (For 6, Against 1, Abstentions 0)
153 (For 5, Against 1, Abstentions 1)

The following amendment was disagreed to (by division):
119 (For 1, Against 6, Abstentions 0)

Amendments 115, 117, 84, 137, and 140 were moved and, with the agreement of the Committee, withdrawn.

Amendments 116, 118, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 133, 134, 135, 136, 138, 139, 33, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, and 152 were not moved and amendment 132 was pre-empted.

Sections 1, 2, 6, 7 and 8 were agreed to without amendment.

Sections 3, 4, 5, Schedule 1 and section 37 were agreed to as amended.

The Committee completed consideration of stage 2 of the bill.
Scottish Parliament

Health Committee

Tuesday 14 June 2005

[THE CONVENER opened the meeting at 14:00]

Smoking, Health and Social Care (Scotland) Bill: Stage 2

The Convener (Roseanna Cunningham): I welcome everybody to the Health Committee’s 18th meeting in 2005, which we want to get started quickly as it will be quite long.

I have apologies from Helen Eadie and Kate Maclean, both of whom are attending a joint all-day meeting of the Edinburgh Tram (Line One) Bill Committee and the Edinburgh Tram (Line Two) Bill Committee. They have a statutory obligation to attend, so it is not possible for them to do anything other than absent themselves from this meeting. I understand that, at some point, Paul Martin will attend as a substitute for one of them, so we will deal with that when he comes in.

I also welcome Margo MacDonald, Stewart Maxwell and Brian Monteith to the committee. They each have an interest in certain amendments and we will no doubt hear from them in due course.

There is only one item on the committee’s agenda today, which is stage 2 consideration of the Smoking, Health and Social Care (Scotland) Bill, at day 5. I remind members that this is the last opportunity to consider the bill at stage 2 and that every one of the amendment groupings must be dealt with. We have a lot to get through, so I ask members to be sensible with their contributions so that we can get through business as quickly as possible.

I welcome Paul Martin. I ask him to confirm that he is attending in his capacity as a Health Committee substitute and to say which member he is substituting for, as there is a choice of two.

Paul Martin (Glasgow Springburn) (Lab): I will make it Kate Maclean; hers is the first name-plate that I saw.

The Convener: I remind members that, under rule 12.2A of standing orders, a committee substitute who attends a committee meeting has the right to participate in all proceedings and to vote. The other non-committee members who are here may not vote.

Before section 1

The Convener: Group 1 is on places covered by the smoking prohibition. Amendment 115, in the name of Brian Monteith, is grouped with amendments 116, 118, 122, 125, 127, 130, 132, 133, 139, 141, 144 and 151. I point out that a number of amendments in later groups pre-empt amendments in this group: amendment 122 is pre-empted by amendment 121; amendment 132 is pre-empted by amendment 95; and amendment 151 is pre-empted by amendment 150.

Mr Brian Monteith (Mid Scotland and Fife) (Con): The principal criticism that can be made of part 1 of the bill is its failure to be absolutely clear about prohibition in no-smoking places. Members might find that ironic, but we are at the stage at which such matters need to be tidied up.

Amendment 115 seeks to make the terminology clear at the start, so that the bill reads more easily and is clearer thereafter. The bill is particularly confused and confusing in its structure and terminology as they relate to the places where smoking is prohibited. No-smoking premises are not defined until section 4, where they are stated to be “premises of a kind … prescribed by regulations” that “are wholly enclosed and—
(a) to which the public or a section of the public has access;
(b) which are being used wholly or mainly as a place of work”.

Much of the confusion arises from the use of the phrase “wholly enclosed”, about which there will be further debate later today.

Although the bill will create two significant new criminal offences of smoking and permitting smoking in no-smoking premises, it does not state precisely what no-smoking premises are, explain which premises are to be exempted from the prohibition or define other terms that are essential to an understanding of the prohibition, and it even fails to specify explicitly the enforcement authorities. The purpose of amendment 115 is to make it quite clear at the outset of the bill what premises are covered by the prohibition that follows. It reduces to its bare minimum the meaning of an “enclosed public space”.

I turn to the schedule that amendment 116 seeks to insert. We want the exempt places to be listed in the bill because part 1 leaves far too much for determination by regulations, which are not subject to the same degree of scrutiny by the Parliament as primary legislation. We make no claim that the list in our proposed schedule is definitive and, if amendment 116 were agreed to,
we would welcome the lodging of further amendments at stage 3.

The overall purpose of my amendments is to simplify the construction of part 1 and of the draft Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005 by imposing a prohibition that applies everywhere—without the need for schedule 1 to the draft regulations—except to the exempt places that are listed in the schedule to the bill that amendment 116 seeks to insert and in those places where smoking may be permitted by virtue of regulations that Scottish ministers make. Smoking is a legal activity and the risks of environmental tobacco smoke to the health of the non-smoker do not mandate an absolute prohibition of smoking, which would be disproportionate. To ensure compliance with the right to respect for private and family life that is enshrined in article 8 of the ECHR, part 1 should exempt—explicitly, not just in regulations—not only domestic premises, but accommodation that, although it may fall outside that definition, is an individual’s sole home, either permanently or for the time being, and which is only occasionally a place of work. A total prohibition on smoking in such accommodation could constitute a disproportionate interference with the right in article 8 of the ECHR to respect for private and family life. The draft regulations attempt to respect that, but not comprehensively.

An outright ban on smoking in enclosed places is not proportionate. There should be a wider range of exemptions—for example, prisons should be excluded—and a licensing system that allows permissions to be granted. In the schedule that amendment 116 seeks to insert, I have included exemptions for theatre productions of which smoking forms an integral part and cigar shops, but I will deal with those later, when I speak to the relevant amendments; I do not want to take up the committee’s time by repeating my arguments.

I move amendment 115.

**Shona Robison (Dundee East) (SNP):** I notice that one of the exempt places would be

*“Any club premises to which the public does not have access as of right.”*

I take it that that is a reference to private clubs. If that is the case, I am concerned that that would give rise to an unfair situation. Someone who operated a public house could end up having a private club that was able to avoid the ban right next door, which would take away from the level playing field that we are trying to create. That is one of the reasons why I will not support amendment 116.

**Mike Rumbles (West Aberdeenshire and Kincardine) (LD):** When he sums up, I invite Brian Monteith to tell us in a little more detail about the

*“Places where religious ceremonies involving the use of tobacco are taking place.”*

We seek enlightenment on that.

**Mr Stewart Maxwell (West of Scotland) (SNP):** It is clear that, in seeking to enlarge the list of exemptions, the purpose of amendment 116 is to reduce the effect of the ban. Lists are normally dealt with in regulations; that is the proper place for lists. Amendment 116 represents an attempt to ring fence exemptions—the fact that the exemptions that it proposes would be contained in primary legislation rather than in regulations would mean that they could not be revisited at a later date. Amendment 116 seeks to undermine parts of the bill.

Amendment 118 and the other amendments that would change the wording from “no-smoking premises” to “enclosed public place” are rather strange. The wording “no-smoking premises” is as clear as we could possibly be about what the premises are. We should stick with that, rather than change the wording to “enclosed public place”.

**Dr Jean Turner (Strathkelvin and Bearsden) (Ind):** I agree with members that we would weaken the bill if we went along with the amendments in the group. I am struggling to understand the religious significance of smoking and the significance of the ban to the theatre. We do not need real cigarettes on the stage, given that most theatres have already banned smoking.

**The Deputy Minister for Health and Community Care (Rhona Brankin):** I will speak against all the amendments in the group. The proposed legislation on smoking is comprehensive and is based on the principle of protecting people from environmental tobacco smoke in enclosed public places. The amendments are completely unnecessary, as the bill already makes adequate provision for the definition of no-smoking premises. I fail to understand why Brian Monteith believes that his approach would be any better, although I realise that he is trying to advocate exemptions from the prohibition for tobacco shops and private clubs. I believe that he seeks to undermine this vital piece of proposed public health legislation to further the interests of a relatively small minority. To deliver the health improvements that the country needs, the bill must be as comprehensive as possible. Therefore, I cannot support the amendments and I urge the committee to reject them.

**Mr Monteith:** I will respond to some of the members’ points first, before I respond to the minister’s argument. Under the proposed schedule in amendment 116, private clubs—not just discos
or dance clubs, but private clubs that people need to be signed into—would be exempt unless the members chose to make them no smoking. That would be an appropriate and proportionate approach to the question of balance. The question is whether we are trying to strike a balance between the rights of individuals—those who smoke, those who may inhale environmental tobacco smoke and the public health considerations thereof—or whether we are seeking a balance between different licensed establishments. If one is concerned about the commercial considerations of the businesses that will be affected by the ban, one must understand that the ban will create a level playing field and will affect all businesses, even though there are different types of businesses. It should be recognised that private clubs are substantially different, operate in a different way and have different rights and responsibilities from other premises. They should therefore be exempted from the ban. They are more private than public houses, for example, and should therefore be entitled to be treated differently when it comes to the balance between people who choose whether to go to such places and those who do not and, therefore, whether they would be able to smoke. Private clubs should be included in the exemptions. Members will be aware that an exemption for private clubs is to be granted in England.

With regard to religious festivals, it is my understanding that there is some tobacco in incense, which may need to be considered in further detail. I do not attend such religious ceremonies, but the issue has been pointed out to me. I have further amendments on theatres, stage productions and tobacco retailers, so I will not explain the issues in detail at the moment.

14:15

The proposed schedule offers guidance about what could be done in the bill, and in saying so I turn to the minister's arguments. I did not hear the minister provide any real reason why the schedules and explanations that I have proposed in amendment 116 should not be in the bill. It is common for us to debate whether the substantive definitions in what we pass as legislation should be in regulations or the bill. That happens time and again and members suggest to the Executive that it would be better to have more specifics in the bill. My amendment 116 seeks to clarify and, in some respects, tighten up the definitions that the Executive is proposing. I would have thought that it would be grateful for that, rather than suggesting that I am trying to undermine the public health benefits that might come with the bill. Let me be honest: I will do that in other amendments and take credit for it there. Amendment 116 simply flags up that there are two approaches to drafting bills and suggests a different approach from that which has been taken. With that argument in mind, I seek leave to withdraw amendment 115.

*Amendment 115, by agreement, withdrawn.*

*Amendment 116 not moved.*

Section 1—Offence of permitting others to smoke in no-smoking premises

The Convener: Group 2 is on the exclusion of theatre performances and rehearsals from the prohibition. Amendment 117, in the name of Brian Monteith, is grouped with amendments 120, 126, 128, 131 and 135.

Mr Monteith: In amendment 117 I seek to obtain an exemption for dramatic and lyric performances on stage. Members will be familiar with dramatic performances. Lyric productions cover ballet and opera. I am not particularly au fait with any ballet productions that currently use tobacco products, but then I tend not to go to contemporary dance; productions such as a modern interpretation of "West Side Story" might in future seek to use tobacco. I have been approached by a number of organisations and theatre managers in Scotland and beyond—many international productions tour to Scotland—and there is a strong feeling that there is no need for a ban on tobacco products used in stage productions.

A number of arguments were put forward to support that. First, given the nature of stages in theatres—almost without exception they have high ceilings and large volume—the suggested health problems associated with passive smoking are diluted to some degree. There are also objections to the ban on the basis of how it might affect the artistic freedom of actors, producers and writers. Smoking is in the plays of the Scottish writer David Greig, and of John Byrne, Chekhov and Ibsen. Smoking forms a significant part of the social milieu and period detail of works and is a defining part of the persona of historical figures such as Winston Churchill and fictional characters such as Sherlock Holmes, who might feature in productions. As far as anybody has been able to identify for me, there are no herbal alternatives to cigar smoking. I believe that to prohibit smoking on stage would amount to a restriction on the creative process for professionals working in the theatre. That would go further than is actually required by the bill. I do not believe that smoking on stage for the purposes of productions would make any particular difference to the public health outcomes that the minister seeks. In that sense, the bill would overreach itself.

I move amendment 117.
Rhona Brankin: I cannot support Brian Monteith's amendments. When developing the proposed smoking legislation, we carefully considered the scope for exemptions. The Executive's proposals are based on sound reasoning. Only places that are equivalent to a person's home—on either a permanent or temporary basis—may be considered exempt. That has been decided on humanitarian grounds.

Theatres do not by any stretch of the imagination fall into that category. Like many people I enjoy theatre performances on a regular basis, as Mr Monteith knows, but I recognise that those performances take place in enclosed buildings to which the public have access. They are also places of work. In order to ensure that the greatest protection is afforded to the greatest number of people, theatres and other comparable premises must be included within the scope of the prohibition.

One of the key benefits that we hope the legislation will achieve will be to denormalise smoking as an acceptable, sociable activity. I do not think that it is beyond the wit of the dramatic arts and theatres to develop alternatives to smoking lit substances during performances. Where actors deal with topics involving other controlled substances, they do not actually partake of them. Why, therefore, do they need to smoke?

I whole-heartedly oppose the amendments, and urge the committee to do the same.

Mr Monteith: I find the minister's reaction disappointing. It suggests a degree of intolerance in the Executive, which cannot identify that smoking during performances, particularly dramatic performances, can even be used to communicate the message that bad people or people who should not be admired smoke, or that smoking is bad for people. It is not necessarily the case that smoking during the performance will glamorise smoking and make it attractive. I am assured by actors that there are difficulties with regard to alternatives, not least the pong of those alternatives. Because the smell is so strong, it is clearly detectable to the audience and betrays the fact that the actor is not smoking a cigarette. Indeed, it creates a different sense of atmosphere—I do not mean that as a pun—and a different sense of artistic and dramatic interpretation.

It strikes me that the issue of artistic freedom is very important. Were the minister and I to sit together on occasion to watch, as we have done, plays such as "Look Back in Anger", which has Jimmy Porter smoking a pipe, we would find that the whole dramatic intensity can change if that is not portrayed accurately. Plays sometimes feature smoke machines billowing out false smoke to look like fog, which is far more likely to cause coughs and splutters among the audience, as we can hear, than a single person smoking a pipe or cigarette on stage. That ban is disproportionate and wholly unnecessary. However, I seek to withdraw the amendment.

Amendment 117, by agreement, withdrawn.

Amendment 118 not moved.

The Convener: Group 3 is on defences. Amendment 119, in the name of Brian Monteith, is grouped with amendments 121, 123, 124, 129, 136 and 152. If amendment 121 is agreed to, I cannot call amendment 122, which has already been debated.

Mr Monteith: I have so many amendments and so many notes.

There is concern about the word "knowingly", which I seek to leave out. It is a key word, because it makes it an offence subject to a substantial penalty to permit others to smoke in no-smoking premises if the person who manages or controls the premises knows or ought to have known that the person was smoking. It is important that we take out "knowingly", because it begins to change the meaning of the defence of the accused. The difficulty is that, as it stands, the bill effectively makes the person guilty until proven innocent, whereas by removing the word "knowingly" it is possible to construe that the body of evidence changes and the person becomes innocent until proven guilty.

That is a simple way of explaining amendment 119. I will leave it at that for the moment, and see whether I need to respond to anything that is raised by the minister or other members.

I move amendment 119.

The Convener: If no members wish to comment, I call the minister.

Rhona Brankin: I cannot support amendments 119, 121, 123, 124, 129, 136 or 152. As with so many of the amendments that have been lodged by the Opposition today, on the face of it they look like they may be helpful, but they are nothing of the sort—they are nothing short of a full attack on the enforcement of the bill. They seek to undermine the provisions by making it more difficult for those who will enforce them to win a case, should it ever go to court. Part 1 sets out a substantial penalty to permit others to smoke in no-smoking premises if the person who
manages or controls the premises knows or ought to have known that the persons were smoking. By removing “knowingly” and making associated changes, the balance is better, and the innocence of those who manage or own the premises is protected. I do not see that as an assault on enforcement; I see it simply as trying to retain a balance with regard to our old and admirable tradition of people being innocent until proven guilty. As the bill stands, I am concerned that that tradition is not being maintained.

The Convener: Are you pressing amendment 119 or seeking leave to withdraw it?

Mr Monteith: I press it.

The Convener: The question is, that amendment 119 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Milne, Mrs Nanette (North East Scotland) (Con)

AGAINST
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 6, Abstentions 0.

Amendment 119 disagreed to.

Amendments 120 to 125 not moved.

Section 1 agreed to.

Section 2—Offence of smoking in no-smoking premises

Amendments 126 to 130 not moved.

14:30

The Convener: We now move to group 4, on the offence of smoking in no-smoking premises. Amendment 84, in the name of Mike Rumbles, is in a group on its own.

Mike Rumbles: The reason why I have introduced the amendment is quite straightforward. When we initially considered the evidence at stage 1, the proposals in this part of the bill—section 1 will make it an offence to permit others to smoke in no-smoking premises and section 2 will make it an offence to smoke in those premises—seemed adequate. However, when we took evidence from the would-be enforcers of the bill’s provisions, especially those from Edinburgh, they seemed keen to enforce the legislation rigorously—so rigorously, in fact, that we were given the impression that on a Friday or a Saturday night environmental health officers would be going round late at night slapping fixed-penalty notices on drinkers in pubs and bars up and down the high streets of the land. They seemed to be enthusiastic in their wish to slap those notices on anybody seen smoking where they should not be.

From the evidence that the committee saw in Ireland, I believe that there should be a more relaxed approach to the enforcement process, which should be about education and speaking to people after the event. We should try to create a non-confrontational enforcement process like the successful one that was achieved in the Republic. I lodged the amendment because I thought that it might be more appropriate for a person guilty of a second offence under the section—rather than a first offence—to face an immediate penalty. However, my real reason for lodging the amendment is to prompt the minister to say on record whether there will be any specific guidance to those people who will have the job of enforcing the legislation. I ask the minister whether it is the Executive’s intention to ensure that the enforcement process in Scotland is similar to that of other successful regimes, such as the one in Ireland.

I realise the difficulties that stipulating that the offence must be “a second or subsequent” one may create, as there may be no record of the first offence. I understand that might be an issue, but I would like to hear the minister’s response.

I move amendment 84.

Rhona Brankin: From what Mike Rumbles has told us, I understand what he is trying to achieve, but I believe that his amendment runs the risk of sending out contradictory signals about the comprehensive nature of the bill. I cannot, therefore, support the amendment either in principle—in my view, an individual must be responsible for their own actions—or on practical grounds, as the effect of the amendment would be to render the fixed-penalty scheme weaker.

Amendment 84 proposes that a person who had smoked in no-smoking premises would be liable on summary conviction only for a second or subsequent offence. That does not mean that a person could not be prosecuted and convicted for the first offence, but simply that they could not be fined if they were convicted of that first offence. Under amendment 84, an individual would be issued with a fixed-penalty notice for a first offence. However, if they refused to pay the fine, although they could still be prosecuted and convicted for failure to comply with the fixed-penalty notice, they could not be fined. That would be a total waste of Crown resources.
Amendment 84 would weaken the basis of the fixed-penalty regime for smoking offences under the bill and would send out all the wrong signals on enforcement of the smoking ban. The bill seeks to ensure that smokers and those who own or manage the premises on which people might otherwise smoke have incentives not to smoke or allow smoking in no-smoking premises. Owners or managers of no-smoking premises might have a more difficult job in trying to prevent people from smoking if the individual smoker had no incentive not to smoke on those premises. The amendment would also present significant operational difficulties, as it would require the establishment of a database of offenders to enable the courts to determine whether a person had already committed an offence.

The Executive’s view on enforcement of the ban—a view that was echoed by Mike Rumbles during stage 1—is that it should be consistent and non-confrontational. Furthermore, the system should be firm, fair and workable. There will be specific guidance for all environmental health officers in Scotland—the professional body of environmental health officers is currently drafting that guidance. I do not believe that amendment 84 is either fair or workable and I invite Mike Rumbles to withdraw it.

Mike Rumbles: I am delighted that the minister has made it clear that there will be specific guidance for a non-confrontational enforcement approach. That is exactly what I sought to achieve. On that basis, I seek the committee’s leave to withdraw the amendment.

Amendment 84, by agreement, withdrawn.

Section 2 agreed to.

Section 3—Display of warning notices in and on no-smoking premises

Amendment 131 not moved.

The Convener: We move to group 5, on warning notices. Amendment 95, in the name of the minister, is grouped with amendments 134 and 96. If amendment 95 is agreed to, amendment 132, which has already been debated, will be pre-empted.

Rhona Brankin: This group of amendments relates to the offence that is created under section 3(1) of failing to display notices in no-smoking premises. Amendment 95 relates to the requirement under section 3(1)(a) for no-smoking notices to be displayed conspicuously both inside and outside premises. Our intention is not that such signs must be physically on the outside of a no-smoking premises but that they must be ‘visible to and legible by’ all those who enter the premises from outside. That intention will be achieved by amendment 95, which will affect only the current wording in the bill that would otherwise require signs to be physically outside premises; the amendment will not alter the requirement for signs to be displayed inside no-smoking premises.

Amendment 96 is a technical amendment to section 3(3). The amendment is designed to clarify that failure to comply with additional requirements on no-smoking signage that might be laid down in regulations under section 3(3) will constitute an offence under section 3(1) in the same way that failure to comply with the signage requirements under section 3(1) will be an offence.

Amendment 134, in the name of Nanette Milne, seeks to create a new offence under section 3 in relation to the display of warning notices in and on no-smoking premises. Although the suggestion seems reasonable, the amendment is not necessary, because the removal, defacing or altering of such notices would constitute theft, vandalism or malicious mischief, which would be an offence anyway. It is appropriate that the law in relation to notices should be consistent, so we should not single out notices under section 3 of the bill for different treatment. Therefore, the Executive cannot support amendment 134.

I move amendment 95.

Mrs Nanette Milne (North East Scotland) (Con): The intention behind amendment 134 is to give some protection to the manager or other person in control of the premises in a case where others damaged or destroyed a notice that he or she had put up to comply with the bill. Of course, if the owner was guilty of such an offence, he would also be caught by amendment 134. However, I am assured by the minister that the intention behind my amendment would be covered by the bill as it stands, so I will not move amendment 134. I have no difficulty with amendments 95 and 96, so I will not comment on them.

Amendment 95 agreed to.

The Convener: Amendment 132 is pre-empted, as previously advised.

Amendments 133 to 136 not moved.

The Convener: Group 6 is about procedures for modifying regulations for no-smoking premises. Amendment 92, in the name of Duncan McNeil, is grouped with amendments 93 and 94.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): Amendments 92 to 94 are technical amendments that are in accordance with the wishes of the Subordinate Legislation Committee. The amendments will require the Executive to consult on future changes to smoking regulations under the bill.
Mr Maxwell: As a member of the Subordinate Legislation Committee, I can confirm that that committee was unanimous in agreeing that it would be helpful if future regulations were laid in draft form, as that would enable people to be consulted properly on them. I support the amendments.

Rhona Brankin: I support the amendments and I am aware that the Subordinate Legislation Committee raised the issue during its stage 1 consideration of the bill. Section 4(2) of the bill allows ministers to prescribe, by means of regulations, no-smoking premises for the purposes of part 1 of the bill. Section 4(7) allows ministers to make regulations in order to modify section 4(4) so as to add or remove a kind of premises from the premises that can be prescribed as no-smoking premises under section 4(2). It is accepted by ministers that the use of those two regulation-making powers could have a serious impact on people’s lives and livelihoods. It is therefore right that we accept amendments that will bind us to consulting on any future regulations that we make under the powers.

The Executive has undertaken extensive consultation on the smoking provisions in the bill and on the associated regulations. It makes sense that any future changes to the regulations should be subject to further consultation.

The requirements on ministers to consult on any regulations made under sections 3(3), 4(2) and 4(7) are currently set out in section 34(4) of the bill. As a consequence of amendments 92 to 94, section 34(4) will become redundant. The Executive will, therefore, bring forward a further technical amendment at stage 3, which will remove section 34(4) from the bill.

Amendment 92 agreed to.
Amendment 96 moved—[Rhona Brankin]—and agreed to.
Section 3, as amended, agreed to.

After section 3

The Convener: Group 7 is on exemptions for certain places. Amendment 137, in the name of Nanette Milne, is grouped with amendment 33.

Mrs Milne: Amendment 137 focuses on air quality. The purpose of the amendment—irrespective of whether the use of the power is envisaged at the time of the commencement of the legislation—is to enable the designation of places in which smoking would be permitted, provided that requirements specified in regulations were complied with. For example, it would enable some places that were not included in the exemption list, such as certain pubs, to permit smoking if they comply with strict air quality standards.

Amendment 137 would allow a little bit more scope and flexibility than Margo MacDonald’s amendment 33. The details would be in the regulations, which is why the text of the amendment does not refer specifically to ventilation systems. That takes into account the fact that new technology might come along that would improve ventilation systems beyond their present state. The amendment would allow more time for further research and consultation to take place and, unlike amendment 33, it would not require primary legislation to be changed if air quality technology were to advance. My amendment would widen the scope for more exemptions, which might be needed in the future, and it would make the bill more flexible.

I move amendment 137.

The Convener: Margo, will you speak to your amendment 33 now? I will not be asking you to move it until later in the proceedings, but you may speak to it now and to the other amendment in the group.

Margo MacDonald (Lothians) (Ind): I do not have a clue what amendment 137 is, so I will confine my remarks to amendment 33.

I assure the committee that I totally support the Executive’s aims. My amendment 33 seeks to probe the rationale, logic and feasibility of the bill and to test its consistency with other legislation. The amendment does not seek to attack the principle of what the Executive hopes to achieve. It does not seek to encourage smokers to continue smoking and it does not seek to minimise the consequences of people being either nicotine dependent or habitual smokers.

My sole intention is to contribute to the Parliament’s achievement of good, consistent legislation that will be understood and supported, which will ensure that it is more easily enforced. I remind the committee of what Angus Glennie said about the Protection of Wild Mammals (Scotland) Bill:

“Bad law comes in many shapes and sizes. Poor drafting is often the culprit. The badly drafted law may miss its target or, which is worse, may catch a wider range of activities than parliament ever intended. Being open to different interpretations, it creates uncertainty.”

Amendment 33 is a probing amendment with which I hope to eliminate all uncertainty. I query what the primary driver of the proposed law is. Is it the health of the smoker, the cost that industry and the national health service incur because of the smoker’s habit, the detrimental health effect of passive smoking or the intention that the bill
should be the first step towards making the purchase of tobacco illegal?

If the rationale is to save the smoker from himself or herself, we must ask whether the bill is inconsistent with our approach to other health-damaging and life-threatening habits, such as drinking or overeating and not exercising.

If smoking is damaging the economy or NHS finances, why do we treat smokers differently from other groups that do similar damage? Some studies show that alcohol-related conditions place public resources under greater strain. I think that Dr Walker of the University of Glasgow—I believe that the committee is familiar with him—has done a study showing that the costs of obesity to the NHS and to the economy in general might outweigh those caused by the detrimental effects of smoking.

If the health effects of passive smoking are the reason for the bill, what is the logic of banning smoking among consenting adults in pubs but permitting smokers to smoke all over children at home? Children are unprotected and we cannot introduce regulations on clean air and ventilation for homes similar to those that we can introduce for commercially operated premises.

If the bill is the first step towards making smoking illegal, has the committee estimated how many smokers would be criminalised because of their habits? The likelihood of extending organised criminality if tobacco is classified as a dangerous drug is great, as is obvious to anyone.

I am simply querying the bill and probing its rationale, although I accept that the questions that I have posed can be difficult to answer and I acknowledge the work that the committee has already done to answer them. However, as long as tobacco is legally sold and purchased, smokers are only exercising a legal right in smoking. Provided that, in exercising that right, smokers do not infringe others’ rights, what justification is there for discriminating against tobacco as opposed to alcohol or foods with a high sugar and fat content? Will legislation that makes it difficult to smoke be a prototype for legislation on other aspects of dangerous, resource-consuming behaviour?

If smoking is harmful enough to be treated more harshly than other habits that induce poor health, logic suggests that it should be made illegal to buy or sell tobacco. Short of that ultimate sanction, which would fail my earlier test of feasibility of enforcement, it seems more in keeping with our legislation on other dangerous behaviour that we should allow people to exercise freedom of choice, having provided them with information and education on the undesirability of their habit.

Amendment 33 would simply introduce a measure of consistency by controlling and licensing a potentially lethal legal substance—tobacco—in a way similar to our method of coping with alcohol, which is another potentially destructive and dangerous substance that is embedded in our culture. The amendment deliberately does not address questions that are properly the province of subordinate legislation, so I leave the committee to consider, should it ever wish to do so, who could apply for a licence to permit smoking, to which body such an application would be made and what environmental considerations would have to be addressed.

I can see the logic in banning the sale or purchase of tobacco, although I would not advocate that because of the extension of criminality that would accompany such a ban. However, if a compromise must be found that limits a harmful habit, should equity of treatment not be sought with other substances and behaviour, unless the social damage that tobacco does is proved to be worse than that from the misuse of alcohol? I say with all due respect that my amendment 33 suggests a way to square the circle.

Janis Hughes (Glasgow Rutherglen) (Lab): I will comment on the air quality issues that have been raised. Nanette Milne’s amendment 137 talks about exclusions from offences because of air quality requirements that may be specified in regulations. Margo MacDonald’s amendment 33 talks about licensing boards granting exemptions to the bill by having regard to the adequacy of ventilation in the licensed premises.

We have taken fairly extensive evidence on that issue during the passage of this bill and Stewart Maxwell’s Prohibition of Smoking in Regulated Areas (Scotland) Bill. I understood from that evidence that, although ventilation systems may be fairly sophisticated nowadays and can take away the discomfort of tobacco smoke in the air, they do not remove the carcinogens, which are of most concern. People might sit comfortably and be lulled into a false sense of security while they were breathing in the carcinogens that remained in the air.

Even in the future, if someone came up with a very sophisticated ventilation system that screened out carcinogens, it would still not diminish the point that has arisen during the passage of both bills that a level playing field would not exist between those who have and those who do not have ventilation. That is another aspect that we must take into account. On that basis, I will certainly not support either amendment.

Mr Monteith: Amendment 137 would allow an air quality standard to be set in regulations that would allow places to become exempt. In other countries, such as Japan and more recently Italy,
where it is generally assumed that smoking in enclosed spaces has been banned, those bans include exemptions that are determined by strict, tight and high air quality regulations.

It is possible to move not only particulates but carcinogenic gases. Any ventilation system can achieve that effectively, because not to do so would be to suspend the laws of physics. If one understands Boyle's law, one will know that gases mix, so to extract gases is to extract not just one set of gases, but the carcinogens, too. Even with current technology, it is possible to provide facilities in which air quality is high.

It is of course the case that members of the public who go into bars and restaurants have a choice to make. It is more difficult for staff to exercise that choice. Someone who is employed in a bar, club or restaurant may not be deemed to have the same amount of choice, other than the choice to give up their job. I understand the argument that they need protection from passive smoking.

However, that argument can be mitigated by raising air quality to a high standard, as happens in places such as Japan. In that way, the dilution of the potential threat is such that the risk becomes no greater than that in other workplaces where carcinogens exist, such as welding shops and places where spray-painting is undertaken—those are less harmful places in which the Health and Safety Executive still takes an interest. We should be able to achieve a balance through amendment 137.

I will say a few words on Margo MacDonald's amendment 33. Her logic is impeccable. She recognises that, in practice, many places will find that they benefit from the bill. I have never disputed that. In many cases, however, practically all the people who are inside a public house already smoke and will not see why, despite the fact that they can buy and consume alcohol, the public house cannot be licensed to allow all the people who live, work, and breathe there to consume tobacco, which is a legal substance. If Margo MacDonald's amendment is agreed to and its logic is applied, we could strike a balance in society whereby people could still visit the Port O'Leith to have a dram and a fag.

Mike Rumbles: I say with due respect to Margo MacDonald and Brian Monteith that they may not be aware of the evidence that has been presented to the Health Committee showing that the ventilation argument is a red herring. The issue is not about air quality. The scientific and medical evidence has shown the committee that ventilation does not work. Despite what Brian Monteith says, it does not remove the carcinogens in the atmosphere. Ventilation systems as we know them make the situation worse, because, as Janis Hughes pointed out, they remove the aspects of the smoke that cause discomfort, so that people spend more time in the atmosphere breathing in the carcinogens and the other agents and more damage is done to them. The evidence that the committee has received is that ventilation does not work. A gale would need to blow to produce a complete change of the air and the atmosphere in the premises.

I say to Margo MacDonald that the bill is about public health. It does not prohibit the activity of smoking; it prohibits smoking in certain enclosed public places. We have a duty to protect the public from what people often call third-hand smoke, second-hand smoke or environmental tobacco smoke. That is an important issue. I cannot accept the suggestion that we have now, or will have in the future, ventilation systems that might work to change the laws of physics, as Brian Monteith reminds us, so I will not support either of the amendments.

Mr McNeill: Amendments 137 and 33 are at least consistent in the rhetoric that is used, but they are not supported by the evidence. People who spoke to the committee about the business element of a smoking ban demanded a level playing field. They did not want places with ventilation to be treated differently and they did not want licensing boards to make different decisions about different establishments. Amendments 137 and 33 would undermine the comprehensive nature of what we are attempting to do.

We come to the issue that resolved my quandary about where we are going with the bill. The questions of choice—whether we infringe people's rights, whether smoking should be legal and whether people should be able to smoke at home or in the pub—were eventually easily resolved for me in my focus on the thousands of hospitality workers who have no choice about their workplace.

That leads us on to the question of adequate ventilation. The first principle in the control of hazards to health is whether the hazard can be eliminated without dramatically affecting the business. That first principle can be applied in this case. As a consequence, we do not need to engineer out carcinogens or whatever may be in the atmosphere. We can both achieve a level playing field and meet some of our public health objectives.

The people who will benefit most from the bill will be the workers who will be protected from exposure to smoke in their workplace for eight or 12 hours a day, seven days a week. That is the basis on which I have resolved the quandary that
Margo MacDonald has described. The issue is not about choice; it is about workers' protection. In no other industry would we tolerate employers exposing their workers to hazardous substances and chemicals without taking action. We are about to take action, for which I am thankful. I therefore oppose amendments 137 and 33.

Rhona Brankin: I, too, cannot support the amendments. Amendment 137 is clearly aimed at permitting exemptions from the prohibition for premises that achieve a certain air quality through some form of ventilation. I agree with members who say that the matter is being revisited—the issue was considered at an earlier stage. It is a myth that there is a safe level of second-hand smoke. Second-hand smoke is a grade A carcinogen that kills and there is no safe level. Only the complete absence of second-hand smoke is acceptable and complete absence can be guaranteed only by the provisions in the bill.

Nanette Milne is pinning her hopes of achieving exemptions on ventilation. However, as the committee accepted in its stage 1 report, ventilation does not provide an adequate alternative to a smoking ban in terms of our health objectives, as it does not remove carcinogens. I reiterate that there is no safe level of exposure to environmental tobacco smoke. On that basis, amendment 137 is fallacious and I invite Nanette Milne to withdraw it.

Margo MacDonald has said that her amendment 33 is not an attack on the bill and that she wishes to have some discussion around the issues that it raises. However, the amendment would fundamentally undermine the comprehensive nature of the bill's provisions on smoke-free environments. We believe that comprehensive measures will deliver major benefits by helping to denormalise smoking and by taking smoking out of everyday experience in restaurants, cafes, pubs and offices; we believe that that will send a huge message to teenagers and children that smoking is something that they do not want to do. That is the very essence of the bill.

The bill seeks to protect the right of smokers and non-smokers to breathe clean air. More than 70 per cent of all people who are aged 16 and over in Scotland are non-smokers and both they and smokers have the right to breathe clean air in public places. I am proud to say that the bill protects everyone's right to breathe clean air. The ban is not about stopping people smoking, although, as the Deputy Minister for Health and Community Care, I would welcome a reduction in the number of people who smoke. However, the evidence of the health risks of passive smoking is now so strong that we would be failing in our duty to protect the health of people in Scotland if we did not act quickly and decisively. As the committee is aware, Scotland's poor health record—in which smoking plays a significant role—demands that we do that.

Margo MacDonald has asked why we are introducing a ban on tobacco smoke and compares the situation to the use of alcohol. I think that there is a fundamental difference. If someone drinks alcohol in moderation, it does not kill them, whereas there is no safe limit for tobacco smoke. We are taking measures to reduce alcohol consumption, but there is a fundamental difference between that and smoking.

The bill will have an immediate impact on smoking, but I hope that that impact will be far outweighed by the impact on future generations as they turn away from smoking as an acceptable activity. Amendment 33 would totally undermine the benefit of the bill to our children and grandchildren.

The bill's provisions address serious public health issues and I do not find logic in the proposal that licensing boards be given powers to remove licensed premises from the scope of the bill. Why should licensing boards have such a public health role? Would the boards that are already hard pressed and doing a good job of issuing and reviewing licences welcome the powers that amendment 33 would give them? Amendment 33 would fundamentally undermine the comprehensive nature of the proposed smoking ban, as I hope I have explained, although I recognise that that was not Margo MacDonald's intention when she lodged the amendment.

I cannot support amendments 137 and 33. I invite Nanette Milne to withdraw amendment 137 and I ask Margo MacDonald not to move amendment 33.

Mrs Milne: I will not rehearse the arguments that we heard during stage 1 and today. I would like there to be a smoke-free atmosphere wherever that is possible. I agree with Margo MacDonald that the logic of what is being proposed would lead us to ban smoking altogether, but tobacco remains a legal substance and there should be an element of choice for people who want to indulge in that substance, much as I disapprove of it.

I am not convinced that the scientific evidence on environmental tobacco smoke is quite as clear cut as has been suggested. Active smoking is lethal, but we are not certain about the level of environmental tobacco smoke that is lethal. The purpose of amendment 137 was to leave the door open in case technology moves on and better ventilation systems are developed that can eliminate carcinogens—I am sure that such systems will be developed. We are never free from exposure to carcinogens. When we walk down
Princes Street, we breathe in the exhaust fumes of motor cars. We cannot eliminate carcinogens altogether, but good ventilation can make the atmosphere pretty safe and in due course could provide clean air even in pubs in which smoking was allowed. However, I will not press amendment 137.

Amendment 137, by agreement, withdrawn.

The Convener: That deals with that group. I propose to suspend—

Margo MacDonald: Excuse me, but what about amendment 33?

The Convener: Amendment 33 will be taken later.

Margo MacDonald: I apologise—you said that earlier.

The Convener: You would not want to interrupt me when I am about to announce a five-minute suspension.

15:13
Meeting suspended.

15:21
On resuming—

Section 4—Meaning of “smoke” and “no-smoking premises”

The Convener: Group 8 is on the meaning of “smoke” and substances not including tobacco. Amendment 85, in the name of Stewart Maxwell, is grouped with amendments 86, 87 and 88.

Mr Maxwell: When I first read the Executive’s bill, I noticed that the meaning of the word “smoke” in section 4(1) is different from that in my Prohibition of Smoking in Regulated Areas (Scotland) Bill. I was concerned that whereas my bill defined smoke as all smoke from all substances that are smoked, the Executive’s bill defined it as coming from tobacco products that are smoked.

It is clear that health issues are related not only to tobacco smoke, but to other smoke. For instance, so-called herbal or non-tobacco cigarettes—which are sometimes called vegetable-based cigarettes—also produce carbon monoxide and tar. Indeed, research has shown that they produce those materials in equivalent or even greater quantities than do tobacco cigarettes. The research on the dangers of carbon monoxide and tar is clear, and the committee received a great deal of evidence at stage 1 on the health effects of tar and inhaling carbon monoxide. To ensure that the smoke-free legislation is comprehensive, we must go further than the current definition in the bill.

We want to protect the health of adults who are around at the moment, which means protecting them from carbon monoxide and tar, no matter what type of cigarette they come from. As the minister said, we are also trying to denormalise smoking for the health benefit of future generations, which means removing all types of smoking from pubs, clubs, licensed premises, restaurants and other public places. If we agree to the amendments, there will be health benefits for adults who are around now and for future generations.

On enforcement, clearly it would be difficult for an enforcement officer or even a publican or a manager of premises to tell on sight whether a person is smoking a tobacco cigarette. I showed members at stage 1 what I am about to show them again. Nobody here can tell me whether the cigarette that I am holding is a tobacco or a non-tobacco cigarette, or whether it is a hybrid of the two, as many herbal cigarettes contain tobacco. How could an enforcement officer—or anybody else, for that matter—enforce the law if they cannot tell the difference?

Members have talked about ensuring that enforcement officers do not have to confront people face to face on Saturday nights in pubs in Glasgow or anywhere else. However, if the definition is left as it is, that would have to happen. To prove a case, the cigarette would have to be removed and taken away for laboratory analysis to find out whether it contains tobacco. That would not be an acceptable way of enforcing the legislation—it would be confrontational and against the ethos that has been discussed today and earlier. Enforcement would be much easier if all smoking were eliminated from enclosed public places.

Amendments 85 to 88 would also future proof the bill. Although we understand how certain products are smoked at the moment, new inventions or other ways of smoking might be devised in future that would not be caught by the bill because the bill refers only to the smoking of tobacco in a certain way. If we widened the scope of the bill to ban all smoking in enclosed public premises, we would make it difficult for people to get round the ban by arguing about the definition of smoking that is framed in the bill. It is important to future proof the bill so that its opponents do not try to undermine the ban by changing how smoking is done.

The importance of providing a level playing field has been an issue throughout our consideration both of my bill—the Prohibition of Smoking in Regulated Areas (Scotland) Bill—and of the Executive bill that is before us today. Indeed, the committee’s stage 1 report on my bill highlighted how difficult it would be to enforce a partial ban.
effect, unless we agree to the amendments in this group, that is what we will get because the Executive’s bill would ban tobacco smoking but not other types of smoking. That would be a mistake. If we want a comprehensive smoking ban that is easy to enforce and that denormalises smoking in society, the committee should support the amendments.

I move amendment 85.

Mr Monteith: Several points require to be addressed by Mr Maxwell when he sums up. He talked about denormalising smoking in pubs, clubs, restaurants and other “wholly enclosed” places—although the next group of amendments might change that phrase to “wholly or substantially enclosed” places—but his amendments would mean that theatres and venues where dramatic and lyric productions take place would be included in the ban. When we debated my amendments in group 2, the committee considered that such productions would have alternatives to smoking. However, the amendments in this group would prevent the use of such alternatives in theatre, opera and ballet. Mr Maxwell should confirm whether that will be the case, so that members and the minister can consider whether, having argued that alternatives would be available, they should agree to amendments that would remove those alternatives.

Furthermore, if the committee is convinced by Mr Maxwell’s arguments, it should accept the need for an amendment at stage 3 to provide an exemption for dramatic and lyric productions, as banning all types of smoking in wholly enclosed spaces would otherwise mean that the alternatives would not be available.

For the committee’s benefit, I draw attention to the need for clarification on that issue.

Mr McNeil: Amendments 85 to 88 are about common sense and consistency. The definition needs to be extended to include the policy thrust of the amendments. Given the actions of tobacco companies in the third world and all over the world, it will not be beyond their imagination to come up with different smoking products that will not fall under the definition of the bill. God forbid that Scotland ever gets itself into the crazy situation of legalising cannabis—I see that Margo MacDonald is no longer present—but if it did so, people would be allowed to smoke cannabis but not tobacco in pubs. The amendments are about common sense and consistency, so they should be supported.

Rhona Brankin: I will speak in support of the amendments in this group.

Amendments 85 to 88 are important because they would extend the scope of the bill by prohibiting in no-smoking premises the smoking of herbal cigarettes and other forms of non-tobacco smoking products. I thank Stewart Maxwell for lodging the amendments, which would make the bill more comprehensive by ensuring that the smoking of both tobacco and non-tobacco smoking products is illegal in premises that are designated as no-smoking premises under the bill.

The amendments would also contribute to achieving a greater denormalising effect by making a more powerful statement about smoking not being socially acceptable. They would also provide flexibility to deal with future changes in smoking products so that such products will fall within the scope of the smoking-free legislation.

Those are all goals that we should support, and the Executive certainly supports them. I thank Stewart Maxwell for lodging his amendments.

15:30

Mr Maxwell: I will answer some of the points that have been raised. Brian Monteith has spoken about theatres. The point is that it is unreasonable to expect theatre staff—actors and others—to be forced to breathe in carbon monoxide and tar. Why does their profession mean that they should have to suffer the associated health problems whereas others in pubs and restaurants do not? We are talking about a level playing field and protecting the health of all staff in all places. I think that that is reasonable.

From what I heard, the minister did not seem to argue that non-tobacco cigarettes were the alternative. I think that she said that it would not be beyond the wit of the entertainment industry to come up with an alternative, which is slightly different. Duncan McNeil talked about the imagination that could be used to deal with the issue. Television programmes and theatre productions can take us backwards or forwards in time, out into space or anywhere else if those who create them apply themselves and use pyrotechnics and other types of special effect. It is not particularly difficult to get round the problem.

Duncan McNeil was quite right on the issue of hash or cannabis. If the bill was left unamended and United Kingdom legislation was changed to decriminalise cannabis or to allow it to be smoked, people in Scotland would not be allowed to smoke a tobacco cigarette in a pub, but would be allowed to smoke a joint. That logic seems rather strange.

I hope that the committee will support my amendments.

The Convener: The question is, that amendment 85 be agreed to. Are we agreed?

Members: No.
The Convener: There will be a division.

FOR
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Milne, Mrs Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 6, Against 1, Abstentions 0.

Amendment 85 agreed to.

The Convener: The question is, that amendment 86 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Milne, Mrs Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 6, Against 1, Abstentions 0.

Amendment 86 moved—[Mr Stewart Maxwell].

The Convener: The question is, that amendment 86 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Milne, Mrs Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 6, Against 1, Abstentions 0.

Amendment 86 agreed to.

Amendment 87 moved—[Mr Stewart Maxwell].

The Convener: The question is, that amendment 87 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Milne, Mrs Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 6, Against 1, Abstentions 0.

Amendment 87 agreed to.

Amendment 88 moved—[Mr Stewart Maxwell].

The Convener: The question is, that amendment 88 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Milne, Mrs Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 6, Against 1, Abstentions 0.

Amendment 88 agreed to.

Amendment 93 moved—[Mr Duncan McNeil]—and agreed to.

The Convener: Group 9 deals with the meaning of “no-smoking premises”. Amendment 97, in the name of the minister, is grouped with amendments 138 and 100. Under the rule of pre-emption, if amendment 138 is agreed to, I will not be able to call amendment 100.

Rhona Brankin: I will speak first to the Executive amendments 97 and 100. Our approach to the smoking provisions in the bill is simple, and the intent and scope of the provisions must be clear. They should be readily enforceable, and there should be as few loopholes for evasion as possible.

A key concept is the kind of premises that may be prescribed as no-smoking premises under regulations, which are premises that are “wholly enclosed” and that fall into one of four specified categories. Therefore, the phrase “wholly enclosed” is of paramount importance in designating no-smoking premises.

In our consultation on the draft smoking regulations, we indicated that we were continuing to examine whether the given definition of “wholly enclosed” would deliver ministers’ policy intention. We specifically invited consultees’ views on the definition of “wholly enclosed” contained in the draft regulations. A broad range of those who responded to our consultation highlighted the issue and asked for greater clarity on it. The response from the against an outright ban group asked the Executive to be more specific and flexible on the definition of “wholly enclosed”, to allow opportunities to create non-wholly enclosed spaces in line with practices established under the Irish smoking ban.

On the evasion issue, we have recognised that there is a risk that the phrase “wholly enclosed” might be too restrictive and could be undermined. For example, the manager of no-smoking premises could remove a brick from a wall and by doing so claim that the premises were no longer “wholly enclosed”. Ultimately, it would be for the
courts to decide whether such an argument could be pursued. Whatever the courts decided, it would be contrary to our policy intention to allow premises to escape the definition of no-smoking premises so readily.

Amendments 97 and 100 will replace the phrase “wholly enclosed” in section 4 with the phrase “wholly or substantially enclosed”. We intend to define further “wholly or substantially enclosed” in the regulations. We have not yet settled on the exact wording but, in common with a range of consultees who responded on the issue, we are attracted by the Irish approach, which may be broadly stated as follows. Where a premises either has no roof, by which I mean that it is possible to see the sky, or has a roof but no walls on 50 per cent of its perimeter, by which I mean that it is possible to see the undergrowth outside, it cannot be considered enclosed. In our view, such a definition makes our policy intention clear, reduces the possibility of evasion and is readily enforceable by environmental health officers on the ground. Our proposed changes will add clarity and will take us towards the level of specificity and flexibility asked of us by respondents to the consultation.

I cannot support amendment 138, in the name of Mr Monteith, which is designed to restrict the places to which the smoking legislation will apply. It draws the definition tightly and defines as a so-called “outdoor part of premises” a place that is so enclosed that there is little chance of environmental tobacco smoke dissipating. The amendment seeks to limit and undermine the comprehensive nature of the bill and thus to reduce its impact on the appalling number of smoking-related deaths in Scotland—13,000 a year, or 35 a day. The Health Committee has already accepted that exposure to environmental tobacco smoke can do damage to a person’s health.

Through subordinate legislation, the Executive will introduce a transparent and easily understood definition of “wholly or substantially enclosed”, with the objective of ensuring that the vast majority of the people of Scotland, who choose not to smoke, are protected from second-hand smoke. I urge the committee to support Executive amendments 97 and 100 and to resist Brian Monteith’s amendment 138.

I move amendment 97.

Mr Monteith: I will speak first to amendments 97 and 100, in the name of the minister. As described by the minister, the amendments seem to be worthy of support and to be consistent with my approach, as they seek to clarify in the bill the definition of “wholly enclosed”. I may or may not agree with the sentiment of the minister’s approach, but I understand the enforcement difficulties were a person to remove a door or a brick. There is no point in having legislation if it is unclear and so abused that people avoid using it.

On the face of it, the minister’s explanation appears wholly acceptable. However, it does not divert me from my approach. Amendment 138 would not undermine the intention behind the bill. The body of the minister’s argument was nothing more than a gratuitous blizzard of assertions and facts about which we will continue to disagree. It was not a legal refutation of the point—which I have made on a number of occasions—that tighter and clearer descriptions should be put on the face of the bill. To do so would not undermine the bill but would aid the process of effecting its provisions.

Concern has been expressed that the drafting of the bill and its reliance on regulations could allow misunderstandings to arise. For instance, although one would expect certain beer gardens to be exempt, that will not be the case. Indeed, if the case is made for the definition of premises to take into account perimeters and boundaries, anyone smoking outdoors at a summit such as the G8 at Gleneagles could become subject to the provisions of the bill—if the bill were enacted when the summit was taking place—because of the new fence that is to be built around the hotel premises.

The minister has lodged amendments 97 and 100, so I am content that she is trying to address some of the points that I have raised. Therefore, I will not move amendment 138.

Amendment 97 agreed to.

The Convener: Group 10 is on premises used as a place of work and extension of the definition. Amendment 98, in the name of the minister, is grouped with amendment 99.

Rhona Brankin: The amendments in the group are intended to make the smoking provisions in the bill as comprehensive as possible. They will extend the protection from environmental tobacco smoke that the bill will provide beyond those in paid employment and draw within the scope of the bill premises in which people work in a self-employed or voluntary capacity. The amendments will ensure that all workers have equal rights in that regard.

I move amendment 98.

Mr Monteith: The minister talked about people who work in a self-employed capacity. Given that so many people who work in a self-employed capacity do so in premises that are either part of domestic premises or are adjoined to them, it would be helpful if the minister would clarify the position of self-employed people who have a room at home that is dedicated to, for instance, their self-employment as an accountant. Could the
provisions of the bill creep into the home? Could one room be a no-smoking room, although the rest of the premises would not be so restricted because they are that person's home?

**Rhona Brankin:** If an accountant works in private premises, the premises are not covered by the provisions of the bill.

Amendment 98 agreed to.

Amendment 99 moved—[Rhona Brankin]—and agreed to.

Amendment 138 not moved.

Amendment 100 moved—[Rhona Brankin]—and agreed to.

Amendment 94 moved—[Mr Duncan McNeil]—and agreed to.

Amendment 139 not moved.

Section 4, as amended, agreed to.

15:45

**The Convener:** Group 11 is on proceedings for offences under sections 1 to 3. Amendment 101, in the name of the minister, is in a group on its own.

**Rhona Brankin:** Amendment 101 is intended to ensure that any lengthy or extended hearing processes that are consequential to the issuing of a fixed-penalty notice under part 1 of the bill do not result in a subsequent prosecution for that offence being time barred. As the bill is drafted, where a person has been given a fixed-penalty notice in relation to an offence under sections 1 to 3, they may request a hearing under schedule 1 in respect of the offence. In that event, I am mindful that there is a danger that any delay in the hearing process might result in any subsequent prosecution of that person being time barred because there is a fixed statutory maximum period between the date of the offence and the date by which the prosecution must be brought.

The issue arises because the offences under sections 1 to 3 are subject to summary trial only, and that type of trial attracts a time bar. Therefore, delays in the hearings system could result in the option of prosecuting offenders being circumvented. Amendment 101 seeks to remove that risk by linking the start of the time limit for summary proceedings in pursuance of sections 1 to 3 to the point at which the Crown is passed sufficient evidence on the offence to justify bringing a prosecution.

I move amendment 101.

Amendment 101 agreed to.

**The Convener:** Members will have noticed that Margo MacDonald is no longer with us. She advised me that she did not intend to move amendment 33, so she was not required to stay on.

Amendment 33 not moved.

**The Convener:** We move on to group 12, on local authority enforcement. Amendment 140, in the name of Nanette Milne, is grouped with amendments 142, 143 and 145 to 150. If amendment 150 is agreed to, I will not be able to call amendment 151 as it will have been pre-empted.

**Mrs Milne:** Amendment 140 seeks to clarify something that appears to us to be indistinct in part 1 of the bill. It seeks to make local authorities responsible for enforcing the bill. It moves the definition of “the appropriate council” to after section 4. Amendment 150 is consequential, in that it seeks to delete that definition from section 6. We think that the matter needs clarification, bearing in mind that the police are not too keen on being responsible for enforcing the legislation.

As pubs and clubs are privately owned, section 6 could infringe on the rights of landlords. The use of the term “search” in section 6(1) could mean that inspectors had the right to search the private areas of premises without a warrant. By substituting “inspect” for “search”, amendment 143 would secure the rights of landlords to respect for their private lives and homes. The approach that amendment 143 proposes would be less intrusive. The bill provides the power to “enter and search any no-smoking premises”, to ascertain whether there has been a contravention of the prohibition on smoking. The power to enter and inspect premises for that purpose should be sufficient.

Amendment 142 would require an enforcement officer to obtain a warrant before entering by force and searching premises. Pubs are private premises, although sections of them are public places, so amendments 142 and 143 would provide protection to the people who live in pubs.

Amendment 145 would strengthen proprietors’ rights. For example, if a case went to court in which an officer had arrived at a pub at 4 am with a warrant for inspection, when the pub was shut and people were in bed, the onus would be on the officer to say why he thought that 4 am was a reasonable time to carry out the inspection. Amendment 145 might provide protection against the unreasonable and perhaps repeated targeting of specific pubs.

Amendments 146 and 147 would also strengthen proprietors’ rights, by giving a person who was accused of breaking the law the right to
refuse to answer questions on the spot or hand over evidence, such as closed-circuit television footage, until a lawyer was present or the case went to court. The amendments would bring the bill in line with other legislation that deals with the rights of the accused. Amendment 148 would set out the basis on which a warrant could be granted.

Under section 6(3), a person who does not provide their name and address when required to do so by an authorised enforcement officer will be committing an offence. Amendment 149 would go further by including other forms of obstruction of an enforcement officer.

The amendments would strengthen the rights of proprietors and individuals. For example, if an employee told their employer that no one had been smoking on the premises and the employer, who believed the employee, subsequently told an enforcement officer that no one had been smoking, but it was subsequently proved through CCTV or other evidence that people had been smoking on the premises, the employer would not have committed an offence.

I move amendment 140.

Mr Monteith: I support the amendments and I will be interested in the minister’s response. I say simply that it is important that the law on rights of entry for officials such as the police or environmental health officers is consistent. Live-in premises are part of many public houses and the searching of no-smoking premises might lead to an invasion of the privacy of a landlord or landlady who lived on the premises. Amendment 143, which would change the tenor of the approach by substituting “inspect” for “search”, would strike a better balance. The amendments try to set out an approach to the rights of the accused that is consistent with that of other legislation, which makes perfect sense. We do not want to create a situation in which the enforcement of the bill leads people to think that there is increasingly a police state. We should ensure that the bill takes the approach to enforcement that is being taken in the Republic of Ireland, which members have discussed, where enforcement has had some success because it has not been regarded as invasive.

The purpose of the amendments in the name of Nanette Milne is to extract an alternative solution from the minister if the amendments are not the solution. Is there an alternative? Can the minister assure us that the bill will not lead to a situation where officials enforce the bill invasively?

Rhona Brankin: I speak against the amendments. I believe that, taken in aggregate, the amendments are, in effect, a rather convoluted means of diminishing the enforcement powers provided for in the bill. They do so by placing a duty on local authorities to enforce the legislation rather than providing, as the bill currently does, for local authorities to be the lead element of a range of possible enforcement agencies. Placing a duty on local authorities ensures simply that they have no discretion whatsoever on how to enforce the legislation.

The bill envisages a flexible approach to enforcement, not the one-size-fits-all approach that the amendments would achieve. Do we really want a situation where environmental health officers have no discretion in applying their knowledge and professionalism? I do not think so.

Furthermore, the amendments seek to limit the power of local authority officers to search premises, reducing it to a power to inspect. In addition, the amendments would create a requirement for enforcement officers to obtain a sheriff’s warrant before entering premises to inspect them. With such a delaying tactic, the environmental health officers would be as well to shout, “Coming, ready or not!” before approaching premises where it was thought that an offence was being committed.

We can see that, taken together, the amendments are another attempt by the Conservatives to water down and subvert enforcement of the provisions of the bill. The distinction between a private dwelling and no-smoking premises will be defined in the regulations. I urge members to oppose the amendments.

Mrs Milne: I do not intend to press amendment 140, but we feel that it is important that local authorities are the enforcement authorities. That is what I understood was the wish of the people who gave evidence to the committee. With regard to requiring a warrant, we would be asking not for a warrant for inspection but for a warrant for entering and searching, and there is a difference between the two.

Amendment 140, by agreement, withdrawn.

Section 5 agreed to.

Schedule 1

FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2, AND 3

Amendment 141 not moved.

The Convener: Amendment 102, in the name of the minister, is grouped with amendments 103 and 104.

Rhona Brankin: Amendments 102 to 104 are technical amendments to paragraph 13 of schedule 1, which sets out what ministers may prescribe in relation to fixed penalty notices—for example, circumstances in which such notices
may not be given, payment periods and methods of payment.

Subparagraph (a) of paragraph 13 provides that Scottish ministers may
"prescribe circumstances in which fixed penalty notices may not be given".
Subparagraph (c) provides that Scottish ministers may
"prescribe the method or methods by which penalties may be paid."
Those references to "prescribe" in schedule 1 are unnecessary, as the interpretation section of the bill—section 35—already provides a definition of "prescribed" for the bill.

16:00
The overall effect of the amendments is to remove all references to prescribing by regulations in paragraph 13 of schedule 1 and to rely instead on the definition of "prescribed" in section 35 to give meaning to the regulation-making power in paragraph 13. Taken together, the amendments have a neutral effect and will simply tidy the drafting of schedule 1.

I move amendment 102.
Amendment 102 agreed to.
Amendments 103 and 104 moved—[Rhona Brankin]—and agreed to.
Schedule 1, as amended, agreed to.

Section 6—Powers to enter and require identification
Amendments 142 to 151 not moved.
Section 6 agreed to.

After section 6
Amendment 152 not moved.
Section 7 agreed to.

After section 7

The Convener: Amendment 153, in the name of Duncan McNeil, is in a group on its own.

Mr McNeil: I remind the committee that the current law on tobacco sales to children is nearly 70 years old—it was set out in the Children and Young Persons (Scotland) Act 1937. No members will remember it but, back then, the attitude was different. Smoking was seen as glamorous and harmless. Despite that, the act still made the majority of working-class children, who left school at 14, wait two years until they could legally buy cigarettes. Reform is overdue and the law is badly in need of an update.

Amendment 153 would give the Executive the power to vary by order the legal age for tobacco purchase by amending section 18 of the 1937 act. Any order would need to amend three subsections of section 18 of that act—subsection (1), on the general prohibition of sales to underage people; subsection (2), on rules that relate to cigarette machines; and subsection (3), on the seizure of tobacco products from underage people. As I said, the amendment would allow section 18 of the 1937 act to be amended by order, after consultation. I presume that an order would be subject to the affirmative resolution procedure.

I move amendment 153.

Mike Rumbles: I understand entirely where Duncan McNeil is coming from in wanting to raise the age at which young people can be sold tobacco. I will concentrate on the amendment that he has lodged to pursue his intention. The amendment would not rigorously achieve his objective. He said that he presumed that an order made under the power that amendment 153 would give to ministers would be subject to the affirmative procedure, but the amendment does not make that clear. The amendment says:

"The Scottish Ministers may make an order under this section only after consulting such persons as they consider appropriate".

The Scottish ministers would not have to consult the Parliament or the Health Committee.

Nor does the amendment require that the age specified in the 1937 act be changed from 16 to 18; Scottish ministers could change it from 16 to 21 or 14. The amendment is not specific and would not achieve what Duncan McNeil intends it to achieve. It is not good legislation to give ministers such unrestricted power.

The minimum age at which people can buy cigarettes was flagged up at stage 1, but the committee received no evidence on the matter. The convener will correct me if I am wrong, but I understand that under parliamentary procedure we are not allowed to take more evidence on the bill.

The Convener: It is too late for us to take evidence on the matter. Of course, if we had been given more notice of the amendment, we could have taken evidence, as we did in relation to other amendments.

Mike Rumbles: That means that we have to either take it or leave it. The committee should not be expected to vote for an amendment that is flawed, despite the good intentions behind it. It has been argued that we can agree to a flawed amendment at stage 2 and put it right at stage 3, but that is not the way to proceed. Whatever we think of the merits of the issue that Duncan McNeil raises, we should not vote for amendment 153.
Shona Robison: I flagged up the issue at stage 1 after the committee’s visit to Ireland, when we learned that the Irish Government is addressing the minimum age at which people can purchase cigarettes as part of a package of measures. I am not convinced that the proposal would do much good on its own, but it could be an important element of a package of measures. ASH Scotland raised issues to do with enforcement and the flouting of the existing law, but that is a different matter. Enforcement must be addressed whatever age is specified.

On what Mike Rumbles said about orders made under amendment 153, I seek the minister’s assurance that such orders would come before the Parliament for approval. On that basis, I support amendment 153.

Mrs Milne: I cannot give my full support to amendment 153 at this stage, mainly because the amendment has been sprung on us. I foresee major problems with enforcement if the amendment is agreed to, but perhaps that is a side issue. More time needs to be spent listening to opinion and researching the matter.

Dr Turner: I look forward to hearing what the minister says about amendment 153. I fully support Duncan McNeil’s proposal. The younger someone is when they become addicted to a substance, the harder it is for them to quit and I welcome any measure that might encourage people not to smoke. Many young girls start smoking between the ages of 9 and 13, despite the educational tools that are available. I am sympathetic towards amendment 153, but I will leave the technicalities to members who are more aware of the rights and wrongs of how the proposal can be put into legislation. I support Duncan McNeil’s proposal.

Paul Martin: Further to what Mike Rumbles said, I do not think that it would be flawed to accept amendment 153 at stage 2. As a member of the Local Government and Transport Committee, I have been advised by the Minister for Transport on a number of occasions that he is happy for us to pass an amendment to a bill at stage 2 that he will consider improving at stage 3. I have no difficulties with Duncan McNeil’s suggestion.

An interesting dimension is the proof-of-age card for the purchase of alcohol that is to be introduced through the Licensing (Scotland) Bill. There will be future opportunities to tie in that card to the purchase of tobacco, if the change in the legal age is introduced. Duncan McNeil should be encouraged to ensure that we pursue the matter further at stage 3.

Rhona Brankin: It is important that steps are taken to denormalise smoking in our society. A key part of that is doing all that we can to discourage young people from starting to smoke in the first place. We are aware that there is a range of opinion on the age issue, which is why in our 2004 tobacco action plan, “A Breath of Fresh Air for Scotland—improving Scotland’s health: the challenge”, we indicated that we will “commission further research with young people to provide a clearer picture of the factors that lead them to start or resist smoking and track awareness of the dangers of smoking and passive smoking amongst key target groups.”

That work will be done by an expert group under the chairmanship of Dr Laurence Gruer of NHS Health Scotland, which is to be known as the Gruer group. As part of the group’s remit, we will ask it to consider the significance of the legal age limit in relation to the uptake of smoking and the evidence on that from other countries, and to make recommendations to ministers. The group will meet for the first time in August and is expected to complete its work in nine to 12 months.

Amendment 153 will enable the Scottish ministers to vary the age limit in relation to the uptake of smoking and the evidence on that from other countries, and to make recommendations to ministers. The group will meet for the first time in August and is expected to complete its work in nine to 12 months.

If the committee agrees to amendment 153, the Executive will lodge a technical amendment to section 34 at stage 3 to clarify that the power will be exercised by an order that is made under the affirmative resolution procedure. That will mean that any order that is made under the amendment will come to the committee in draft form and will be subject to ratification by the full Parliament.

Mr McNeil: I welcome the minister’s reassurance—I hope that it will also give reassurance to my colleagues.

Shona Robison will remember that, when we first heard of the evidence from Ireland, where the legal age was increased from 16 to 18, there was a debate about whether such a change here would be a reserved or a devolved matter. I sought parliamentary advice through the Scottish Parliament information centre, which confirmed, after discussions with the Scottish Executive, that the matter is devolved. I was pleased to hear that and so began to put together an amendment.

I take heart from Paul Martin’s rebuttal of Mike Rumbles and his comment that we can improve on the measure. Given the minister’s assurances, we should not miss this opportunity. ASH Scotland
has been advised today that Guernsey, an area from which we did not take evidence, had twice the United Kingdom average of teenage smokers in the 1990s but, after the age limit was increased from 16 to 18—among other measures, it is fair to say—it now has half the UK average of teenage smokers. I hope that we will use the coming period for consultation and reflection on how to tackle the issue of young people and smoking.

The Convener: The question is, that amendment 153 be agreed to. Are we all agreed?

Members: No.

The Convener: There will be a division.

FOR
Hughes, Janis (Glasgow Rutherglen) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)

ABSTENTIONS
Milne, Mrs Nanette (North East Scotland) (Con)

The Convener: The result of the division is: For 5, Against 1, Abstentions 1.

Amendment 153 agreed to.

Section 8 agreed to.

Section 37—Short title and commencement

16:15

The Convener: We move on to group 15, which contains amendments relating to commencement. Amendment 105, in the name of the minister, is grouped with amendments 106 and 107.

Rhona Brankin: The current drafting of the bill means that the smoking provisions would come into effect on the day after royal assent is granted, which is currently anticipated for August 2005. Our intention is that the smoke-free legislation should instead come into force in spring 2006. In order to achieve that, amendments 105 and 106 provide that the smoking provisions that are contained in part 1 and schedule 1 will come into force by means of a commencement order, rather than on the day after royal assent. That will allow the smoking provisions to be commenced next year in tandem with the supporting regulations, once those regulations have been agreed to by Parliament.

Amendment 107 means that ministers will also be able to specify within the commencement order the time at which those smoking provisions will come into force. That will allow the Executive flexibility as to the timing of the commencement of the legislation. We wish to be able to avoid a situation where the legislation comes into effect and has to be enforced from midnight. Commencement will be from a time chosen to avoid unnecessary confrontations.

Overall, this group of amendments will allow the Scottish ministers suitable flexibility as to the date and time of the implementation of the smoking provisions.

I move amendment 105.

Amendment 105 agreed to.

Amendments 31, 106, 32 and 107 moved—[Rhona Brankin]—and agreed to.

Section 37, as amended, agreed to.

Long Title

The Convener: Group 16 comprises amendments relating to the long title. Amendment 108, in the name of the minister, is grouped with amendments 109 to 114.

Rhona Brankin: These amendments are technical amendments to the long title, which describes the provisions that are legislated for in the bill. The amendments are required to reflect the bill's provisions as amended at stage 2.

Amendment 108 updates the reference to "wholly enclosed places" to "wholly or substantially enclosed places". That is one of the criteria for the kinds of premises that can be prescribed as no-smoking premises under the bill.

Amendment 109 makes it clear that the long title's reference to Scottish ministers establishing a scheme for the payment of persons suffering from hepatitis C as a result of NHS treatment also includes payments to secondary infectees. The extension of the scheme to secondary infectees was introduced at stage 2.

Amendment 109 makes it clear that the long title's reference to Scottish ministers establishing a scheme for the payment of persons suffering from hepatitis C as a result of NHS treatment also includes payments to secondary infectees. The extension of the scheme to secondary infectees was introduced at stage 2.

Amendments 110 and 111 insert into the long title a reference to the minimum frequency of inspection of care services by the Scottish Commission for the Regulation of Care, as introduced to the bill at stage 2.

Amendment 112 inserts a reference to the new right of appeal that was introduced at stage 2 for those people with infectious diseases who are detained under the Public Health (Scotland) Act 1897.

Amendments 110 and 111 insert into the long title a reference to the minimum frequency of inspection of care services by the Scottish Commission for the Regulation of Care, as introduced to the bill at stage 2.

Amendment 112 inserts a reference to the new right of appeal that was introduced at stage 2 for those people with infectious diseases who are detained under the Public Health (Scotland) Act 1897.

Amendments 113 and 114 add "and for connected purposes" to the end of the long title. That brings under the long title the provisions of schedules 2 and 3 regarding the functions of health boards, special health boards and the Common Services Agency under the National Health Service (Scotland) Act 1978 and the amendment to the Mental Health (Care and Rehabilitation) Act 2003.
Treatment) (Scotland) Act 2003, as introduced to the bill at stage 2.

I move amendment 108.

Amendment 108 agreed to.

Amendments 109 to 114 moved—[Rhona Brinkin]—and agreed to.

Long title, as amended, agreed to.

The Convener: That ends stage 2 consideration of the Smoking, Health and Social Care (Scotland) Bill. I thank all members of the committee and those who have visited us for their work and forbearance throughout the proceedings, which could have been a great deal longer than they turned out to be. I also thank the Deputy Minister for Health and Community Care and her officials for their attendance.
Smoking, Health and Social Care (Scotland) Bill
[AS AMENDED AT STAGE 2]

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Amendments to the Bill since the previous version are indicated by sidelining in the right margin. Wherever possible, provisions that were in the Bill as introduced retain the original numbering.

**Smoking, Health and Social Care (Scotland) Bill**

[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to prohibit smoking in certain wholly or substantially enclosed places; to make provision in relation to general dental services, general ophthalmic services, personal dental services and pharmaceutical care services; to make provision in relation to disqualification by the NHS Tribunal; to enable the Scottish Ministers to establish a scheme for the making of payments to certain persons infected with hepatitis C as a result of NHS treatment and to certain persons infected with the virus by transmission of it from a person infected with it as a result of such treatment; to amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission; to make provision providing further time for applications to be made for registration of child care agencies and housing support services under the Regulation of Care (Scotland) Act 2001 and provide authorisation for the payment of certain grants to such services while not registered under that Act; to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland; to amend the rules as to membership of and other matters relating to the Scottish Hospital Endowments Research Trust; and for connected purposes.

**PART 1**

**SMOKING: PROHIBITION AND CONTROL**

1 **Offence of permitting others to smoke in no-smoking premises**

1. A person who, having the management or control of no-smoking premises, knowingly permits another to smoke there commits an offence.

2. A person accused of an offence under this section is to be regarded as having knowingly permitted another to smoke in no-smoking premises if that person ought to have known that the other person was smoking there.

3. It is a defence for an accused charged with an offence under this section to prove—
(a) that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence; or

(b) that there were no lawful and reasonably practicable means by which the accused could prevent the other person from smoking in the no-smoking premises.

(4) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 4 on the standard scale.

2 Offence of smoking in no-smoking premises

(1) A person who smokes in no-smoking premises commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged that the accused was smoking was no-smoking premises.

(3) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

3 Display of warning notices in and on no-smoking premises

(1) If notices are not conspicuously displayed—

(a) in, on, or near no-smoking premises so as to be visible to and legible by persons in and persons approaching the premises; and

(b) stating—

(i) that the premises are no-smoking premises; and

(ii) that it is an offence to smoke there or knowingly to permit smoking there,

the person having the management or control of the premises commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence.

(3) The Scottish Ministers may, after consulting such persons as they consider appropriate, by regulations provide further as to the manner of display, form and content of the notices referred to in subsection (1) and that any such provision is to be treated, for the purposes of that subsection, as if incorporated in it.

(4) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4 Meaning of “smoke” and “no-smoking premises”

(1) In this Part, “smoke” means smoke tobacco, any substance or mixture which includes it or any other substance or mixture; and a person is to be taken as smoking if the person is holding or otherwise in possession or control of lit tobacco, of any lit substance or mixture which includes tobacco or of any other lit substance or mixture which is in a form or in a receptacle in which it can be smoked.

(2) In this Part, “no-smoking premises” means such premises or such classes of premises, being premises of a kind mentioned in subsection (4), as are prescribed by regulations made by the Scottish Ministers after consulting such persons as they consider appropriate on a draft of the regulations.
(3) Regulations under subsection (2) may prescribe premises or parts of premises or classes of premises or parts of premises which are excluded from the definition of “no-smoking premises”.

(4) The kind of premises referred to in subsection (2) is premises which are wholly or substantially enclosed and—

(a) to which the public or a section of the public has access;
(b) which are being used wholly or mainly as a place of work;
(c) which are being used by and for the purposes of a club or other unincorporated association; or
(d) which are being used wholly or mainly for the provision of education or of health or care services.

(4A) In subsection (4)(b), the reference to work includes work undertaken for no financial advantage.

(5) Regulations under subsection (2) may, for the purposes of that subsection, define or elaborate the meaning of any of the expressions—

(a) “premises”;  
(b) “wholly or substantially enclosed”;
(c) “the public”; and
(d) “has access”.

(6) Regulations under subsection (2) may define or elaborate the meaning of “premises”—

(a) by reference to the person or class of person who owns or occupies them;
(b) so as to include vehicles, vessels, trains and other means of transport (except aircraft), or such, or such classes, of them as are specified in the regulations.

(7) The Scottish Ministers may, by regulations, after consulting such persons as they consider appropriate on a draft of the regulations, modify subsection (4) so as—

(a) to add a kind of premises to; or
(b) remove a kind of premises (but not the kind referred to in paragraph (a) of that subsection) from,

those in that subsection.

(8) Regulations made by virtue of subsection (6)(b) may provide as to how the statement referred to in section 3(1)(b) is to be expressed in the case of each of the means of transport referred to in the regulations.

4A Proceeding for offences under sections 1 to 3

(1) Summary proceedings in pursuance of section 1, 2 or 3 may be commenced at any time within the period of 6 months from the date on which evidence sufficient in the opinion of the Lord Advocate to justify the proceedings comes to the Lord Advocate’s knowledge.

(2) Subsection (3) of section 136 of the Criminal Procedure (Scotland) Act 1995 (c.46) (date of commencement of summary proceedings) has effect for the purposes of subsection (1) as it has effect for the purposes of that section.
(3) For the purposes of subsection (1), a certificate of the Lord Advocate as to the date on which the evidence in question came to the Lord Advocate’s knowledge is conclusive evidence of the date on which it did so.

5 Fixed penalties

(1) Schedule 1 (which provides as to fixed penalties for offences under this Part) has effect.

(2) Schedule 1 does not extend to an offence under section 1 or 3 committed otherwise than by a natural person.

6 Powers to enter and require identification

(1) An authorised officer of the appropriate council may enter and search any no-smoking premises in order to ascertain whether an offence under section 1, 2 or 3 has been or is being committed there.

(2) A power under this section may be exercised, if need be, by force.

(3) A person who—

(a) an authorised officer of a council reasonably believes—

(i) is committing or has committed an offence under section 1, 2 or 3; or

(ii) has information relating to such an offence; and

(b) fails without reasonable excuse to supply the officer with the person’s name and address on being so required by the officer,

commits an offence.

(4) A person guilty of an offence under subsection (3) is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

(5) In this section—

“authorised” means authorised for the purposes of this section by the appropriate council;

“the appropriate council” means, in relation to no-smoking premises, the council of the area in which those premises are.

7 Bodies corporate etc.

(1) Where an offence under this Part which has been committed by a body corporate other than a council is proved to have been committed with the consent or connivance of, or to be attributable to, any neglect on the part of—

(a) a director, manager or secretary, member or other similar officer of the body corporate; or

(b) any person who was purporting to act in any such capacity, that person, as well as the body corporate, is guilty of the offence and liable to be proceeded against and punished accordingly.

(2) Where an offence under this Part which has been committed by a council is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—

(a) an officer or member of the council; or
5 Part 2—General dental services, general ophthalmic services and personal dental services

(b) any person who was purporting to act in any such capacity,

that person, as well as the council, is guilty of the offence and liable to be proceeded
against and punished accordingly.

(3) Where an offence under this Part which has been committed by a Scottish partnership is
proved to have been committed with the consent or connivance of, or to be attributable
5 to any neglect on the part of—

(a) a partner; or

(b) any person who was purporting to act in any such capacity,

that person, as well as the partnership, is guilty of the offence and liable to be proceeded
against and punished accordingly.

(4) Where an offence under this Part which has been committed by an unincorporated
association other than a Scottish partnership is proved to have been committed with the
consent or connivance of, or to be attributable to any neglect on the part of—

(a) a person who is concerned in the management or control of the association; or

10 (b) any person who was purporting to act in any such capacity,

that person, as well as the unincorporated association, is guilty of the offence and liable
to be proceeded against and punished accordingly.

7A Sale of tobacco to under-age persons: variation of age limit

(1) The Scottish Ministers may, by order, modify section 18 of the Children and Young
Persons (Scotland) Act 1937 (c.37) (offence of selling tobacco etc. to under-age persons
and other preventative measures) so as to substitute for the age specified in any of its
provisions (at the passing of this Act, 16) such other age or ages as they consider
20 appropriate.

(2) The Scottish Ministers may make an order under this section only after consulting such
persons as they consider appropriate on a draft of the order.

8 Crown application

(1) This Part binds the Crown.

(2) No contravention by the Crown of this Part or any regulations under it makes the Crown
criminally liable; but the Court of Session may, on the application of a council in the
30 area of which the contravention is alleged to have taken place, declare unlawful any act
or omission of the Crown which would, but for this subsection, have been an offence.

(3) Subsection (2) does not extend to persons in the public service of the Crown.

PART 2

GENERAL DENTAL SERVICES, GENERAL OPHTHALMIC SERVICES AND PERSONAL DENTAL SERVICES

9 Free oral health assessments and dental examinations

(1) Oral health assessments and dental examinations carried out on or after 1st April 2006 in
accordance with arrangements made under section 17C of the 1978 Act, arrangements
for the provision of general dental services under Part II of that Act or a pilot scheme
under Part I of the National Health Service (Primary Care) Act 1997 (c.46) (the “1997 Act”) are to be free of charge; and accordingly those Acts are amended as follows.

(2) In the 1978 Act—

(a) in section 70A(2) (personal dental services as respects which regulations under section 70A(1) may provide for the making and recovery of charges), for the words “other than those” substitute “except—

(a) oral health assessments and dental examinations carried out on or after 1st April 2006; and

(b) those services”;

(b) in section 71 (charges for general dental services under Part II)—

(i) in subsection (1), after the words “not being—” insert—

“(a) oral health assessments and dental examinations carried out on or after 1st April 2006;”;

(ii) in subsection (2), after “services” where it first occurs insert “(but not being oral health assessments or dental examinations carried out on or after 1st April 2006)”.

(3) In the 1997 Act, in section 20 (charges for dental treatment in accordance with pilot schemes)—

(a) in subsection (1), for the words from “dental” to the end substitute “personal dental services provided in accordance with pilot schemes except—

(a) those services to which section 78(1A) of the 1977 Act or (as the case may be) section 70(1A) of the 1978 Act applies; and

(b) oral health assessments and dental examinations carried out on or after 1st April 2006.”;

(b) subsection (2) is repealed.

10 Free eye examinations and sight tests

(1) Arrangements under section 26(1) of the 1978 Act for the provision of general ophthalmic services are to include eye examinations and the provision of free eye examinations and sight tests in accordance with such arrangements is to be extended on and after 1st April 2006; and accordingly that Act is amended as follows.

(2) In section 26 (arrangements for the provision of general ophthalmic services)—

(a) in subsection (1), for the words from “the testing” to the end substitute “the carrying out of eye examinations including where clinically necessary testing of sight.”;

(b) subsections (1A) to (1E) are repealed.

(3) In paragraph 2A of Schedule 11 (additional provision as to regulations under section 70(1) on charges for optical appliances), sub-paragraph (3)(a) is repealed.

11 Charges for certain dental appliances and general dental services

(1) The 1978 Act is amended as follows.

(2) In section 70 (regulations as to charges for dental or optical appliances)—
(a) in subsection (1), for the words “optical appliances” substitute “dental or optical appliances”;
(b) subsection (1A) is repealed;
(c) in subsection (2), for the words “(1A)” substitute “(1)”.

(3) In section 70A(2) (personal dental services as respects which regulations under section 70A(1) may provide for the making and recovery of charges), for the words “70(1A)” substitute “70(1)”.

(4) In section 71(1) (charges for certain general dental services), for the words “an amount calculated in accordance with section 71A” substitute “the amount authorised by this section”.

(5) Section 71A (regulations as respects amount of any charge authorised by section 70(1A) for supply of dental appliances or by section 71 for certain general dental services) is repealed.

(6) In paragraph 2 of Schedule 11 (additional provision as to regulations under section 70)—
(a) after sub-paragraph (1), insert—
“(1A) The dental appliances referred to in that section are dentures, bridges, crowns and orthodontic appliances.”;
(b) in sub-paragraph (2)(a), for the words “optical appliance” substitute “dental or optical appliance”;
(c) in sub-paragraph (3), the words “or (1A)” are repealed;
(d) in sub-paragraph (4), for the words “70(1A)” substitute “70(1)”.

12 Arrangements for provision of general dental services
In section 25 of the 1978 Act (arrangements for provision of general dental services) in subsection (1)—

(a) after the words “dental practitioners” insert “or bodies corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(aa) after the words “dental practitioner” insert “or body corporate”.

13 Assistance and support: general dental services
After section 28C of the 1978 Act, insert—

“Assistance and support: general dental services

28D Assistance and support: general dental services

(1) A Health Board may provide assistance and support to any person providing, or proposing to provide, general dental services.

(2) Assistance and support provided by a Health Board under subsection (1) is to be provided on such terms, including terms as to payment, as the Board think fit.

(3) In this section, “assistance” includes financial assistance.”.
14 Provision of certain services under NHS contracts

(1) Section 17AA of the 1978 Act (arrangements for provision of certain services to be treated as NHS contract for certain purposes) is amended as follows.

(2) In subsection (1), for the words from “to”, where it first occurs, to the end of paragraph (b) substitute “to—

(a) any arrangement under which a Health Board or such other health service body as may be prescribed arrange for the provision to them by a person on an ophthalmic list, or

(b) any arrangement under which a Health Board arrange for the provision to them by a person on a dental list,”.

(3) In subsection (3)—

(a) after the word “section—” insert—

““dental list” means, in relation to a list published in accordance with regulations made under subsection (2) of section 25 of this Act, the first part of the list which is referred to in paragraph (a) of that subsection;”;

(b) the definition of “pharmaceutical list”, and the immediately preceding “and”, are repealed.

15 Lists of persons undertaking to provide or approved to assist in the provision of general dental services

In section 25 of the 1978 Act (arrangements for provision of general dental services), for subsections (2) to (2B), substitute—

“(2) Regulations may make provision as to the arrangements to be made under subsection (1), and shall include provision as to the preparation, maintenance and publication by every Health Board of a list—

(a) the first part of which shall be of dental practitioners who, and bodies corporate referred to in that subsection which, undertake to provide general dental services under arrangements with the Board;

(b) the second part of which shall be of persons who do not undertake to provide such services under such arrangements but who are approved by the Board to assist in the provision of such services provided under such arrangements.

(2A) In making provision as to the preparation, maintenance and publication of a list referred to in subsection (2), the regulations may include in particular provision as to—

(a) the division of either part (or both parts) of a list into further sub-parts;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;
(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.

(2B) Regulations may provide that—

(a) a dental practitioner who, and a body corporate referred to in subsection (1) which, undertakes to provide general dental services under arrangements with a Health Board may not provide such services unless his name or, as the case may be, the body corporate’s name is included in the first part of the Board’s list referred to in subsection (2)(a);

(b) a person who does not undertake to provide general dental services under arrangements with a Health Board may not assist in the provision of such services provided under arrangements with the Board unless his name is included in the second part of the Board’s list referred to in subsection (2)(b).”.

16 Lists of persons performing personal dental services under section 17C arrangements or pilot schemes

After section 17E of the 1978 Act, insert—

“17F Lists of persons performing personal dental services

(1) Regulations may provide that a person may not perform personal dental services under section 17C arrangements or a pilot scheme with a Health Board unless his name is included in a list maintained under the regulations by the Board.

(2) Regulations under subsection (1) may make provision in relation to such lists and in particular as to—

(a) the preparation, maintenance and publication of a list;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);
(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.”.

17 Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

In section 26 of the 1978 Act (arrangements for provision of general ophthalmic services), for subsection (2), substitute—

“(2) Regulations may make provision as to the arrangements to be made under subsection (1), and shall include provision—

(a) as to the preparation, maintenance and publication by every Health Board of a list—

(i) the first part of which shall be of medical practitioners and ophthalmic opticians who undertake to provide general ophthalmic services under arrangements with the Board;

(ii) the second part of which shall be of persons who do not undertake to provide such services under such arrangements but who are approved by the Board to assist in the provision of such services provided under such arrangements;

(b) conferring on any person a right to choose in accordance with the prescribed procedure the medical practitioner or ophthalmic optician by whom his eyes are to be examined, his sight is to be tested or from whom any prescription for the supply of optical appliances is to be obtained.

(2A) In making provision as to the matters referred to in subsection (2)(a), the regulations may include in particular provision as to—

(a) the division of either part (or both parts) of a list into further sub-parts;

(b) eligibility for inclusion in a list;
(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.

(2B) Regulations may provide that—

(a) a medical practitioner or ophthalmic optician who undertakes to provide general ophthalmic services under arrangements with a Health Board may not provide such services unless his name is included in the first part of the Board’s list referred to in subsection (2)(a)(i);

(b) a person who does not undertake to provide general ophthalmic services under arrangements with a Health Board may not assist in the provision of such services provided under arrangements with the Board unless his name is included in the second part of the Board’s list referred to in subsection (2)(a)(ii).”.

PART 3

PHARMACEUTICAL CARE SERVICES ETC.

18 Health Boards’ functions: provision and planning of pharmaceutical care services

(1) The 1978 Act is amended as follows.

(2) After section 2C (functions of Health Boards: primary medical services), insert—

“2CA Functions of Health Boards: pharmaceutical care services

(1) Every Health Board—

(a) must, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of pharmaceutical care services as respects the Board’s area; and
(b) may, to such extent, provide or secure the provision of pharmaceutical care services as respects the area of another Health Board, and pharmaceutical care services provided, or the provision of which is secured, by a Health Board under or by virtue of this subsection may be performed outside their area.

(2) For the purpose of securing the provision of pharmaceutical care services under subsection (1), a Health Board may make such arrangements for the provision of the services as they think fit (and may in particular make contractual arrangements with any person).

(3) A Health Board must publish information about such matters as may be prescribed in relation to the pharmaceutical care services provided under this Part.

(4) Without prejudice to section 13, Health Boards must co-operate with one another in discharging their respective functions relating to the provision of pharmaceutical care services under this Part.

(5) Regulations may provide that services of a prescribed description are, or are not, to be regarded as pharmaceutical care services for the purposes of this Act.

(6) Regulations under subsection (5) may in particular—

(a) classify services as services which are to be regarded as essential services or which are to be regarded as additional services;

(b) describe services by reference to the manner or circumstances in which they are provided;

(c) provide that pharmaceutical care services for the purposes of this Act include the provision, in circumstances specified in directions given by the Scottish Ministers, of drugs, medicines and appliances included in a list specified in such directions;

(d) describe services which involve the ordering of a drug, medicine or appliance included in such a list by reference to the description of person by whom the drug, medicine or appliance is ordered.

(7) The Scottish Ministers must publish directions given by them under regulations under subsection (5) in the Drug Tariff or in such other manner as they consider appropriate.

(8) Arrangements made under this Part by a Health Board for the provision of pharmaceutical care services may provide for such services to be performed outside Scotland.

(9) Anything done by a Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on the Health Board by an order under section 2(1)(a).

2CB Functions of Health Boards: planning of pharmaceutical care services

(1) Regulations may make provision requiring every Health Board, in accordance with the regulations, to—

(a) prepare a plan for the discharge of their duty under section 2CA(1);

(b) keep a plan prepared under paragraph (a) under review;
(c) prepare a revised plan; and
(d) without prejudice to section 2CA(3), publish a plan so prepared or revised.

(2) Regulations under subsection (1) may in particular make provision as to—

(a) identification by a Health Board in any such plan prepared by them of—

(i) what pharmaceutical care services they consider are necessary in order to discharge their duty under section 2CA(1);

(ii) whether as respects their area there is convenient access (as regards location and opening hours) to pharmaceutical care services; and

(iii) any under-provision of pharmaceutical care services as respects their area;

(b) the period within which a plan is to be prepared and published;

(c) consultation which a Health Board must undertake in relation to the preparation of a plan;

(d) the duration of a plan;

(e) the frequency with which a plan must be reviewed and revised by a Health Board;

(f) the availability and accessibility of a plan to persons who are resident in a Health Board’s area; and

(g) such other matters as the Scottish Ministers consider appropriate.

(3) Regulations making provision as to a matter referred to in subsection (2)(a) may provide that the matter is to be identified in accordance with such criteria as may be specified in directions given by the Scottish Ministers.”.

(3) In section 18 (duty of the Scottish Ministers), the words “, and of pharmaceutical services,” are repealed.

19 Pharmaceutical care services contracts

For section 17Q of the 1978 Act (assistance and support), substitute—

“Pharmaceutical care services contracts

17Q Health Boards’ power to enter into pharmaceutical care services contracts

(1) A Health Board may enter into a contract under which pharmaceutical care services are provided (whether directly or indirectly) by a contractor in accordance with the provisions of this Part.

(2) A contract under this section is referred to in this Act as a “pharmaceutical care services contract”.

(3) Subject to any provision made by or under this Part, a pharmaceutical care services contract may make such provision as may be agreed between the Health Board and the contractor as respects—

(a) the services to be provided under the contract;

(b) the remuneration to be paid under the contract; and
(c) any other matters.

(4) The services to be provided under a pharmaceutical care services contract may include services which are not pharmaceutical care services; and the contract may provide for such other services to be performed in any place where, by virtue of section 2CA(1), pharmaceutical care services may be performed.

(5) In this Part, “contractor”, in relation to a pharmaceutical care services contract with a Health Board, means the other party to the contract.

17R Mandatory contract term: provision of prescribed pharmaceutical care services

(1) A pharmaceutical care services contract must require the contractor to provide as respects the area of the Health Board pharmaceutical care services of such descriptions as may be prescribed.

(2) Regulations under subsection (1) may in particular describe the pharmaceutical care services by reference to the manner or circumstances in which they are provided.

17S Eligibility to be contractor under pharmaceutical care services contract

(1) A Health Board may, subject to such conditions as may be prescribed, enter into a pharmaceutical care services contract with—

(a) a registered pharmacist; or

(b) a person other than a registered pharmacist who, by virtue of section 69 of the Medicines Act 1968 (c.67), is taken to be a person lawfully conducting a retail pharmacy business in accordance with that section, who undertakes that all pharmaceutical care services provided under the contract will be provided by, or under the supervision of, a registered pharmacist.

(2) Regulations may make provision as to the effect on a pharmaceutical care services contract entered into with a partnership of a change in the membership of the partnership.

17T Payments by Health Boards under pharmaceutical care services contracts

(1) The Scottish Ministers may give directions as to payments to be made under pharmaceutical care services contracts.

(2) A pharmaceutical care services contract must require payments to be made under it in accordance with directions for the time being in force under this section.

(3) A direction under subsection (1) may in particular—

(a) provide for payments to be made by reference to compliance with standards or the achievement of levels of performance;

(b) provide for payments to be made by reference to—

(i) any scheme or scale specified in the direction;
(ii) a determination made by any person in accordance with factors specified in the direction;

(e) provide that the whole or any part of a payment is subject to conditions (including a condition that the whole or any part of a payment is liable to be paid by a Health Board only if they are satisfied as to such conditions as may be specified in the direction);

(d) make provision having effect from a date before the date of the direction, provided that, having regard to the direction as a whole, the provision is not detrimental to the persons to whose remuneration it relates.

Before giving a direction under subsection (1), the Scottish Ministers—

(a) must consult any body appearing to them to be representative of persons to whose remuneration the direction would relate; and

(b) may consult such other persons as they think appropriate.

The Scottish Ministers must publish directions given by them under subsection (1) in the Drug Tariff or in such other manner as they consider appropriate.

References in this section to payments include fees, allowances and reimbursements.

**Other mandatory contract terms: pharmaceutical care services contracts**

(1) A pharmaceutical care services contract must include (in addition to provisions required by or under other provisions of this Part) such provision as may be prescribed.

(2) Regulations under subsection (1) may in particular—

(a) make provision as to the manner in which, and the standards to which, services must be provided;

(aa) provide that the Scottish Ministers may give directions as to the manner in which, and the standards to which, services must be provided;

(ab) make provision as to—

(b) the persons who are to perform services;

(c) the area in which services are to be provided;

(d) the persons to whom services are to be provided;

(e) requirements to be complied with where a contractor provides any pharmaceutical care services indirectly (including requirements as to the pharmaceutical care services which may or may not be so provided);

(f) the variation of terms of the contract (except terms required by or under this Part);

(g) rights of entry and inspection (including inspection of clinical records and other documents);

(h) the circumstances in which, and the manner in which, the contract may be terminated;

(i) enforcement;
(j) the adjudication of disputes.

(3) Regulations making provision in pursuance of subsection (2)(ab)(d) may make provision as to the circumstances in which a contractor—

(a) must, or may, accept a person as a person to whom services are provided under the contract;

(b) may decline to accept a person as such a person; or

(c) may terminate the contractor’s responsibility for a person.

(4) Regulations making provision in pursuance of subsection (2)(ab)(f) may—

(a) make provision as to the circumstances in which a Health Board may unilaterally vary the terms of a contract;

(b) make provision suspending or terminating any duty under the contract to provide services of a prescribed description.

(5) Regulations making provision of the kind described in subsection (4)(b) may prescribe services by reference to the manner or circumstances in which they are provided.

(6) A pharmaceutical care services contract must contain provision requiring the contractor to comply with directions for the time being in force given by the Scottish Ministers under regulations under subsection (1).

17V Resolution of disputes and entry into NHS contracts: pharmaceutical care services contracts

(1) Regulations may make provision for the resolution of disputes as to the terms of a proposed pharmaceutical care services contract, including, without prejudice to that generality, provision for—

(a) the referral of the terms of the proposed contract to the Scottish Ministers; and

(b) the Scottish Ministers, or a person or panel of persons appointed by them, to determine the terms on which the contract may be entered into.

(2) Regulations may make provision for any person entering, or who has entered, into a pharmaceutical care services contract to be regarded as a health service body for any purposes of section 17A, in circumstances where the person so elects.

(3) Where a person is to be regarded as a health service body for any purposes of section 17A by reason only of an election by virtue of subsection (2) of this section, that section has effect in relation to that person with the omission of the words “under any enactment” in subsection (1) and with such other modifications (if any) as may be prescribed.

(4) Regulations under subsection (2) may include provision as to the application of section 17A in cases where—

(a) a partnership is to be regarded as a health service body; and

(b) there is a change in the membership of the partnership.”.
19A  **Drug Tariff**

After section 17V of the 1978 Act (as inserted by section 19 above), insert—

“**Drug Tariff**

17VA  **Drug Tariff**

(1) The Scottish Ministers must prepare, maintain and publish a document (to be known as the “Drug Tariff”).

(2) The Scottish Ministers—

(a) must include in the Drug Tariff, such information relating to pharmaceutical care services as may be prescribed;

(b) may include in it such other information relating to such services as they consider appropriate.”.

20  **Persons performing pharmaceutical care services**

After section 17VA of the 1978 Act (as inserted by section 19A above), insert—

“**Persons performing pharmaceutical care services**

17W  **Persons performing pharmaceutical care services**

(1) Regulations may provide that a registered pharmacist may not perform any pharmaceutical care service which a Health Board is, under section 2CA(1), under a duty to provide or secure the provision of unless that pharmacist is included in a list maintained under the regulations by the Health Board.

(2) Regulations under subsection (1) may make provision in relation to such lists and in particular as to—

(a) the preparation, maintenance and publication of a list;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from the list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusal of applications, or suspensions, removals or references to the Tribunal.
(3) Regulations making provision as to the matters referred to in subsection (2)(j) may in particular authorise the disclosure of information—
(a) by a Health Board to the Scottish Ministers; and
(b) by the Scottish Ministers to a Health Board.”.

21 Assistance and support: primary medical services and pharmaceutical care services

After section 17W of the 1978 Act (as inserted by section 20 above), insert—

“Assistance and support: primary medical services and pharmaceutical care services

17X Assistance and support: primary medical services and pharmaceutical care services

(1) A Health Board may provide assistance and support to—
(a) any person providing, or proposing to provide, primary medical services under a general medical services contract;
(b) any person providing, or proposing to provide, such services in accordance with section 17C arrangements;
(c) any person providing, or proposing to provide, pharmaceutical care services under a pharmaceutical care services contract.

(2) Assistance and support provided by a Health Board under subsection (1) is to be provided on such terms, including terms as to payment, as the Board think fit.

(3) In this section, “assistance” includes financial assistance.”.

22 Disqualification by the NHS Tribunal

(1) The 1978 Act is amended as follows.

(2) In section 29 (conditions of disqualification and persons subject to jurisdiction of NHS Tribunal)—

(a) for subsection (2) substitute—

“(2) If the Tribunal receive from a Health Board representations that a person—

(a) who has applied to be included; or
(b) who is included,

in any list meets any of the conditions for disqualification, the Tribunal shall inquire into the case.”;

(b) in subsection (4)(b), the words “the representations are that the second condition for disqualification is met and” are repealed;

(c) in subsection (6)—

(i) for the word “continued” substitute “inclusion or continued”;

(ii) for the words from “list”, where it second occurs, to the end substitute
“list—
(a) in relation to a list referred to in subsection (8)(a), (cc) or (e), perform;
(b) in relation to a list referred to in subsection (8)(c) or (d), undertake to
provide or are approved to assist in providing;”;

d) after subsection (7), insert—
“(7A) The third condition for disqualification is that the person concerned is
unsuitable (by virtue of professional or personal conduct) to be included, or to
continue to be included, in the list.”;

e) in subsection (8)—
(i) paragraph (b) is repealed;
(ii) for paragraphs (c) to (e) substitute—
“(c) a list of dental practitioners and bodies corporate referred to in section
25(1) undertaking to provide, and of persons who are approved to assist
in providing, general dental services;
(cc) a list of persons performing personal dental services;
(d) a list of medical practitioners and ophthalmic opticians undertaking to
provide, and of persons who are approved to assist in providing, general
ophthalmic services; or
(e) a list of registered pharmacists performing pharmaceutical care
services,”;

(f) in subsection (11)—
(i) the word “and” is repealed;
(ii) at the end insert “; and cases in which representations are made that the
third condition for disqualification is met are referred to below as
unsuitability cases”.

(3) In section 29A (cases before Tribunal: supplementary provision)—
(a) in subsection (1), after “the second condition for disqualification” insert “or, as
the case may be, the third condition for disqualification”;

(b) after subsection (1), insert—
“(1A) A body corporate entitled, by virtue of section 43 of the Dentists Act 1984
(c.24), to carry on the business of dentistry is to be treated for the purposes of
this group of sections as meeting the second condition for disqualification or,
as the case may be, the third condition for disqualification if any director meets
that condition (whether or not he first met that condition when he was a
director).”;

(ba) in subsection (3)—
(i) in paragraph (a), after the word “providing,” insert “assisting in
providing,”;

(ii) in paragraph (b), after the word “provision,” insert “assistance in
provision,”;
(c) in subsection (5), for the words “a fraud case” substitute “an unsuitability case, a fraud case or an efficiency case”;

(d) in subsection (6), after the word “in” insert “an unsuitability.”.

(4) In section 29B (disqualification by Tribunal)—

(a) in subsection (1), after paragraph (b) insert “;

(c) on inquiring into an unsuitability case, that the person meets the third condition for disqualification”;

(b) for subsection (2), substitute—

“(2) The Tribunal shall disqualify him for inclusion in—

(a) the list to which the case relates;

(b) all lists within the same paragraph of subsection (8) of section 29 as that list; and

(c) where the list to which the case relates is a list referred to in—

(i) paragraph (c) of that subsection, all lists within paragraph (cc) of that subsection;

(ii) that paragraph (cc), all lists within that paragraph (c).”;

(c) in subsection (4), for the word “any” substitute “a”.

(5) In section 29C (conditional disqualification)—

(a) in subsection (2)—

(i) the word “or” following paragraph (a) is repealed;

(ii) after paragraph (b), insert “;

(c) ensuring that the person—

(i) performs, undertakes to provide or assists in providing only services specified (or of a description specified) in the condition;

(ii) undertakes an activity (or course of activity) of a personal or professional nature, or refrains from conduct of a personal or professional nature, so specified (or of a description so specified)”;

(b) in subsection (5)(aa), for the words “17P” substitute “17F, 17P or 17W or this Part”.

(6) In section 32(2) (regulations: inquiry into more than one category of case), for the words “both an efficiency case and a fraud case” substitute “an efficiency case and a fraud case or an unsuitability case or any other combination of more than one such category of case”.

(7) In section 32A (interim suspension by the Tribunal)—

(a) in subsection (2), for the words from “services” to the end substitute “—

(a) services of the kind to which the case in question, or the case to which the review in question, relates; and

(b) if the services are either general dental services or personal dental services, both general dental services and personal dental services.”;

(b) in subsection (2A)—
(i) in paragraph (a), after the words “primary medical services” insert “pharmaceutical care services”;

(ii) for paragraph (b), substitute “or

(b) that it is otherwise in the public interest to do so.”;

(c) in subsection (6)(a), for the words from “a list” to “services” substitute—

“(i) a list of persons performing;

(ii) a list of persons undertaking to provide and of persons approved to assist in providing,

services”;

(d) after subsection (6), insert—

“(7) Regulations may provide that where a Health Board, in accordance with regulations made under section 17F, 17P, 17W, 25(2) or 26(2), suspend a person from a list prepared under regulations made under the section in question and the Board apply to the Tribunal for a direction to be made under subsection (2) in relation to the person to whom the suspension applies, the suspension may continue until the Tribunal determine the application.”.

23 Corresponding provision in England or Wales or Northern Ireland

For section 32D of the 1978 Act (suspension provisions in England and Wales or Northern Ireland), substitute—

“32D Corresponding provision in England or Wales or Northern Ireland

(1) This section applies where it appears to the Scottish Ministers that there is provision in England or Wales or Northern Ireland under which a person may be dealt with in any way which corresponds (whether or not exactly) with a way in which a person may be dealt with under sections 29 to 32B.

(2) A decision in England or Wales or Northern Ireland to deal with such a person in such a way is referred to in this section as a “corresponding decision”.

(3) If this section applies, the Scottish Ministers may make regulations providing for the effect to be given in Scotland to a corresponding decision; and where the decision corresponds (whether or not exactly) with a decision which may be made under section 29C or (so far as relating to conditional disqualification) the regulations may provide for the effect to be given to be determined in the prescribed manner by the Scottish Ministers.

(4) That effect need not be the same as the effect of the corresponding decision in the place where it was made.”.
PART 5

MISCELLANEOUS

Infection with hepatitis C as a result of NHS treatment etc.

24 Payments to certain persons infected with hepatitis C as a result of NHS treatment etc.

(1) The Scottish Ministers may make a scheme for the making of payments by them, or out of money provided by them, to, or in respect of—

(ya) persons who—

(a) before 1st September 1991, were treated anywhere in the United Kingdom under the National Health Service by way of the receipt of blood, tissue or a blood product; and

(b) as a result of that treatment, became infected with the hepatitis C virus;

(za) persons who—

(i) became infected with the hepatitis C virus by transmission of the virus by means specified in the scheme from a person who before 1st September 1991 was treated anywhere in the United Kingdom under the National Health Service by way of the receipt of blood, tissue or a blood product and as a result of that treatment became infected with the hepatitis C virus;

(ii) were at the time of transmission in a relationship mentioned in subsection (1A) with the person from whom the virus was transmitted; and

(iii) did not die before 29th August 2003.

(1A) The relationships referred to in subsection (1)(za)(ii) are—

(a) spouse or civil partner;

(b) person who was living with the person from whom the virus was transmitted as husband or wife or in a relationship which had the characteristics of the relationship between civil partners (or if the person from whom the virus was transmitted was in hospital immediately before death, had been so living when that person was admitted to hospital);

(c) other cohabitant (whether or not of the same sex as the person from whom the virus was transmitted);

(d) where the person from whom the virus was transmitted was a mother, a son or daughter of the mother;

(e) such other relationship as the scheme may specify; and the scheme may specify or elaborate the meaning of relationship for this purpose.

(2) A scheme under this section must—

(a) provide that the questions of whether—

(i) a person became infected with the hepatitis C virus as a result of treatment such as is mentioned in subsection (1)(ya)(a) before the date mentioned there; and

(ii) a person became infected with the virus by transmission of it by means specified in the scheme from a person who became infected as mentioned in sub-paragraph (i),
are to be determined on the balance of probabilities;

(b) provide that a person is not eligible for the making of a payment under the scheme unless, when the claim for the payment is made or, in the case of a claim made in respect of a dead person, when the person died either—

(i) the person’s sole or main residence is or was in Scotland; or

(ii) the person’s sole or main residence is or was outside the United Kingdom but, immediately before acquiring such sole or main residence, the person’s sole or main residence is or was in Scotland;

(c) provide for the procedure to be followed in relation to claims under the scheme (including the time within which claims must be made and matters relating to the provision of information) and the determination of such claims; and

(d) provide that a claim may be made in respect of a dead person, without such a claim having to have been made prior to that person’s death.

(3) Without prejudice to the generality of subsection (1), a scheme under this section may—

(za) specify conditions for eligibility for the making of a claim by another person under the scheme in respect of a person falling within subsection (1)(za) who has died without having made a claim under the scheme;

(a) specify conditions for eligibility for the making of a payment under the scheme (and may specify different conditions in relation to different payments);

(b) provide that the making of a claim, or the receipt of a payment, under the scheme is not to prejudice the right of any person to institute or carry on proceedings in relation to the matter which is the subject of the claim or payment;

(c) appoint a person (other than a Minister of the Crown) to manage the scheme on behalf of the Scottish Ministers;

(d) confer functions on the Scottish Ministers or any person appointed under paragraph (c);

(e) provide for any function so conferred on the Scottish Ministers to be carried out on their behalf by any person appointed under paragraph (c); and

(f) make transitional, transitory or saving provision.

(4) Provision such as is mentioned in subsection (3)(c) or (e) does not affect the responsibility of the Scottish Ministers for the management of the scheme or the carrying out of the functions.

(5) The Scottish Ministers may revoke or amend a scheme under this section.

(6) The Scottish Ministers must publish a scheme under this section in such manner as they consider appropriate.

Amendment of Regulation of Care (Scotland) Act 2001

25 Independent health care services

In section 2(5) of the 2001 Act (meaning of “independent health care service”), after paragraph (d) insert “,

but a service may be excepted from this definition by regulations”.

895
26 Implementation of certain decisions under the 2001 Act

(1) The 2001 Act is amended as follows.

(2) In section 16 (right to make representations to Scottish Commission for the Regulation of Care as respects proposals under Part 1), for subsection (2) substitute—

“(2) Where such a notice has been given—

(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the person to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) that person notifies the Commission in writing that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(2A) In section 37 (right to make representations to Commission under Part 2 as respects conditions), for subsection (2) substitute—

“(2) Where a notice to which this section applies has been given—

(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the local authority to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) the local authority notify the Commission that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(3) In section 48 (right to make representations to Scottish Social Services Council as respects proposal in notice under section 46(2) or 47(1)), for subsection (2) substitute—

“(2) Where such a notice has been given—

(a) the Council may not decide to implement the proposal until (whichever first occurs)—

(i) where the person to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;
(ii) that person notifies the Council in writing that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Council receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Council shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(4) In section 51(1) (appeal against decision of Council), for the words from “section” to “proposal” substitute “subsection (2) of section 50 of this Act of a decision mentioned in that subsection”.

26A Frequency of inspection of care services under the 2001 Act

(1) The 2001 Act is amended as follows.

(2) In section 25 (inspection of registered care services), after subsection (5) insert—

“(5A) The Scottish Ministers may, after consulting the Commission and thereafter such other persons (or groups of persons) as they consider appropriate, by order amend—

(a) subsection (3)(a) above by substituting for “twelve months” in either or both sub-paragraphs (i) and (ii) a different period (being a period which is not less than twelve months);

(b) subsection (5) above by substituting for “twelve months” in either or both paragraphs (a) and (b) a different period (being a period which is not less than twelve months).

(5B) An order under subsection (5A) above may make different provision for different purposes.”.

(3) In section 78 (orders and regulations), in subsection (2)(b), after the word “3” insert “or 25(5A)”.

27 Provision of information to the Scottish Social Services Council

After section 57 of the 2001 Act, insert—

“Notification of dismissal etc. for misconduct and provision of other information to Council

57A Notification of dismissal etc. to Council

The employer of a social service worker shall—

(a) on dismissing the social service worker on grounds of misconduct; or

(b) on the social service worker resigning or abandoning the worker’s position in circumstances where, but for the resignation or abandonment—

(i) the worker would have been dismissed on grounds of misconduct; or

(ii) dismissal on such grounds would have been considered by the employer,
forthwith notify the Council of the dismissal, resignation or abandonment; and the employer shall in doing so provide the Council with an account of the circumstances which led to the dismissal or which were present when the resignation or abandonment took place.

57B **Provision of other information to Council by employer**

The employer of a social service worker shall, when requested to do so by the Council, provide it with such information as respects the worker as it may reasonably require in connection with the exercise of the functions assigned to it under this Act or any other enactment.”.

10 **Child care agencies and housing support services**

28 **Registration of child care agencies and housing support services**

(1) Subsections (2) to (4) apply where—

(a) on 1st April 2003 a person was providing a care service to which the 2003 Order applies;

(b) the service—

(i) was, by virtue of article 3(1) of the 2003 Order, treated as if it were registered on that date; and

(ii) by virtue of article 3(2) of that Order, ceased on 1st October 2003 or on 1st April 2004 to be treated as if it were registered; and

(c) the person continued (or continues) to provide the service after it ceased to be so treated as if it were registered at any time during which it was not registered.

(2) If any of the circumstances mentioned in subsection (3) apply, the service is, subject to subsection (4), to be treated for all purposes as if it were registered—

(a) on 1st October 2003 or, as the case may be, 1st April 2004; and

(b) for the period during which there was (or is) a continuation of service as mentioned in subsection (1)(c).

(3) The circumstances are—

(a) that an application for registration of the service was made by the person before 30th September 2004;

(b) that—

(i) no application for registration of the service was made by the person before that date; and

(ii) the person ceased to provide the service before that date.

(4) The service ceases to be so treated as registered by virtue of subsection (2) on whichever of the following first occurs—

(a) where the Commission decides to refuse the application and—

(i) no appeal is made under section 20(1) of the 2001 Act against the decision, the fifteenth day after the day on which notice of the decision is given under section 17(3) of that Act;
(ii) such an appeal is made timeously and the sheriff confirms the decision, the day on which the sheriff does so;

(iii) such an appeal is made timeously but is abandoned, the day on which abandonment of the appeal is intimated to the sheriff clerk or if abandonment is not so intimated the day on which the sheriff deems the appeal to have been abandoned;

(b) where the Commission decides (other than in accordance with an application under section 14(1)(b) of the 2001 Act) to cancel the registration of the service effected by virtue of subsection (2) and—

(i) no appeal is made under section 20(1) of the 2001 Act against the decision, the fifteenth day after the day on which notice of the decision is given under section 17(3) of that Act;

(ii) such an appeal is made timeously and the sheriff confirms the decision, the day on which the sheriff does so;

(iii) such an appeal is made timeously but is abandoned, the day on which abandonment of the appeal is intimated to the sheriff clerk or if abandonment is not so intimated the day on which the sheriff deems the appeal to have been abandoned;

(c) where the sheriff grants an application by the Commission under section 18 of that Act for cancellation of the registration of the service, the day on which the sheriff does so;

(d) the day on which the person ceases to provide the service;

(e) 1st April 2006 or such later day as may be substituted for it by order made by the Scottish Ministers.

(5) In this section—

“the 2003 Order” means the Regulation of Care (Scotland) Act 2001 (Commencement No. 3 and Transitional Provisions) Order 2003 (SSI 2003 No. 205 (C.9));

“the Commission” means the Scottish Commission for the Regulation of Care;

“registered” means registered under Part 1 of the 2001 Act; and references to “registration” are to be construed accordingly.

29 Grants in respect of housing support services

Payments by a local authority—

(a) made out of sums, or descriptions of sum, received by it from the Scottish Ministers under section 91(1) of the Housing (Scotland) Act 2001 (asp 10); and

(b) purportedly made in compliance with the condition specified in paragraph 2 of the Schedule to the Housing (Scotland) Act 2001 (Payments out of Grants for Housing Support Services) Order 2003 (SSI 2003 No. 140),

which were not validly made merely by virtue of the condition not having been complied with are to be treated as having been validly made notwithstanding the non-compliance with the condition.
Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

(1) The Adults with Incapacity (Scotland) Act 2000 (asp 4) is amended as follows.

(2) In section 47 (authorisation of medical treatment)—
(a) in subsection (1)—
(i) for the words “the medical practitioner primarily responsible for the medical treatment of an adult” substitute “any of the persons mentioned in subsection (1A)”;
(ii) in paragraph (a), for the words “the adult” substitute “an adult”;
(b) after that subsection, insert—
“(1A) The persons are—
(a) the medical practitioner primarily responsible for the medical treatment of the adult;
(b) a person who is—
(i) a dental practitioner;
(ii) an ophthalmic optician;
(iii) a registered nurse; or
(iv) an individual who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfies such requirements as may be so prescribed and who is primarily responsible for medical treatment of the kind in question.”;
(c) in subsection (2)—
(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who by virtue of subsection (1) has issued a certificate for the purposes of that subsection”; 
(ii) for the words “medical treatment” where they second occur substitute “the medical treatment in question”; 
(d) in subsection (3)—
(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person on whom that authority is conferred”;
(ii) for the words “medical treatment”, where they second occur, substitute “the medical treatment in question”;
(e) in subsection (5)—
(i) in paragraph (a), for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issues the certificate”; 
(ii) in paragraph (b), for the words “does not exceed one year from” substitute “does not exceed—

Authority of medical treatment
(i) one year; or

(ii) if, in the opinion of the person issuing the certificate any of the conditions or circumstances prescribed by the Scottish Ministers applies as respects the adult, 3 years,

from”;

(f) in subsection (6)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued it”;

(ii) in paragraph (b), for the words “not exceeding one year from” substitute “not exceeding—

(i) one year; or

(ii) if, in the opinion of that person any of the conditions or circumstances prescribed by the Scottish Ministers apply as respects the adult, 3 years,

from”;

(g) after subsection (10) insert—

“(11) In subsection (1A)—

“dental practitioner” has the same meaning as in section 108(1) of the National Health Service (Scotland) Act 1978 (c.29);

“ophthalmic optician” means a person registered in either of the registers kept under section 7 of the Opticians Act 1989 (c.44) of ophthalmic opticians.”.

(3) In section 49(1) (medical treatment where there is an application for intervention or guardianship order)—

(a) for the words “Section 47(2)” substitute “Subsection (2) of section 47”;

(b) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person on whom authority is conferred by that subsection”.

(4) In section 50 (medical treatment where guardian etc. has been appointed)—

(a) in subsection (2)—

(i) in paragraph (b), for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) in paragraph (c), for the words “medical practitioner” substitute “person”;

(b) in subsection (3)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) for the words “any person having an interest” substitute “the medical practitioner primarily responsible for the medical treatment of the adult or any person having an interest”;

(c) in subsection (4)—
(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) for the words “medical practitioner”, where they second occur, substitute “person who issued the certificate”;

(iii) for the words “a medical practitioner (the “nominated medical practitioner”)” substitute “a practitioner who the Commission consider has professional knowledge or expertise relevant to medical treatment of the kind in question (the “nominated practitioner”);

(d) in subsection (5)—

(i) for the words “nominated medical practitioner” substitute “nominated practitioner”;

(ii) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(e) in subsection (6)—

(i) for the words “nominated medical practitioner” substitute “nominated practitioner”;

(ii) after the words “personal welfare of the adult” insert “(including, where the certificate issued for the purposes of section 47(1) was issued by another person, that person)”;

(f) in subsection (9)—

(i) for the words “medical practitioners” substitute “practitioners”;

(ii) for the words “medical practitioner” substitute “practitioner”.

Appeals under Public Health (Scotland) Act 1897

30A Amendment of Public Health (Scotland) Act 1897: appeal against certain orders etc.

After section 156 of the Public Health (Scotland) Act 1897 (c.38), insert—

“156A Appeal to sheriff or sheriff principal in certain cases: sections 54, 55 and 96

(1) Any person in respect of whom—

(a) an order under section 54(1) (for removal to a hospital) or under section 54(3) (for transfer to another hospital) (referred to in this section and section 156C as a “section 54 order”);

(b) a direction under section 55(1) (for detention in a hospital) or under section 55(3) (for removal to another hospital) (referred to in this section and section 156C as a “section 55 direction”); or

(c) a decision under section 96 (for removal to a hospital) (referred to in this section and sections 156B and 156C as a “section 96 decision”),
is made, or any person having an interest in the welfare of the person in respect
of whom the order, the direction or, as the case may be, the decision is made,
may appeal under this section against the order, the direction or, as the case
may be, the decision.

(2) An appeal under this section against—

(a) a section 54 order or a section 55 direction by a sheriff may be made to
the sheriff principal;

(b) a section 54 order or a section 55 direction by a justice may be made to
the sheriff principal of either of the sheriffdoms mentioned in subsection
(3);

(c) a section 96 decision may be made to the sheriff of either of those
sheriffdoms.

(3) The sheriffdoms are—

(a) the sheriffdom in which the person (in respect of whom the section 54
order, section 55 direction or section 96 decision in question is made) is
resident immediately before it is made;

(b) the sheriffdom in which the hospital (in which that person is detained
pursuant to the section 54 order, section 55 direction or section 96
decision in question) is situated.

(4) An appeal under this section may be made on either or both of the following
grounds—

(a) that the section 54 order, section 55 direction or section 96 decision in
question was based on an error of law;

(b) that the section 54 order, section 55 direction or section 96 decision in
question was not supported by the facts found to be established by the
sheriff or justice who made the order or direction or, as the case may be,
the local authority who made the decision.

(5) An appeal against a section 54 order, section 55 direction or section 96
decision may be made before the expiry of the period of 21 days beginning
with the day on which the order, the direction or, as the case may be, the
decision is made.

(6) An appeal against a section 54 order or section 55 direction by a justice or a
section 96 decision is to be made by way of summary application.

(7) In an appeal under this section against a section 54 order, section 55 direction
or section 96 decision, the sheriff principal or, as the case may be, the sheriff
may—

(a) confirm the order, the direction or, as the case may be, the decision;

(b) direct that the order, the direction or, as the case may be, the decision
ceases to have effect;

(c) make such other order or direction as the sheriff principal or, as the case
may be, the sheriff thinks fit.
156B Further appeal to sheriff principal: section 96 decision

(1) Where, in an appeal under section 156A against a section 96 decision, the sheriff confirms the decision, the person in respect of whom the section 96 decision was made, or any person having an interest in the welfare of that person, may appeal to the sheriff principal against the decision of the sheriff in the appeal on either or both of the grounds mentioned in subsection (2).

(2) The grounds are—

(a) that the decision of the sheriff in the appeal under section 156A was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff in the appeal.

(3) An appeal under this section may be made before the expiry of the period of 21 days beginning with the day on which the decision of the sheriff in the appeal under section 156A is made.

(4) In an appeal under this section, the sheriff principal—

(a) may allow the appeal and when doing so must direct that the section 96 decision ceases to have effect;

(b) may refuse the appeal and confirm the decision of the sheriff;

(c) may make such other order or direction as the sheriff principal thinks fit.

156C Further appeal to Court of Session: sections 54, 55 and 96

(1) Where, in an appeal under section 156A against a section 54 order or section 55 direction, the sheriff principal confirms the order or, as the case may be, the direction, the person in respect of whom the decision in the appeal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

(a) that the decision of the sheriff principal in the appeal under section 156A was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.

(2) Where, in an appeal under section 156B against a decision of the sheriff in an appeal under section 156A, the sheriff principal confirms the decision of the sheriff in the appeal under section 156A, the person in respect of whom the decision of the sheriff principal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

(a) that the decision of the sheriff principal in the appeal under section 156B was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.
156D Effect of appeal in relation to section 54 order, section 55 direction or section 96 decision

A section 54 order, a section 55 direction or a section 96 decision may be given effect notwithstanding that an appeal may be or is made against, or in relation to, it under this Act.”.

Joint ventures

31 Joint ventures

(1) After section 84A of the 1978 Act, insert—

“Joint ventures

84B Joint ventures

(1) The Scottish Ministers may do any (or all) of the following—

(a) form or participate in forming companies to provide facilities or services for persons or groups of persons exercising functions, or otherwise providing services, under this Act;

(b) participate in companies providing facilities or services for persons or groups of persons falling within paragraph (a);

(c) with a view to securing or facilitating the provision by companies of facilities or services for persons or groups of persons falling within paragraph (a)—

(i) invest in the companies (whether by acquiring assets, securities or rights or otherwise);

(ii) provide loans and guarantees and make other kinds of financial provision to or in respect of them.

(2) For the purpose of subsection (1), it is immaterial that the facilities or services provided or to be provided by a company are not provided or to be provided—

(a) only to persons or groups of persons exercising functions, or otherwise providing services, under this Act; or

(b) to such persons or groups of persons only in that capacity.

(3) In this section—

“companies” means companies within the meaning of the Companies Act 1985 (c.6);

“facilities” includes the provision of (or the use of) premises, goods, equipment, materials, vehicles, plant or apparatus.”.

(2) After section 7(7B) of the Health and Medicines Act 1988 (c.49) (powers of the Secretary of State for financing the health service), insert—

“(7C) The power specified in paragraph (g) of subsection (2) above includes power for the Scottish Ministers—

(a) to form or participate in forming companies,

(b) to—

(i) participate in companies,
(ii) invest in companies (whether by acquiring assets, securities or rights or otherwise),

(iii) provide loans and guarantees and make other kinds of financial provision to or in respect of companies,

where it appears to them that to do so is calculated to facilitate, or to be conducive or incidental to, the exercise of any power conferred by that subsection.

(7D) In subsection (7C) above “companies” means companies within the meaning of the Companies Act 1985; and that subsection is without prejudice to the generality of subsection (2) above.”.

Scottish Hospital Endowments Research Trust

32 Scottish Hospital Endowments Research Trust

(1) The 1978 Act is amended as follows.

(2) In section 12 (establishment and functions of the Trust)—

(a) subsections (1) and (2) are repealed;

(b) in subsection (3), for the words “the Research Trust” substitute “the Scottish Hospital Endowments Research Trust (referred to in this Act as “the Research Trust”);”;

(c) in subsection (4B), the words from “Subject to” to “activity,” are repealed;

(d) subsection (5) is repealed;

(e) in subsection (6), the words from “, and shall send” to the end are repealed;

(f) subsection (6A) is repealed;

(g) for subsection (7), substitute—

“(7) The Research Trust shall prepare an annual report of their proceedings which shall include an abstract of their accounts.”;

(h) after that subsection, insert—

“(8) Schedule 7 shall have effect in relation to the Research Trust.

(3) In Schedule 7 (further provision as respects the Trust)—

(a) paragraph 1 is repealed;

(b) for paragraph 3, substitute—

“Members

3 Subject to paragraph 3A, the Research Trust shall consist of such number of members appointed by the Trust as the Trust may determine.

3A(1) The persons who are the members of the Research Trust immediately before the day on which section 32 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00) comes into force shall, on that day, continue to be members (the “continuing members”).

(2) The terms and conditions of appointment of the continuing members shall, on the 90th day after whichever of the following occurs first—
(a) the day on which that section comes into force; or

(b) the day on which the Research Trust first make standing orders under paragraph 3F,

be the terms and conditions of appointment the Research Trust determine for the members appointed by them under paragraph 3B(1).

(3) The provisions of paragraphs 3B(2) and (3) to 3D and 3F shall apply to the continuing members as they apply to members appointed under paragraph 3; and in the application of paragraph 3C any period of appointment of a continuing member as a member (before he became a continuing member by virtue of sub-paragraph (1)) shall count for the purposes of determining eligibility for re-appointment in accordance with paragraph 3C.

Terms of office etc.

3B(1) Subject to the provisions of this Schedule, the appointment of a member under paragraph 3 shall be on such terms and conditions as the Research Trust may determine, but shall not be for a period exceeding 4 years.

(2) A person holds and vacates office as member in accordance with the person’s terms of appointment.

(3) A person may resign office as member at any time by notice in writing to the Research Trust.

Eligibility for re-appointment

3C A person who ceases to be a member of the Research Trust shall be eligible for re-appointment, but only once.

Payments to members

3D The Research Trust may make payments from their funds to their members in respect of any loss of earnings the members would otherwise have made or any additional expenses to which they would not otherwise have been subject, being loss of expenses necessarily suffered or incurred for the purpose of enabling the members to discharge their duties as members of the Trust.

Staff

3E(1) The Research Trust may appoint such staff, on such terms and conditions (including as to remuneration and allowances), as they consider appropriate.

(2) The Research Trust may—

(a) pay, or make arrangements for the payment of;

(b) make payments towards the provision of; and

(c) provide and maintain schemes (whether contributory or not) for the payment of,

such pensions, allowances and gratuities to or in respect of such of their employees, or former employees, as they may determine.

(3) The reference in sub-paragraph (1) to pensions, allowances and gratuities includes a reference to pensions, allowances and gratuities by way of compensation for loss of employment or reduction in remuneration.
Standing orders

3F (1) The Research Trust—

(a) shall make and maintain standing orders regulating—

(i) the appointment by them of members;

(ii) the appointment of a member as convener;

(iii) the terms and conditions of office of members and convener;

(iv) their procedure;

(v) such other matters as the Research Trust consider appropriate;

(b) may, subject to sub-sub-paragraph (a), amend such standing orders from time to time.

(2) The first set of standing orders under this paragraph shall be made before the expiry of the period of 90 days beginning with the day on which section 32 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00) comes into force.

(3) Subject to the provisions of this Schedule, the Research Trust may regulate their own procedure.

(4) The validity of any proceedings of the Research Trust shall not be affected by any vacancy in membership nor by any defect in the appointment of a member.

Powers etc.

3G The Research Trust may do anything which appears to them to be necessary or expedient for the purpose of, or in connection with, the exercise of their functions.

(c) in paragraph 6, the words from “, unless” to “case,“, where it first occurs, are repealed;

(d) paragraph 7 is repealed.

PART 6
GENERAL

Ancillary provision

(1) The Scottish Ministers may by order make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.

(2) An order under this section may—

(a) make different provision for different purposes;

(b) modify any enactment, instrument or document.

Regulations or orders

(1) Any power conferred by this Act on the Scottish Ministers to make orders or regulations—

(a) must be exercised by statutory instrument;
(b) may be exercised so as to make different provision for different purposes.

(2) A statutory instrument containing an order or regulations made under this Act (except an order under section 37(3)) is, subject to subsection (3), subject to annulment in pursuance of a resolution of the Parliament.

(3) A statutory instrument containing—

(a) regulations under section 3(3) or 4(2) or (7) or paragraph 2, 4(1), 5(2), 12 or 13 of schedule 1 or an order under section 28(4)(e);

(b) an order under section 33 containing provisions which add to, replace or omit any part of the text of an Act,

is not to be made unless a draft of the instrument has been laid before, and approved by resolution of, the Parliament.

(4) The Scottish Ministers must consult such persons as they consider appropriate before laying a draft of a statutory instrument containing regulations under section 3(3) or 4(2) or (7).

35 Interpretation

In this Act—

“the 1978 Act” means the National Health Service (Scotland) Act 1978 (c.29);

“the 2001 Act” means the Regulation of Care (Scotland) Act 2001 (asp 8);

“council” means a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994 (c.39);

“prescribed” means prescribed by regulations made by the Scottish Ministers.

36 Minor and consequential amendments and repeals

(1) Schedule 2 contains minor amendments and amendments consequential on the provisions of this Act.

(2) The enactments specified in column 1 of schedule 3 are repealed to the extent specified in column 2.

37 Short title and commencement

(1) This Act may be cited as the Smoking, Health and Social Care (Scotland) Act 2005.

(2) Sections 28, 29, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36 and paragraph 1(1A) and (1C) of schedule 2 come into force on the day after Royal Assent.

(3) The remaining provisions of this Act, except this section and sections 33 and 34, come into force on such day as the Scottish Ministers may by order appoint, and an order under this section appointing a day for sections 1 to 8 or schedule 1 may specify the time in the day for the commencement of those provisions.

(4) Different days may be appointed under subsection (3) for different purposes.
SCHEDULE 1
(introduced by section 5)

FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2, AND 3

Power to give fixed penalty notices

1 (1) An authorised officer of a council may, if having reason to believe that a person is committing or has committed an offence under section 1, 2 or 3 in no-smoking premises within the area of the council, give that person a fixed penalty notice in relation to that offence.

(2) A constable may, if having reason to believe that a person is committing or has committed an offence under section 1, 2 or 3, give that person a fixed penalty notice in relation to that offence.

(3) In this schedule, “fixed penalty notice” means a notice offering a person the opportunity of discharging any liability to conviction for an offence under section 1, 2 or 3 by payment of a fixed penalty.

2 A fixed penalty notice for an offence under section 1, 2 or 3 may not be given after such time relating to the offence as may be prescribed.

Contents of fixed penalty notice

3 (1) A fixed penalty notice must identify the offence to which it relates and give reasonable particulars of the circumstances alleged to constitute that offence.

(2) A fixed penalty notice must also state—

   (a) the amount of the penalty and the period within which it may be paid;
   (b) the discounted amount and the period within which it may be paid;
   (c) the person to whom and the address at which payment may be made;
   (d) the method or methods by which payment may be made;
   (e) the person to whom and the address at which any representations relating to the notice may be made;
   (f) the consequences of not making a payment within the period for payment.

(3) The person specified under sub-paragraph (2)(c) must be the council in the area of which the offence was alleged to have been committed or a person acting on its behalf.

The amount of the penalty and the period for payment

4 (1) The fixed penalty for an offence under section 1, 2 or 3 is (subject to paragraph 5) such amount as may be prescribed.

(2) The period for payment of the fixed penalty is the period of 29 days beginning with the day on which the notice is given.

(3) The council may extend the period for paying the fixed penalty in any particular case if it considers it appropriate to do so.
Smoking, Health and Social Care (Scotland) Bill
Schedule 1—Fixed penalty for offences under sections 1, 2, and 3

The discounted amount

5 (1) A discounted amount is payable instead of the amount prescribed under paragraph 4(1) if payment is made before the end of the period of 15 days beginning with the day on which the notice is given.

(2) The discounted amount for a fixed penalty offence is such amount as may be prescribed.

(3) If the last day of the period specified in sub-paragraph (1) does not fall on a working day, the period for payment of the discounted amount is extended until the end of the next working day.

Effect of notice and payment of penalty

6 (1) This paragraph applies where a person is served with a fixed penalty notice in respect of a fixed penalty offence.

(2) No proceedings for the offence may be commenced before the end of the period for payment of the penalty.

(3) No such proceedings may be commenced or continued if payment of the penalty is made before the end of that period or is accepted by the council after that time.

(4) Payment of the discounted amount counts for the purposes of sub-paragraph (3) only if it is made before the end of the period for payment of the discounted amount.

(5) In proceedings for the offence, a certificate which—

(a) purports to be signed by or on behalf of a person having responsibility for the financial affairs of the council; and

(b) states that payment of an amount specified in the certificate was or was not received by a date so specified,

is sufficient evidence of the facts stated.

Request for hearing

7 (1) A person to whom a fixed penalty notice has been given may, before the expiry of the period for payment of the penalty, give notice requesting a hearing in respect of the offence to which the fixed penalty notice relates.

(2) A notice requesting a hearing under sub-paragraph (1) must be in writing and must be sent by post or delivered to the person specified under paragraph 3(2)(c) in the fixed penalty notice at the address so specified.

(3) For the purposes of this paragraph and unless the contrary is proved, the sending of a notice by post is deemed to have been effected at the time at which the notice would be delivered in the ordinary course of post.

(4) Where a person has requested a hearing in accordance with this section—

(a) the council must hold the hearing;

(b) a person authorised for the purpose by the council of the area in which the offence was committed must notify the procurator fiscal of the request; and

(c) the period for payment of the fixed penalty must be calculated so that the period beginning with the giving of the notice under this paragraph and ending with the
receipt by the person who gave that notice of the decision reached at the hearing is left out of account.

**Power to withdraw notices**

8 (1) If the council considers (whether after holding a hearing under paragraph 7 or not) that a fixed penalty notice which has been given ought not to have been given, it may give to the person to whom it was given a notice withdrawing the fixed penalty notice.

(2) Where a notice under sub-paragraph (1) is given—

(a) the council must repay any amount which has been paid by way of penalty in pursuance of the fixed penalty notice; and

(b) no proceedings are to be commenced or continued against that person for the offence in question.

(3) The council must consider any representations made by or on behalf of the recipient of a fixed penalty notice and decide in all the circumstances whether to withdraw the notice.

**Effect of prosecution on notice**

9 Where proceedings for an offence in respect of which a fixed penalty notice has been given are commenced, the notice is to be treated as withdrawn.

**Recovery of unpaid fixed penalties**

10 Subject to paragraphs 8 and 9, where a fixed penalty remains unpaid after the expiry of the period for payment of the penalty it is enforceable in like manner as an extract registered decree arbitral bearing a warrant for execution issued by the sheriff for any sheriffdom.

**Judicial determination of enforcement of fixed penalty**

11 (1) A person against whom a fixed penalty bears to be enforceable under paragraph 10 may apply to the sheriff by summary application for a declaration that the fixed penalty is not enforceable on the ground that—

(a) the fixed penalty was paid before the expiry of the period for paying; or

(b) the person has made a request for a hearing in accordance with paragraph 7 and no hearing has been held within a reasonable time after the request.

(2) On an application under sub-paragraph (1), the sheriff may declare—

(a) that the person has or, as the case may be, has not paid the fixed penalty within the period for payment of the penalty;

(b) that the person has or, as the case may be, has not requested a hearing in accordance with paragraph 7;

(c) that, where such a request has been made, a hearing has or, as the case may be, has not been held within a reasonable time after the request; and

accordingly, that the fixed penalty is or, as the case may be, is not enforceable.
General and supplementary

12 The Scottish Ministers may make regulations about—

(a) the application by councils of fixed penalties paid under this schedule;

(b) the keeping of accounts, and the preparation and publication of statements of account, relating to fixed penalties under this schedule.

13 (1) Fixed penalty notices may not be given in such circumstances as may be prescribed.

(2) The method or methods by which fixed penalties may be paid may be prescribed.

(3) The Scottish Ministers may by regulations modify paragraph 4(2) or 5(1) so as to substitute a different period for the period for the time being specified there.

SCHEDULE 2
(introduced by section 36(1))

MINOR AND CONSEQUENTIAL AMENDMENTS

Public Health (Scotland) Act 1897 (c.38)

A1 In section 157 of the Public Health (Scotland) Act 1897, for the words “the preceding section” substitute “section 156 or as provided in sections 156A to 156C”.

National Health Service (Scotland) Act 1978 (c.29)

1 (1) The 1978 Act is amended as follows.

(1A) In section 2(1) (Health Boards and Special Health Boards), in each of paragraphs (a) and (b), for the words “under this Act” substitute “relating to the health service”.

(1B) In section 4 (Scottish Dental Practice Board)—

(a) in subsection (1A)—

(i) in paragraph (a), for the words from the second “to” to “he” substitute “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry to submit to the Board, in relation to treatment which he, or as the case may be, it”;

(ii) in paragraph (b), after the words “a dental practitioner” insert “or such a body corporate”;

(b) in subsection (1B), after the words “dental practitioner” insert “or body corporate”.

(1C) In section 10(3) (Common Services Agency), for the words “under this Act” substitute “relating to the health service”.

(2) In section 17AA(3) (meaning of “ophthalmic list” for purpose of section), in the definition of “ophthalmic list”—

(a) for the words from “a list” to the end of paragraph (a) substitute “—

(a) in relation to a list published in accordance with regulations made under paragraph (a) of section 26(2) of this Act, the first part of the list which is referred to in sub-paragraph (i) of that paragraph;”;
(b) at the beginning of each of paragraphs (b) and (c) insert “a list published in accordance with regulations made under”.

(2A) In section 17C(2A)(b)(ii) (other Part 1 services which may be included in arrangements for the provision of personal dental services), after the word “Part” insert “(but not pharmaceutical care services).”.

(2B) In section 17D (persons with whom agreements may be made)—

(a) in subsection (1)(b)(vi), for the words “an individual” substitute “a person”;

(b) in subsection (2)—

(i) in paragraph (b)(v) of the definition of “NHS employee”, for the words “an individual” substitute “a person”;

(ii) in paragraph (c)(i) of that definition, for the words from the beginning to “or” substitute “a dental practitioner or body corporate whose name is included in the first part of a list prepared under section 25(2) of this Act or in a list prepared under”;

(iii) in paragraph (c)(ii) of that definition, after the word “who” insert “, or body corporate which,”;

(iv) in paragraph (b) of the definition of “qualifying body”, for the words “which, in accordance with the provisions of Part IV of the Dentists Act 1984, is entitled to carry on the business of dentistry” substitute “entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(v) in the definition of “section 17C employee”, for the words from “by” to the end substitute “by a person providing services in accordance with the arrangements”.

(3) In section 28A(1) (remuneration for provision of Part II services), for the words “, general ophthalmic services or pharmaceutical services” substitute “or general ophthalmic services”.

(4) In section 28C(3) (indemnity cover)—

(a) in the definition of “list”, for the words from “has” to the end substitute “means—

(a) the first part of a list prepared under section 25(2);

(b) the first part of a list prepared under section 26(2)”;

(b) in the definition of “Part II services”, for the words “general dental services, general ophthalmic services or pharmaceutical services” substitute “general dental services or general ophthalmic services”.

(5) In section 29(8A) (meaning of health care professional in section 29(8)(a)), for the words “17D” substitute “17P”.

(6) In section 30(1) (review etc. of disqualification), for the words “any disqualification, conditional disqualification or declaration of unfitness” substitute “a disqualification or conditional disqualification”.

(7) In section 32(1)(a) (regulations as to sections 29 and 31), for the words “31” substitute “30”.

(8) In section 32A(3) (interim suspension), after paragraph (a) insert “and”.

(9) In section 33(1)(a), after paragraph (a) insert “and”.

(10) In section 33(1)(b)(ii), after “date” insert “or”.
(9) In section 32E(1) (payments in consequence of suspension), for the words “32D(2)” substitute “32D(3)”. 

(10) In section 33 (powers of Scottish Ministers where services are inadequate), for the words from “any list” to the end of paragraph (d) substitute “—

(a) the first part of any list prepared under section 25(2), being the part which is of dental practitioners and bodies corporate referred to in section 25(1) who undertake to provide general dental services;

(b) the first part of any list prepared under section 26(2), being the part which is of medical practitioners and ophthalmic opticians who undertake to provide general ophthalmic services.”.

(10A) In section 64(5) (permission for use of facilities in private practice), in paragraph (b), after the word “provide” insert “dental.”.

(11) In section 85AA (means of meeting expenditure of Health Boards out of public funds)—

(a) in subsection (2)(b), for the words “paragraphs (b) to (e)” substitute “paragraph (b)”;

(b) in subsection (4)—

(i) in paragraph (a)(ii), for the words “paragraphs (b) or (c)” substitute “paragraph (b)”;

(ii) paragraphs (c) and (e) are repealed;

(c) in subsection (5), for the words “paragraphs (b) to (e)” substitute “paragraph (b)”.

(12) In section 85AB (further provision as to expenditure on drugs)—

(a) in subsection (6), for the words “pharmaceutical services” substitute “pharmaceutical care services”;

(b) after that subsection insert—

“(7) In this section, “drugs” includes—

(a) medicines; and

(b) appliances included in a list specified in directions given under regulations made under section 2CA(5).”.

(13) In section 108 (interpretation)—

(a) in subsection (1)—

(i) after the definition of “dispensing optician”, insert—

““Drug Tariff” means the Drug Tariff required to be prepared, maintained and published by the Scottish Ministers under section 17VA of this Act;”;

(ii) after the definition of “general medical services contract”, insert—

““general ophthalmic services” is to be construed in accordance with section 26(1F);”;

(iii) after the definition of “personal dental services”, insert—

““pharmaceutical care services” is to be construed in accordance with section 2CA(5);”.


“pharmaceutical care services contract” has the meaning given by section 17Q(2);”;

(iv) for the definition of “the Research Trust”, substitute—

““the Research Trust” means the Scottish Hospital Endowments Research Trust constituted under subsection (1) of section 12 of this Act (before the repeal of that subsection by section 32(2)(a) of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00);”;

(b) after that subsection, insert—

“(1A) References in this Act to “carrying on the business of dentistry” are to be construed in accordance with section 40 of the Dentists Act 1984 (c.24).”.

(14) In Schedule 8, in paragraph 8(2)(b), for the words “disqualification, conditional disqualification or declaration of unfitness” substitute “disqualification or conditional disqualification”.

**Health and Medicines Act 1988 (c.49)**

15 2 In section 17 of the Health and Medicines Act 1988—

(a) in subsection (1)—

(i) for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”;

(ii) after the words “1978” insert “(referred to in this section as “the 1978 Act”);

(iii) in paragraph (a), for the words from “or” to the end, substitute “or—

(i) in relation to section 17F of the 1978 Act, personal dental services;

(ii) in relation to section 17P of that Act, primary medical services;

(iii) in relation to section 17W of that Act, pharmaceutical care services”;

(b) in subsection (2)(a)(ii), for the words from “or,” to the end substitute “or, with any requirements placed on him by regulations made under section 17F, 17P, 17W, 25(2) or, as the case may be, 26(2) of the 1978 Act”;

(c) in subsection (2)(b)—

(i) after the words “dental practitioner” insert “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(ii) after the word “his” insert “or its”.

**National Health Service (Primary Care) Act 1997 (c.46)**

35 2A(1) The 1997 Act is amended as follows.

(2) In section 1 (pilot schemes)—

(a) in subsection (3)(b), after the word “services” insert “nor pharmaceutical care services”;

(b) in subsection (8) insert “;
“pharmaceutical care services” has the same meaning as for the purposes of Part 1 of the 1978 Act.”

(3) In section 3(3) (persons with whom pilot schemes for personal dental services may be made)—

(a) in paragraph (b) of the definition of “dental list”—

(i) after the word “Scotland,” insert “the first part of”;

(ii) for the words “section 25(2)(a)” insert “section 25(2)”;

(b) in the definition of “NHS employee”—

(i) in paragraph (b), after the words “dental practitioner” insert “or body corporate”;

(ii) in paragraph (c), after the word “who” insert “, or body corporate which,”.

(4) In section 17(5) (the Dental Practice Boards)—

(a) after the words “dental practitioner” insert “or body corporate”;

(b) after the word “he” insert “or it”.

Police Act 1997 (c.50)

3 In section 115 of the Police Act 1997 (enhanced criminal record certificates)—

(a) in subsection (6C) (as inserted by section 70(3)(c) of the Criminal Justice (Scotland) Act 2003 (asp 7))—

(i) for paragraph (b) substitute—

“(b) dental practitioners or bodies corporate undertaking to provide, and persons approved to assist in providing, general dental services;”;

(ii) in paragraph (c), after the word “provide” insert “, and persons approved to assist in providing;”;

(iii) paragraph (d) is repealed;

(b) in subsection (6D)(a) (as inserted by the said section 70(3)(c)), for the words “(c) or (d)” substitute “(b) or (c)”;

(c) in subsection (6E) (as inserted by the said section 70(3)(c)), for the words “section 17P of the National Health Service (Scotland) Act 1978 (persons performing primary medical services)” substitute “section 17F (persons performing personal dental services), 17P (persons performing primary medical services) or 17W (persons performing pharmaceutical care services) of the National Health Service (Scotland) Act 1978”.

The Scottish Public Services Ombudsman Act 2002 (asp 11)

4 In paragraph 14 of schedule 4 to the Scottish Public Services Ombudsman Act 2002, for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”.
## SCHEDULE 3
*(introduced by section 36(2))*

### REPEALS

<table>
<thead>
<tr>
<th>Enactment</th>
<th>Extent of repeal</th>
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| National Health Service (Scotland) Act 1978 (c.29) | In section 17C(6), the words “by a general dental practitioner”. Section 25(3) to (5). Sections 27 to 28. In section 28B(6), the words “Subject to section 25(3),”.
| | In section 29A, subsection (2) and in subsection (5), the words “(including provision modifying the effect of this Part)”.
| | Section 29B(3). In section 29B(4), the words “or declaration”.
| | In section 30(2), in paragraph (a) the words from “or” to the end of the paragraph, and the words from “, and, on a review” to the end of the subsection.
| | Section 30(4). In section 30(5), the words from “and” to the end. Section 30(6) and (7)(b) and (c) and the word “or” immediately preceding paragraph (b). Section 31.
| | In section 32A, in subsection (3) paragraph (c) and the word “and” immediately preceding that paragraph and in subsection (6) paragraph (b) and the word “, and” immediately preceding that paragraph.
| | In section 32B, in each of subsections (1) and (2)(a) the word “national” and subsection (3). Section 85AA(11).
| | In section 85AB(6), the words “section 85AA and”.
<p>| | In Schedule 8, paragraph 8(2A). |
| Health Services Act 1980 (c.53) | Section 20(2). In Schedule 6, paragraph 4. In Schedule 7, the entry for section 25(3) of the 1978 Act. |
| Health and Social Services and Social Security Adjudications Act 1983 (c.41) | Section 16(a). |
| Dentists Act 1984 (c.24) | In Schedule 5, paragraph 12. |
| Health and Social Security Act 1984 (c.48) | In Schedule 1, in Part II, paragraphs 2, 3 and 4. |</p>
<table>
<thead>
<tr>
<th>Enactment</th>
<th>Extent of repeal</th>
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<tbody>
<tr>
<td>National Health Service (Amendment) Act 1986 (c.66)</td>
<td>Section 3(3).</td>
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<tr>
<td>Health and Medicines Act 1988 (c.49)</td>
<td>Section 8.</td>
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<td>Section 11(4) to (6).</td>
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<td>In section 17(3A) the words from “or section 27A” to the end.</td>
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<td>In Schedule 2, in paragraph 15, sub-paragraphs (2) and (3).</td>
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|                                                                          | In Schedule 3, the entry concerning section 70(1) of the 1978 Act; and in the entry concerning Schedule 11, the words “the words “dental or” and”.
| National Health Service and Community Care Act 1990 (c.19)               | Section 40.                                                                       |
|                                                                          | In Schedule 9, paragraph 19(6), (7) and (8).                                      |
| National Health Service (Primary Care) Act 1997 (c.46)                    | In section 1(8), the words “by a general dental practitioner”.                    |
|                                                                          | Section 27(2).                                                                    |
|                                                                          | Section 28(2).                                                                    |
|                                                                          | Section 29(2).                                                                    |
|                                                                          | In Schedule 2, paragraphs 43, 44 and 45.                                          |
|                                                                          | In Schedule 3, the entry concerning section 25(2)(c) of the 1978 Act.             |
| Health Act 1999 (c.8)                                                    | Section 56(3) and (4).                                                            |
|                                                                          | In Schedule 4, paragraphs 49, 51(d) and (g), 52(c) and 53.                        |
|                                                                          | In Schedule 5, in the entry concerning section 32A of the 1978 Act, the words “and, in subsection (6)(a), “prepared under this Part of this Act””. |
| Public Finance and Accountability (Scotland) Act 2000 (asp 1)             | In schedule 4, paragraph 4(2).                                                    |
| Ethical Standards in Public Life etc. (Scotland) Act 2000 (asp 7)         | In schedule 3, the entry relating to the Scottish Hospital Endowments Research Trust. |
| Community Care and Health (Scotland) Act 2002 (asp 5)                     | In schedule 2, paragraphs 2(6)(c), (7), (8), (9)(b), (10)(b) and (11).           |
| Freedom of Information (Scotland) Act 2002 (asp 13)                      | In schedule 1, paragraph 43.                                                     |
| Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)           | In schedule 2, paragraph 4(3)(b) and (6)(b).                                     |
| Primary Medical Services (Scotland) Act 2004 (asp 1)                      | Section 5(3)(a).                                                                 |
|                                                                          | In the schedule, paragraph 1(8), (10), (11)(a), (13) and (16)(a).                |
Smoking, Health and Social Care (Scotland) Bill
[AS AMENDED AT STAGE 2]

An Act of the Scottish Parliament to prohibit smoking in certain wholly or substantially enclosed places; to make provision in relation to general dental services, general ophthalmic services, personal dental services and pharmaceutical care services; to make provision in relation to disqualification by the NHS Tribunal; to enable the Scottish Ministers to establish a scheme for the making of payments to certain persons infected with hepatitis C as a result of NHS treatment and to certain persons infected with the virus by transmission of it from a person infected with it as a result of such treatment; to amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission; to make provision providing further time for applications to be made for registration of child care agencies and housing support services under the Regulation of Care (Scotland) Act 2001 and provide authorisation for the payment of certain grants to such services while not registered under that Act; to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland; to amend the rules as to membership of and other matters relating to the Scottish Hospital Endowments Research Trust; and for connected purposes.

Introduced by: Mr Andy Kerr
On: 16 December 2004
Supported by: Rhona Brankin
Bill type: Executive Bill
INTRODUCTION

1. As required under Rule 9.7.8A of the Parliament’s Standing Orders, these revised Explanatory Notes are published to accompany the Smoking, Health and Social Care (Scotland) Bill as amended at Stage 2:

2. These Explanatory Notes have been prepared by the Executive in order to assist the reader of the Bill and to help inform debate on it. They do not form part of the Bill and have not been endorsed by the Parliament.

3. The Notes should be read in conjunction with the Bill. They are not, and are not meant to be, a comprehensive description of the Bill. So where a section or schedule, or a part of a section or schedule, does not seem to require any explanation or comment, none is given.

THE BILL – AN OVERVIEW

4. The main provisions of the Bill are set out below.

Part 1 – makes provision for a ban on smoking in certain wholly or substantially enclosed places:
- creating an offence of permitting others to smoke in and on no-smoking premises;
- creating an offence of smoking in no-smoking premises;
- creating an offence of failing to display warning notices in no-smoking premises;
- setting out the powers of enforcement officers to enter no-smoking premises;
- creating an offence of failing without reasonable excuse to give one’s name and address on request by an authorised officer;

Part 1 also enables Scottish Ministers to vary the age for the purchase of tobacco.

Part 2 – provides for various matters concerning general dental services, personal dental services and general ophthalmic services:
- free oral health assessments and dental examinations;
- free eye examinations and sight tests;
- assistance and support in the provision of general dental services;
- NHS provision of certain dental services;
- listing of those persons undertaking to provide or approved to assist in the provision of general ophthalmic services;
- listing of those persons undertaking to provide or approved to assist in the provision of general dental services and those persons performing personal dental services under section 17C arrangements and pilot schemes.

Part 3 – makes a series of provisions regarding pharmaceutical care services:
- requirements on Health Boards to plan provision of pharmaceutical care services;
- contracts for provision of pharmaceutical care services;
- listing of persons performing pharmaceutical care services;
- provision of assistance and support for pharmaceutical care services.

Part 4 – makes provisions for strengthening the powers of the NHS Tribunal, extending its jurisdiction and giving effect to corresponding provision made in England or Wales or Northern Ireland.

Part 5 – makes provisions for a number of miscellaneous issues:
- payments to certain persons infected with hepatitis C;
- amendment of the Regulation of Care (Scotland) Act 2001;
- registration of child care agencies and housing support services;
- amendment of the Adults with Incapacity (Scotland) Act 2000;
- appeals against certain orders under the Public Health (Scotland) Act 1897;
- the ability of Scottish Ministers and health bodies to enter into joint ventures;
- the Scottish Hospital Endowments Research Trust.

Part 6 – makes general provisions.

Schedule 1 – Fixed penalty for offences under sections 1, 2 and 3.

Schedule 2 – Minor and consequential amendments:
- including clarification of Scottish Ministers’ powers under National Health Service (Scotland) Act 1978.

Schedule 3 – Repeals.
- including repeal of the age limit for serving on Mental Health Tribunal.
PART 1: PROHIBITION OF SMOKING IN CERTAIN WHOLLY ENCLOSED PLACES

Section 1 – Offence of permitting others to smoke in no-smoking premises

5. Subsections (1) and (2) make it an offence for the person who is in charge of no-smoking premises, having the management or control of those premises, to knowingly permit others to smoke there. The person in charge will be regarded as having permitted that other person to smoke if he or she knew, or ought to have known, that the other person was smoking there.

6. Two defences are provided under subsection (3). The first defence open to the accused person is to prove that they, or anyone working for them, had taken all reasonable precautions and had tried to the best of their ability to stop any other person from smoking in their premises. The second defence open to the accused is to prove that there were no lawful and reasonably practicable means by which they could prevent the other person from smoking in their premises.

7. Subsection (4) provides that the offence of permitting others to smoke in no-smoking premises is subject to a maximum penalty, on summary conviction, of a fine not exceeding level 4 on the standard scale (currently £2500).

Section 2 – Offence of smoking in no-smoking premises

8. Subsection (1) makes it an offence for a person to smoke in no-smoking premises.

9. Subsection (2) provides that it is a defence if the person accused of smoking can prove that they did not know, and could not reasonably be expected to have known, that the premises in which they were smoking were no-smoking premises. This might arise in instances where, for example, no-smoking signs had been removed or had failed to be displayed. The onus is however on the accused to prove this.

10. Subsection (3) provides that the offence of smoking in no-smoking premises is subject to a maximum penalty on summary conviction of a fine not exceeding level 3 on the standard scale (currently £1000).

Section 3 – Display of warning notices in and on no-smoking premises

11. Subsection (1) requires “no-smoking” signs to be conspicuously displayed in, on or near, and so as to be visible and legible from outside, no-smoking premises. The person who is in charge of those no-smoking premises, having the management or control of the premises, is liable for any failure to display such signs. Failure to display signs is an offence. The signs to be displayed must state that the premises are no-smoking premises and that it is an offence to smoke there or knowingly to permit smoking there.

12. Under subsection (2) it is a defence for anyone accused of failing to display “no-smoking” signs to prove that they or anyone working for them or representing them as an agent took all reasonable precautions and exercised all due diligence to ensure that signs were in place as required.
13. Subsection (3) gives the Scottish Ministers powers to make regulations which will provide further details as to the manner of display, form and content of the no-smoking signs. Regulations under this provision will be made under the affirmative resolution procedure, so that they cannot be made until the Parliament has approved a draft.

14. Subsection (4) provides that the offence of failing to display warning notices in and on no-smoking premises is subject to a maximum penalty on summary conviction of a fine not exceeding level 3 on the standard scale (currently £1000).

Section 4 – Meaning of “smoke” and “no-smoking premises”

15. Subsection (1) provides the meaning of “smoke” which in the context of Part 1 of the Bill means to smoke tobacco or any other substance or mixture which can be smoked. This subsection further clarifies that a person is to be taken as smoking if the person holds or is otherwise in possession or control of lit tobacco or any other lit substance or mixture which can be smoked.

16. Subsection (2) provides for “no-smoking premises” to be defined as such premises or classes of premises of a kind mentioned in subsection (4), which will be prescribed by the Scottish Ministers under regulations. Subsection (3) allows the Scottish Ministers to exclude, by means of those regulations, certain premises, or parts of premises, or classes or premises or parts of premises, from the definition of “no-smoking premises”. Regulations made under subsection (2) are to be made by affirmative procedure.

17. Subsection (4) lists the kinds of premises which are to be prescribed as “no-smoking premises” under subsection (2), being premises which are wholly or substantially enclosed and (a) to which the public or a section of the public have access, (b) which are used wholly or mainly as a place of work, (c) which are being used for the purposes of a club or an other unincorporated association and (d) which provide education, health or care services.

18. Subsection (4A) clarifies that those premises described in subsection (4)(b) as a place used for work include those premises where people work for no financial advantage such as, for example, voluntary workers.

19. Subsection (5) gives a further power to the Scottish Ministers to define or elaborate by means of regulations on the meaning of certain expressions used under subsection (2).

20. Similarly, and as above, subsection (6)(a) empowers the Scottish Ministers to define or elaborate by means of regulations the meaning of “premises” by reference to the person or class of person who owns or occupies the premises, whilst subsection (6)(b) allows the Scottish Ministers to define or elaborate the meaning of “premises” to include specific forms of public transport as they see fit.

21. Subsection (7) allows the Scottish Ministers to make regulations to modify subsection (4) by adding to or removing from the kinds of premises listed there. Again, any such regulations will require to be made by affirmative resolution.
22. Subsection (8) relates to the “no-smoking” notices which are to be displayed under section 3(1). Subsection (8) provides that where regulations are made under subsection (2) which define or elaborate the meaning of “premises” to cover certain forms of transport, those regulations may provide how the “no-smoking” sign in relation to each form of transport is to be expressed, thus enabling bespoke “no-smoking” signs for the various forms of transport.

Section 4A – Proceeding for offences under sections 1 to 3

23. Subsection (1) links the start of the time limit for summary proceedings in pursuance of sections 1, 2 or 3 to the point at which the Crown is passed sufficient evidence on the offence to justify bringing a prosecution. This will prevent any lengthy or extended hearing processes consequential to the issuing of a fixed penalty notice under Part 1 of the Bill resulting in a subsequent prosecution for that offence being time barred.

24. Subsection (2) provides that section 136(3) of the Criminal Procedure (Scotland) Act 1995 (c.46) applies to section 4A(1) as it does to that section. Section 136(3) of the 1995 Act provides that summary proceedings are deemed to commence when a warrant is granted, if it is executed without undue delay. Subsection (3) clarifies that a certificate from the Crown as to the date that evidence came to the knowledge of the Crown is conclusive evidence of that date.

Section 5 – Fixed penalties

25. Subsection (1) provides for a fixed penalty scheme under Schedule 1 to have effect. Schedule 1 sets out the details of how the fixed penalty system will work for offences committed under sections 1, 2 and 3 of the Bill. An explanation of the provisions in the Schedule is given at the end of these notes.

26. Subsection (2) provides that the fixed penalty system will not extend to offences under section 1 (permitting others to smoke in no-smoking premises) or section 3 (failure to display warning notices in or on no-smoking premises) committed otherwise than by a natural person.

Section 6 – Powers to enter and require identification

27. Subsection (1) empowers an officer of a council to enter no-smoking premises in order to check whether an offence under sections 1, 2 or 3 has taken place or is being committed. The council which authorises the officer under this subsection will be the council in the area where the premises are situated. Officers of the council will, in general terms, have access to premises to which the public has access; this additional power is therefore a back-up power.

28. A council officer exercising a power of entry under subsection (1), may use force to gain entry if necessary under subsection (2) and may, under subsection (1) search the premises.

29. An offence is committed under subsection (3) if a person who an authorised officer of a council reasonably believes is committing or has committed an offence under sections 1, 2 or 3, or has information relating to the offence fails without reasonable excuse to give their name and address when requested to do so by the enforcing officer. The penalty for a person guilty of an offence under this subsection is on summary conviction a fine not exceeding level 3.
Section 7 – Bodies corporate etc.

30. Section 7 provides that officers of companies and other corporations and members of partnerships can be held personally liable, in certain circumstances, for offences under Part 1 of the Bill that their companies or partnerships commit.

Section 7A – Sale of tobacco to under-age persons: variation of age limit

31. Subsection (1) enables Scottish Ministers to vary the age in section 18 of the Children and Young Persons (Scotland) Act 1937 (c.37) (offence of selling tobacco etc. to under-age persons and other preventative measures). This would allow them to provide for an age different from the current one of 16 years for, for example, the purchase of tobacco.

32. Subsection (2) requires that Scottish Ministers only make an order under subsection (1) after they have consulted on a draft with persons as they see as appropriate, for example local authorities and police bodies.

Section 8 – Crown application

33. Many enclosed public places will be operated and controlled by the Crown. Section 8 provides that Part 1 of the Bill and any regulations made under it shall bind the Crown. Subsection (2) ensures that instead of making the Crown criminally liable for any contravention under this Part of the Bill, the Court of Session may declare unlawful any act or omission of the Crown which constitutes a contravention.

34. Although the Crown itself cannot be prosecuted, subsection (3) ensures that the provisions in Part 1 apply to people in the public service of the Crown.

PART 2: GENERAL DENTAL SERVICES, GENERAL OPHTHALMIC SERVICES AND PERSONAL DENTAL SERVICES

Section 9 – Free oral health assessments and dental examinations

35. The provisions discussed in paragraphs 30 to 33 fulfil the partnership agreement of introducing free dental checks for all before 2007. In subsection (2) of section 70A of the National Health Service (Scotland) Act 1978 new wording is substituted, creating new paragraphs (a) and (b). Subsection (2) defines the dental treatment provided in accordance with section 17C arrangements for which regulations made under subsection (1) may prescribe the manner of making and recovering patient charges. New paragraph (a) excludes oral health assessments and dental examinations undertaken on or after 1 April 2006 from that definition.

36. In subsection (1) of section 71 of the 1978 Act, a new paragraph (a) is inserted. This excludes oral health assessments and dental examinations undertaken on or after 1 April 2006 from the Part II general dental services for which regulations may provide for the making of charges.
37. In subsection (2) of section 71 of the 1978 Act, new wording is substituted. This again excludes oral health assessments and dental examinations made on or after 1 April 2006 from the prescribed special dental treatment provided under general dental services for which regulations may provide for the making of charges.

38. In subsection (1) of section 20 of the National Health Service (Primary Care) Act 1997, new wording is substituted creating new paragraphs (a) and (b). New paragraph (a) replaces subsection (2) of section 20 which is repealed. Section 20 empowers regulations to be made to prescribe the manner of making and recovering patient charges for personal dental services under a pilot scheme. New paragraph (b) excludes oral health assessments and dental examinations undertaken on or after 1 April 2006 from these powers.

Section 10 – Free eye examinations and sight tests

39. Section 10 makes provision in relation to free eye examinations and sight tests. It does so by extending the meaning of general ophthalmic services, the provision of which must be secured under section 26 of the 1978 Act. At present, general ophthalmic services to be provided free of charge are limited to the testing of sight, which would determine whether or not a person requires an optical appliance (e.g. spectacles), of certain categories of person. This section extends the duty in section 26(1) of the 1978 Act both to include eye examinations, tailored to meet the needs of the individual patient and which may, or may not, include a sight test, and to apply to all.

40. In subsection (1) of section 26 of the 1978 Act, new wording is substituted in order to provide that Health Boards are placed under a duty to make arrangements with ophthalmic opticians and ophthalmic medical practitioners for the carrying out of eye examinations which will include the testing of the patient’s sight where this is considered necessary in the clinical opinion of the ophthalmic optician or medical practitioner who is undertaking the eye examination.

41. Subsections (1A) to (1E) of section 26 of the 1978 Act are repealed. These set out the categories of patient who are currently entitled to have their sight tested free of charge under general ophthalmic services and are therefore otiose.

42. Sub-paragraph (3)(a) of paragraph 2A of Schedule 11 to the 1978 Act is repealed. This provides for Scottish Ministers or a Health Board to contribute towards the cost of sight tests for those persons whose income/capital does not exceed their requirements as calculated in accordance with regulations but falls within the regulatory parameters for help with costs.

Section 11 – Charges for certain dental appliances and general dental services

43. In section 70 of the 1978 Act, new wording is substituted in order to provide, by regulations, more flexibility for the way in which dental charges are made or recovered. In section 70, wording is expanded to add the category of dental appliances to allow for more flexibility in the charging system. Section 70(1A) is repealed as dental appliances are now included in subsection 1. Similarly, in section 70(2) the reference to subsection (1A), is amended to refer to subsection (1).
44. In section 70A(2) new wording is substituted to take account of the repeal of section 70 subsection (1A) and to refer to section 70(1) for the making and recovery of charges for dental appliances.

45. In section 71 of the 1978 Act new wording is substituted to reflect that section 71A is repealed.

46. In paragraph 2 of schedule 11 of the 1978 Act new wording is substituted. A new sub-paragraph (1A) is introduced to provide by regulations charges for dental appliances which are defined as dentures, bridges, crowns and orthodontic appliances. The wording in sub-paragraph (2) (a) is also amended to include dental appliance. In sub-paragraph 3 the reference to section 1A is repealed and the wording in sub-paragraph (4) is amended to reflect that section 70(1A) is repealed.

Section 12 – Arrangements for provision of general dental services

47. In section 25 of the 1978 Act, new wording is substituted to expand the categories of persons with whom Health Boards can make arrangements for the provision of dental services. In subsection (1), new wording is substituted to allow arrangements to be made with bodies corporate as defined in section 43 of the Dentists Act 1984 (the 1984 Act).

Section 13 – Assistance and support: general dental services

48. After section 28C of the 1978 Act a new section 28D is inserted to enable a Health Board to provide assistance, including financial assistance, to providers of general dental services in a way that the Board thinks fit.

49. A new subsection (1) is introduced which enables a Health Board to provide assistance and support to any person providing, or proposing to provide, general dental services under section 25 of the 1978 Act.

50. New subsection (2) enables the Health Board to provide such assistance and support in a way that it thinks fit, and new subsection (3) enables the assistance to include financial assistance.

Section 14 – Provision of certain services under NHS contracts

51. In section 17AA of the 1978 Act new wording is substituted to make provision regarding certain arrangements between dentists and Health Boards. This will facilitate the participation of dentists in co-management schemes whereby Health Boards may make arrangements with dentists to undertake functions complementary to the work of hospital departments.

52. In subsection (1) new wording is substituted to treat arrangements between a Health Board and persons on a dental list as NHS contracts. An NHS contract is an arrangement where disputes with respect to it or its proposed terms may be determined by the Scottish Ministers. New wording is inserted at subsection (3) to define a dental list and repeal the otiose reference to pharmaceutical list. Subsection (3)(b) repeals the reference to pharmaceutical lists; the reference
to pharmaceutical lists at subsection (1) of section 17AA is also repealed. These are because the provisions in Part 3 of the Bill introduce new contract arrangements for the provision of pharmaceutical care services which, at new section 17V, provide for the service contracts in certain circumstances are to be classed as NHS Contracts. Section 17AA currently makes a similar provision and is, therefore, redundant.

Section 15 – Lists of persons undertaking to provide or approved to assist in the provision of general dental services

53. A new subsection (2) is substituted in section 25 of the 1978 Act for the existing subsection (2). The new subsection (2) provides a regulation-making power as to arrangements for the provision of general dental services (GDS).

54. The regulations as to arrangements shall provide for the listing of those who are approved to assist in the provision of GDS in the area of the Health Board for the first time. The subsection sets out those persons who will be listed on each part of a list to be prepared, maintained and published by each Health Board. Under paragraph (a), those persons who have undertaken to provide GDS will be named on the first part of the list. The second part will include those persons who are approved by the Health Board to assist in the provision of GDS and this is provided for in paragraph (b).

55. A new subsection (2A) is substituted for existing subsection (2A) of section 25. Paragraphs (a) to (j) of subsection (2A) set out issues that may be included in the regulations as to the preparation, maintenance and publication of the list.

56. Paragraph (a) provides that the first or second part of the list or both parts may be divided into further sub-parts to enable different categories of persons undertaking to provide or assisting with the provision of GDS to be distinguished as necessary – for example, those who provide domiciliary visits to nursing homes and similar establishments.

57. Paragraphs (b) to (j) provide that the regulation making powers may include provision as to: eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused, or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Health Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

58. A new subsection (2B) is substituted for existing subsection (2B) of section 25. Under this, regulations may specify that a person who acts as practitioner in a Health Board area may not provide GDS unless named on the first part of the Board’s list and a person who acts only as an assistant practitioner in a Health Board area may not assist with GDS provision unless named on the second part of the Board’s list.
Section 16 – Lists of persons performing personal dental services under section 17C arrangements or pilot schemes

59. A new section 17F is inserted into the 1978 Act. This provides an enabling power so that regulations may be made to establish lists of persons performing personal dental services (PDS) under pilot schemes or section 17C arrangements, that is, permanent schemes.

60. New subsection (1) provides that no person may perform PDS in an area unless that person’s name is included in a list maintained by the Health Board.

61. Paragraphs (a) to (j) of new subsection (2) set out issues that may be included in the regulations and provide that the regulation making powers may in particular include provision as to: the preparation, maintenance and publication of a list by a Health Board, eligibility and applications for inclusion in such a list; the grounds on which an application must be granted, or refused, or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

Section 17 – Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

62. A new subsection (2) is substituted in section 26 of the 1978 Act for the existing subsection (2). As with existing subsection (2) this provides a regulation-making power as to arrangements made by medical practitioners and ophthalmic opticians undertaking to provide general ophthalmic services (GOS). The regulations as to arrangements shall provide for the listing of those who are approved to assist in the provision of GOS in the area of the Health Board for the first time. Paragraph (a) sets out those persons who will be listed on each part of a list to be prepared, maintained and published by each Health Board. Under (2)(a)(i), ophthalmic contractors, i.e. those persons who undertake to provide GOS, will be named on the first part of the list. The second part will include those persons who are approved by the Board to assist in the provision of GOS and this is provided for in (2)(a)(ii).

63. A new, expanded subsection (2)(b) replaces the former subsection (2)(c). Regulations will also provide for the procedure by which patients will have a right to choose the person that examines their eyes as well as the person that tests their sight or gives a prescription. Previously, the right to choose related only to the person by whom a patient’s sight would be tested or from whom any prescription could be obtained but the Bill now proposes that GOS should include eye examinations.

64. A new subsection (2A) is inserted into section 26. Paragraphs (a) to (j) of subsection (2A) set out issues that may be included in the regulations as to the preparation, maintenance and publication of the list.

65. Paragraph (a) provides that the first or second part of the list or both parts may be divided into further sub-parts to enable different categories of persons undertaking to provide or assist
with GOS provision to be distinguished as necessary – for example, those who provide domiciliary visits to nursing homes and similar establishments.

66. Paragraphs (b) to (j) provide that the regulating making powers may include: particular provision as to eligibility and applications for inclusion in a list; the grounds on which an application must be granted or refused or a removal made and the consequences of removal; requirements with which a person included in a list must comply; circumstances in which a listed person may not withdraw from that list; the grounds under which a Health Board may suspend a person from its list; provision as to payments while subject to suspension by a Board; and disclosure of information about applications, refusal of applications, or suspensions, removal or references to the Tribunal.

67. A new subsection (2B) is inserted into section 26 of the 1978 Act. Under this, regulations may provide that a person who acts as practitioner in a Health Board area may not provide GOS unless named on the first part of the Board’s list and a person who acts only as an assistant practitioner in a Health Board area may not assist with GOS provision unless named on the second part of the Board’s list.

PART 3: PHARMACEUTICAL CARE SERVICES ETC.

Section 18 – Health Boards’ functions: provision and planning of pharmaceutical care services

68. This inserts two new sections, 2CA and 2CB, into the 1978 Act.

New section 2CA – Functions of Health Boards: pharmaceutical care services

69. Subsection (1) of the new section 2CA requires Health Boards to provide pharmaceutical care services or to secure the provision of those services by others. This gives Health Boards a new obligation to provide services themselves, in contrast to current legislation that only permits them to secure provision by others.

70. The subsection also creates a power for Health Boards to provide or secure the provision of pharmaceutical care services for persons for whom they would not be under a duty to provide. This makes it possible for Health Boards to deliver pharmaceutical care services in a location that is outwith the area they cover.

71. Subsection (2) of the new section enables a Health Board securing the provision of pharmaceutical care services by others to do so by means of such arrangements as they think fit. The main arrangement available will be a pharmaceutical care service contract under new section 17Q, which replaces the current section 27 pharmaceutical services arrangements.

72. Subsection (3) of the new section places a duty on Health Boards to publish prescribed information about the pharmaceutical care services that they secure the provision of by others, or provide themselves. The information that can be prescribed is in relation to the provision of pharmaceutical care services under Part 1 of the 1978 Act and not just section 2CA.
73. Subsection (4) of the new section creates an obligation on Health Boards to co-operate with each other in discharging their functions connected with every aspect of the provision of pharmaceutical care services. This will be relevant where Health Boards choose to deliver pharmaceutical services in a location outwith their geographical area as described above. This specific duty of co-operation is in addition to the existing general duty on Health Boards and others under section 13 of the 1978 Act to co-operate with one another in exercising their functions in order to secure and advance the health of people in Scotland.

74. Subsection (5) of the new section allows regulations to be made that will define “pharmaceutical care services” for the purposes of the 1978 Act. The regulation will set out types of services that are and are not pharmaceutical care services for this purpose.

75. Subsection (6) of the new section allows the regulations made under subsection (5) to classify what services are to be regarded as essential or additional pharmaceutical care services and under paragraph (b) the manner or circumstances in which they will be provided. This would include, for example, categorising the type of premises from which different services are to be provided and the time of day during which services should be available. Subsections (c) and (d) provide that where the service provided involves dispensing it is undertaken in accordance with directions that list drugs, medicines and appliances (i.e. the current Drug Tariff) and the circumstances in which they may be prescribed, and against orders raised by prescribed persons, for example appropriately registered medical and dental practitioners.

76. Subsection (7) provides that any directions to be issued by Scottish Ministers (by virtue of their regulation powers at subsection (5)) must be published in the ‘Drug Tariff’, or other such other manner as they consider appropriate. The Drug Tariff already exists and, *inter alia*, lists or details the drugs, medicines and appliances that can be ordered and dispensed as part of the provision of pharmaceutical care services.

77. Subsection (8) makes it clear that arrangements which a Health Board may make for the provision of pharmaceutical care services may provide for the delivery of those services at a location outside Scotland. For instance, this would allow a Health Board to make arrangements that would enable persons to receive pharmaceutical care services outside Scotland where it was more practical or convenient for them to do so.

78. Subsection (9) of the new section provides that while Health Boards are exercising their own statutory functions to provide or secure the provision of pharmaceutical care services, they are to be regarded in law as exercising functions of the Scottish Ministers conferred on the Health Boards.

**New section 2CB – Functions of Health Boards: planning of pharmaceutical care services**

79. Subsection (1) provides the Scottish Ministers with broad regulation and direction-making powers that will prescribe the arrangements by which Health Boards will prepare, publish and keep under review plans that will enable them to discharge their duty under new section 2CB(1).

80. Subsection (2) gives examples of what the regulations under subsection (1) may cover and includes identification of what pharmaceutical care services are required in a Health Board’s
area, whether there is convenient access and where provision of those services is considered inadequate. It also includes the periods in which Health Boards are to prepare, publish and review their pharmaceutical care services (PCS) plan; and the consultation process by which the PCS plan is prepared and ultimately made available to public.

81. Subsection (3) gives the Scottish Ministers power to publish in directions what criteria ought to be considered in the identification by the Health Boards of the matters in subsection (2)(a) in preparing a PCS plan. For example, the directions might require Health Boards to compare the locations of NHS community pharmacies and GP surgeries relative to and the size and proximity of populations they serve and their pharmaceutical care service needs.

Section 19 – Pharmaceutical care services contracts

82. This section inserts new sections 17Q to 17V into the 1978 Act (in place of existing sections on pharmaceutical services). The new sections govern the terms and content of the new pharmaceutical care services (PCS) contracts and who may provide or perform PCS under the contracts. They contain regulation-making powers that will be used to set out the detail of the rights and obligations under the new contracts.

83. New section 17Q refers to the general content of the contract.

84. Subsection (1) allows a Health Board to enter into a PCS contract with a contractor to provide pharmaceutical care services in accordance with the provisions of Part I of the 1978 Act.

85. Subsection (3) sets out parameters for services to be provided under the contract, the remuneration for their provision and other matters. Health Boards and contractors are free to agree the terms of the contract – subject to any restrictions on this freedom contained in Part I of the 1978 Act (restrictions set out in new sections 17R to 17V and in regulations under new section 17Q and those sections).

86. Subsection (4) allows the contract to cover a range of services, such as those that are provided in other primary and acute care settings and for the services to be delivered at a location outside the Health Board’s geographical area.

87. New section 17R makes it compulsory for a PCS contract to require the contractor to provide pharmaceutical care services of such descriptions as may be set out in regulations under the section. The regulations may describe services by reference to the manner or circumstances in which they are to be provided. The intention is to set out in regulations that providers must provide certain essential services.

88. New section 17S sets out the persons with whom a Health Board may enter into a PCS contract. Subsection (1) allows a Health Board to enter into a PCS contract with a registered pharmacist or, where the statutory conditions are satisfied, a person or business lawfully conducting a retail pharmacy business (in accordance with section 69 of the Medicines Act 1968) provided that the contractor undertakes that the pharmaceutical care services are provided by, or under the supervision of, a registered pharmacist.
89. Subsection (2) enables regulations to set out the effect on the contract of a change in the membership of a partnership contracted to provide pharmaceutical care services. The intention is to allow the membership of a partnership to change without requiring a new contract to be entered into merely because such a change in partnership has taken place.

90. New section 17T deals with payments to be made under PCS contracts.

91. Subsection (1) enables Scottish Ministers to give directions as to payments to be made under the contracts. This follows the practice of using direction-making powers to ensure that Health Boards make payments that adhere to Scotland-wide rates and levels.

92. Subsection (2) makes it compulsory for a PCS contract to require payments to be made in accordance with the directions then in force.

93. Subsection (3) gives examples of the matters for which directions may provide.

94. Subsection (4) requires Scottish Ministers to consult before giving any direction under subsection (1)

95. Subsection (4A) requires Scottish Ministers to publish directions under subsection (1) in the Drug Tariff or in such other manner as they consider appropriate, for example, a Health Department Letter of Circular.

96. New section 17U allows regulations to be made identifying those requirements that must be included in all PCS contracts.

97. Subsection (2) gives examples of the issues that the regulations under subsection (1) may cover, such as: the manner in which and standards to which services are to be provided; the persons who may perform services; contract variation and enforcement; and the adjudication of disputes. Subsection (2)(aa) provides that the regulations may give the Scottish Ministers power to issue directions with regard to the manner and standards to which services under a PCS contract must be provided. The use of directions recognises the clinical nature of the services that will be provided and the need for them to be reviewed and revised on a regular basis.

98. Subsection (3) provides for regulations made under subsection (2)(d) to set out prescribed circumstances in which a contractor must accept a person to whom services are to be provided and in which a contractor may decline to accept such a person or may terminate responsibility under the PCS contract for the person.

99. Subsection (4) provides that regulations varying the contract terms (by virtue of subsection (2)(f)) may include provision as to the circumstances in which a Health Board may so vary the terms or to suspend or terminate any duty under the contract to provide services of a prescribed description.
100. Subsection (6) provides that all PCS contracts must include a requirement that the contractors comply with any directions given by the Scottish Ministers under the regulation powers at subsection (1).

101. New section 17V essentially provides for two things.

102. Subsection (1) creates a regulation-making power to set national procedures for internal dispute resolution for the terms of proposed PCS contracts. The regulations may provide for the proposed terms to be referred to the Scottish Ministers and for the Scottish Ministers, or a person or panel of persons appointed by them, to determine what the terms of contract should be.

103. Subsection (2) creates a regulation making power to enable the parties to a PCS contract and parties who are already providing pharmaceutical care services under a PCS contract to opt to be treated as a health service body for any purposes in the existing section 17A of the 1978 Act. Section 17A allows health service bodies to enter into contracts with other health service bodies for the supply of goods and services. Such contracts are health service contracts, and are not regarded for any purpose as giving rise to contractual rights and liabilities, and they are not enforceable in courts. Section 17A instead provides for either party to a NHS contract to refer any matter in dispute to the Scottish Ministers for determination. It also provides for any determination made by the Scottish Ministers to contain directions (including directions about payments) and places a duty on the parties to the NHS contract to comply with any such directions.

104. Subsection (3) provides that if a PCS contractor or potential provider elects to become a health service body under subsection (2), section 17A of the 1978 Act applies with appropriate modifications. Where a business opts for its PCS contract to be an ordinary contract at law, it will have the option of asking the courts to resolve any resultant contractual disputes.

Section 19A – Drug Tariff

105. This section inserts a new section 17VA into the 1978 Act.

106. New section 17VA provides that Scottish Ministers must prepare, maintain and publish a document to be referred to as the Drug Tariff, and provides for what it must or may contain. As stated above (paragraph [72]), the Drug Tariff already exists for the purposes of pharmaceutical services. However, its requirement in primary legislation terms is only implicit and for limited purposes. This new provision makes clear the status and purposes for which the Drug Tariff must or may be used.

Section 20 – Persons performing pharmaceutical care services

107. This section inserts a new section 17W into the 1978 Act.

108. Subsection (1) provides for regulation-making powers governing the ways in which persons performing pharmaceutical care services are listed. The regulations may prevent registered pharmacists from performing pharmaceutical care services for Health Boards unless their name appears on a list held by the Health Board that has the duty to secure or provide those
services. An obligation to be on the list of a Health Board before performing services in that Health Board’s area remains even if the services are carried out as part of a contract with a neighbouring Health Board that is using its powers under section 2D(1) of the Act to provide or secure the provision of pharmaceutical care services in the area of another Health Board.

109. Section 17W ends the current arrangements whereby the Health Board’s pharmaceutical list contains the names of persons or businesses with whom the Health Board has made an arrangement to provide pharmaceutical services, and under which only the principal providers of those services are listed, and thereby subject to ‘terms of service’ requirements. The need to list contractors for ‘terms of service’ requirements is no longer necessary as arrangements will be governed by the terms of arrangements which Health Boards enter into with persons to secure the provisions of pharmaceutical care services under section 2D.

110. The new listing arrangements will apply to all registered pharmacists wishing to perform pharmaceutical care services, i.e. whether contractors or employed or engaged by contractors.

111. Subsection (2) of section 17W sets out the particular issues that may be included in the regulations. These include, for example: how the list will be drawn up and maintained; what criteria an individual will have to meet to qualify to be on the list; the process by which decision on applications will be made; and mandatory grounds under which a Health Board would have to reject an application.

Section 21 – Assistance and support: primary medical services and pharmaceutical care services

112. This section inserts a new section 17X into the 1978 Act, which makes new provision in relation to PCS and does this by replacing the existing section 17Q, which is an existing provision for Primary Medical Services (PMS). The existing PMS provision (replicated in new section 17X) enables a Health Board to provide assistance and support (including financial assistance) to those providing, or proposing to provide, PMS. The new section 17X extends the provision of assistance and support to PCS. The terms on which such assistance and support are given, including terms as to payment, are a matter for the Health Board.

113. Further provision relating to financial matters are made by amendments listed in Schedule 2 (paragraphs 1(10) and (11)).

PART 4: DISCIplINE

114. This part makes a number of changes to those sections of the 1978 Act relating to the NHS Tribunal. The Tribunal is the principal NHS disciplinary body for family health service practitioners. It is an independent body comprising a Chair appointed by the Lord President of the Court of Session, a member of the relevant profession and a lay member both appointed by the Scottish Ministers.
Section 22 – Disqualification by the NHS Tribunal

115. A new subsection (2) is substituted in section 29 of the 1978 Act for the existing subsection. The substitution, taken together with the repeal of the words “the representations are that the second condition for disqualification is met and” in subsection (4)(b), enables the Tribunal to inquire into any case referred by a Health Board or other person within prescribed time limits and involving an applicant to any Health Board lists or a person who is already listed who meets any condition for disqualification.

116. Subsection (6) sets out the first condition for disqualification by the Tribunal. In subsection (6) of section 29, the words “inclusion or continued” are substituted for “continued” so that the first condition of disqualification may be satisfied by those applying to be included in a list. Subsection (6)(a) is expanded to cover the list of persons performing personal dental services described in section (8)(cc) and performing pharmaceutical services described in subsection (8)(e).

117. Subsection (6)(b) is inserted to make similar provision for the list of persons described in subsection (8)(c) or (d) who provide, and assist in the provision of, services.

118. The new subsection (7A) inserted into section 29 adds a third condition of disqualification – unsuitability (by virtue of professional or personal conduct) – to the existing 2 disqualification conditions of fraud and prejudice to the efficiency of the relevant service. It enables disqualification of both list applicants and listed persons who meet this condition.

119. Subsection (8) is amended as follows. The reference to the list of medical practitioners providing general ophthalmic services in paragraph (8)(b) is deleted. The existing paragraphs (8)(c) to (e) are replaced with references to the lists of those who provide, and assist in providing, general dental or general ophthalmic services and perform personal dental or pharmaceutical care services.

120. In subsection (11) of section 29, the insertion of the words “and cases in which representations are made that the third condition for disqualification is met are referred to below as unsuitability cases”, taken together with the repeal of the word “and”, provides for the categorisation of cases referred by Health Boards or other persons which meet the third condition of disqualification as “unsuitability cases” and adds this category to the other 2 categories of cases regarding the 2 existing disqualification conditions.

121. In section 29A, subsection (1) is amended so that the new third condition of disqualification can be met by any body corporate carrying on business as ophthalmic opticians if a director meets that condition. A new subsection, (1A), is inserted to make similar provision to subsection (1) for any body corporate which carries out dentistry as a business. The Tribunal may direct disqualification of the body corporate on ground of fraud or unsuitability if any director meets those conditions. Subsection (3) is amended to provide that those who assist in the provision of services, as with those who provide or perform services currently, will be treated as meeting the disqualification condition of fraud if someone acting on their behalf meets that condition and they failed to take reasonable steps to prevent that happening. Subsection (5) is amended so that this may be done in efficiency and unsuitability cases also. In subsection (6) the
circumstances in which a fraud or efficiency case is finally concluded are set out. It is amended so that it also applies to an unsuitability case.

122. A new paragraph (c) is inserted into section 29B(1). This adds the new third condition of disqualification to the grounds on which the Tribunal shall make a disqualification.

123. A new subsection (2) is substituted in section 29B for the existing subsection. The effect is that the Tribunal shall disqualify a person from all lists of persons delivering those services where it determines a condition of disqualification is met, unless it would be unjust to do so. In the case of dental services, the disqualification is from all lists of persons undertaking to provide and approved to assist in providing general dental services and of persons performing personal dental services.

124. A new paragraph (c) is added to subsection 29C(2) dealing with conditional disqualification which extends the scope of the conditions which the Tribunal may place on those who are permitted to practice conditionally.

125. Subsection (5)(aa) is amended to refer to section 17F, 17W and Part II of the 1978 Act. This allows the Tribunal, for the purpose of or in connection with the imposition of conditions, to vary any requirements to which a person subject to the inquiry is subject. This is in addition to the Tribunal’s power under subsection (5)(a) to vary any terms of service the person is subject to by virtue of subsection (5)(a).

126. In section 32(2) the words “both an efficiency case and a fraud case” are replaced by “an efficiency case and a fraud case or an unsuitability case or any other combination of more than one such category of case”. Section 32(2) provides that where representations are made to the Tribunal against the same person on grounds of efficiency and fraud, regulations may provide that it may inquire into one or other matter and, when then matter is finally disposed off, it may decide to adjourn the other matter indefinitely. This allows regulations to provide, for example, for situations such as where the Tribunal has decided that a condition for disqualification was met for, say, proven fraud and there would be nothing to be gained by considering other allegations. The amendment extends the regulation-making power to take account of the new ground of unsuitability.

127. Subsection (2) of section 32A is amended so that directions by the Tribunal for suspension of a person as respects services applies, in the case of dental services to both general and personal dental services. A new paragraph (b) is substituted in subsection 32A(2A). This widens the second ground on which the Tribunal may direct interim suspension from one only related to the further perpetration of fraud/the prejudicing of investigation of a fraud case or review to a public interest ground. This includes cases where suspension is intended to ensure that further fraud is not perpetrated or evidence/witnesses in a fraud case are not interfered with. It will also enable the Tribunal to direct the interim suspension where it is otherwise in the public interest. It could include, for example, interim suspension to prevent serious disruption to the efficiency of services.
128. Subsection 6(a) is amended so that the definition of “relevant list” now covers persons providing services, and persons performing, undertaking to provide and approved to assist in providing services.

129. A new subsection (7) is inserted into section 32A. This will enable regulations to provide for the continuation of the suspension of a person whom a Health Board has suspended from one of its lists in terms of regulations under sections 17F, 17P, 17W, 25(2) or 26(2) of the 1978 Act and referred to the Tribunal until such time as the Tribunal has decided whether or not to suspend the person.

Section 23 – Corresponding provision in England or Wales or Northern Ireland

130. Section 23 substitutes a new section 32D. At present section 31 governs the effect in Scotland of decisions under provisions in force in England or Wales or Northern Ireland which correspond to provisions in force in Scotland regarding disqualification, and section 32D governs the effect in Scotland of decisions under provisions in force in England and Wales or Northern Ireland which correspond to provisions in force in Scotland regarding suspension by the Tribunal. However provisions in other parts of the UK may not correspond exactly to the provisions in force in Scotland. This new section replaces section 31 and 32D and allows regulations to provide for the effect of such decisions in Scotland, by providing for the effect that is to be given in Scotland to decisions made in other parts of the UK which correspond (whether or not exactly) with decisions made by the Tribunal.

PART 5: MISCELLANEOUS
INFECTION WITH HEPATITIS C AS A RESULT OF NHS TREATMENT ETC.

Section 24 – Payments to certain persons infected with hepatitis C as a result of NHS treatment etc.

131. Subsection (1) provides for the Scottish Ministers to make a scheme for making payments to, or in respect of, persons who have been infected with the hepatitis C virus in certain circumstances.

132. Subsection (1A) defines the relationships of persons covered by subsection (1) where the infection is acquired by transmission from a person infected as a result of NHS treatment.

133. Subsection (2) prescribes certain matters which must be included in a scheme such as the procedure to be followed in making a claim under the scheme and how claims are to be determined.

134. Subsection (3) provides that a scheme may include certain matters such as conditions for eligibility and the subsection also allows the Scottish Ministers to make provision in the scheme for other persons to undertake functions or manage the scheme on their behalf.

135. Subsection (4) provides that, where a scheme provides that it is to be managed, or functions are to be undertaken, on behalf of the Scottish Ministers, the Scottish Ministers remain responsible for those functions or the management of the scheme.
AMENDMENT OF REGULATION OF CARE (SCOTLAND) ACT 2001

Section 25 – Independent health care services

136. Under the Regulation of Care (Scotland) Act 2001 (the 2001 Act) the Care Commission registers and inspects a range of care services, deals with complaints and, where necessary, takes enforcement action. Section 2 of the 2001 Act lists and defines care services which are regulated by the Scottish Commission for the Regulation of Care (the Care Commission). This section of the Bill amends section 2(5) of the 2001 Act which defines “an independent healthcare service” as: an independent hospital; a private psychiatric hospital; an independent clinic; and an independent medical agency. This amendment gives Scottish Ministers the power to except services from this definition by regulations, bringing it into line with other relevant care service definitions.

Section 26 – Implementation of certain decisions under the 2001 Act

137. This section amends sections 16(2), 37(2), 48(2) and 51(1) of the 2001 Act.

138. The Care Commission has powers under Part 1 (the Care Commission and Care Services) and Part 2 (Local Authority Adoption and Fostering Services etc.) of the 2001 Act to issue a condition notice to service providers already registered and those applying to register as providers of care services (for example to require a care home provider to keep a door closed at all times to prevent residents from having access to a busy road). When such a notice is issued the 2001 Act allows a person receiving to make representation to the Care Commission. Subsection (2) and (2A) respectively amend section 16(2) and 37(2) of the 2001 Act to make further provision regarding representations. In particular it ensures that where representations are made to the Care Commission about a notice given under either 16(2)(a) or 37(2)(a) these will be considered by the Care Commission before it decides whether or not to do the thing proposed in the notice.

139. The Scottish Social Services Council (the Council) has the power under section 46 of the 2001 Act to grant registration to a social service worker either unconditionally or give notice to the worker that registration will be granted subject to certain conditions (for example to require a worker to complete a specific training requirement within a specified period of time). Section 48 allows the person who has received notice to make representations to the Council. Subsection (3) amends section 48 to make further provision about representations. In particular it ensures that where representations are made these will be considered by the Council in deciding whether or not to do the thing proposed.

140. Subsection (4) amends section 51 to ensure that there is a right of appeal against all decisions of the Council and not just an appeal against the implementation of a proposal.

Section 26A – Frequency of inspection of care services under the 2001 Act

141. This section inserts a new section 25(5A) and (5B) into the 2001 Act and amends section 78(2)(b) of that Act.
142. The Care Commission is required by section 25 of the 2001 Act to inspect all care services at least once every 12 months (or twice every 12 months, in the case of certain services). In respect of inspections section 25 distinguishes between the first 12 months after registration with the Care Commission and subsequent 12 month periods.

143. Subsection (2) of the new provision gives the Scottish Ministers the power, after consulting the Care Commission and other appropriate persons, to amend by Order either or both sections 25(3)(a)(i) and (ii) and either or both sections 25(5)(a) and (b) of the 2001 Act to increase (but not decrease) the length of the periods specified in those sections, and therefore reduce the minimum frequency of mandatory inspections. The power is capable of being exercised in different ways in respect of different care services.

144. Subsection (3) of the new provision amends section 78(2)(b) of the 2001 Act to provide that an Order made under the new section 25(5A) is subject to affirmative resolution procedure.

Section 27 – Provision of information to the Scottish Social Services Council

145. This section inserts new sections 57A and 57B into the Regulation of Care (Scotland) Act 2001.

146. The new section 57A requires the employer of a social service worker to inform the Scottish Social Services Council where the social service worker has been dismissed on grounds of misconduct or has resigned or abandoned their position in circumstances where there would have been grounds for their dismissal. The employer must also provide the Council with an account of the circumstances.

147. The new section 57B requires that the employer of a social service worker will provide to the Council any information as respects that worker that the Council requires in the pursuit of its functions.

CHILD CARE AGENCIES AND HOUSING SUPPORT SERVICES

Section 28 – Registration of child care agencies and housing support services

148. This section is concerned with persons providing certain child care agencies and housing support services on 1 April 2003 who were deemed to have their service registered with the Care Commission until 30 September 2003. Where a provider did not make an application to the Care Commission for registration before 1 October 2003 or did not have their application granted by 1 April 2004 their deemed registration lapsed and continuation of the service was unlawful. The effect of this provision is that where such a person applied for registration by 30 September 2004, they are to be treated as if their deemed registration had not lapsed and, subject to the earlier occurrence of certain events, they are deemed to be registered until 1 April 2006. It also provides that, where, before 1 April 2006, the application for registration is granted or refused, registration is cancelled, or if the provider ceases providing the service, the deemed registration ceases on the date that happens.

149. Subsection (1) provides that subsections (2) to (4) apply where:
from 1 April 2003, a person was providing a housing support service or a previously unregulated child care agency which was deemed to be registered with the Care Commission under Part 1 of the 2001 Act by virtue of transitional provisions contained in subordinate legislation;

that deemed registration lapsed, either on 1 October 2003 because the provider had not submitted an application for registration before that date, or on 1 April 2004 because registration had not been granted; and

the provider continued to provide the service when it was no longer deemed registered.

150. Subsection (2) provides that, where the circumstances described in subsection (3) apply, such a service is to be treated as if it was registered, from the date deemed registration ran out and for the period during which the service continued to be provided until one of the events in subsection (4) occurs.

151. Subsection (3) provides that the circumstances referred to in subsection (2) are where an application for registration has been made before 30 September 2004 or no such application was made before that date and the person ceased providing the service before then.

152. Subsection (4) provides that the service ceases to be treated as if it were registered on the earliest of the following events:

- the date that the Commission refuses an application where no appeal is made under section 20(1) of the 2001 Act;
- the date that the sheriff confirms the Commission’s decision after a timeous appeal has been made;
- where an appeal is made under section 20(1) but is later abandoned, the date on which that is intimated to the sheriff clerk or, where there is no intimation, the date on which it is deemed by the Sheriff to be abandoned;
- the date the Care Commission decides (other than in the case of an application from the provider) to cancel the registration effected by subsection (2);
- where there is no appeal under section 17(3) of the 2001 Act from the provider against the Care Commission’s decision to cancel the registration effected by subsection (2), the fifteenth day after the day the Care Commission gave notice of that intention;
- where there is such appeal and the sheriff decides to grant it, the day the sheriff decides to do so;
- the day the sheriff grants an application by the Care Commission under section 18 of the 2001 Act for cancellation of registration;
- where an appeal under section 17(3) is made and later abandoned, the date on which that is intimated to the sheriff clerk or, where there is no intimation, the date on which it is deemed by the court to be abandoned.
- the day the person ceases to provide the service; or
1 April 2006 – unless this date has been changed to a later one in an order made by Scottish Ministers.

Section 29 – Grants in respect of housing support services

153. This section provides that payments to providers of regulated housing support services which were not registered with the Care Commission, by local authorities out of money they had received from Scottish Ministers under the Housing (Scotland) Act 2001, were made lawfully.

AUTHORISATION OF MEDICAL TREATMENT

Section 30 – Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

154. This section provides for two substantive changes, and consequent amendments, to Part 5 of the Adults with Incapacity (Scotland) Act 2000. First an extension to the range of health professionals who can sign certificates of incapacity and second extending the length of certificates from one to three years in certain prescribed circumstances.

155. Subsection (1) signposts the two main amendments to the 2000 Act.

156. Subsection (2)(a) widens the scope of who can issue a certificate under section 47 of the 2000 Act from the ‘medical practitioner primarily responsible’ for the treatment of an adult, to include other named healthcare professionals as listed in subsection 2(b) and other who meet various requirements set out by the Scottish Ministers. A certificate under section 47 of the Act confers a general authority to treat an adult with incapacity, where the medical practitioner primarily responsible for the medical treatment of the adult is of the opinion that the adult is incapable in relation to a decision about the medical treatment in question. Only a ‘registered medical practitioner’ currently has the power to complete and sign a certificate.

157. Subsection (2)(b) lists the healthcare professionals who will be able to issue a certificate, they are: the medical practitioner primarily responsible for the medical treatment of the adult; a dental practitioner; an ophthalmic optician; a registered nurse. This section also makes provision for others to be added by regulation as and when appropriate. The additional ‘healthcare professionals’ (dentists, ophthalmic options and registered nurses) will only be allowed to certify for treatment in respect of their own specialist area. The subsection also enables Scottish Ministers to prescribe requirements that would need to be met by the healthcare professionals before they could issue certificates, for example they will need to have undertaken accredited training in the assessment of capacity.

158. Subsection (2)(c)(i) makes consequential amendments to the references in section 47(2) of the 2000 Act to the medical practitioner primarily responsible for the health of the adult.

159. Subsection (2)(c)(ii) sets out that a healthcare professional who is competent to sign a certificate of incapacity can only do so within his or her own professional area.
160. Subsection (2)(d) clarifies that treatment can be delegated to any other person authorised by the certificate signatory and acting on his or her behalf, under instructions, or with his or her approval and agreement.

161. Subsection (2)(e)(i) amends section 47(5)(a) of the 2000 Act as to who can issue the certificate from ‘medical practitioner primarily responsible for the medical treatment of the adult’ to ‘person who issues the certificate’.

162. Subsection (2)(e)(ii) amends section 47(5)(b) of the 2000 Act so that, in certain circumstances and in relation to certain conditions to be prescribed by the Scottish Ministers the maximum duration of the certificate is 3 years. The prescribed conditions will be listed in the regulations, which will be subject to consultation with key stakeholders.

163. Subsection (2)(f)(i) amends section 47(6) of the 2000 Act as to who can issue the certificate from ‘medical practitioner primarily responsible for the medical treatment of the adult’ to ‘person who issued it’.

164. Subsection (2)(f)(ii) amends section 47(6)(b) of the 2000 Act so that, in certain circumstances to be prescribed by Scottish Ministers the maximum duration of the certificate is 3 years.

165. Subsection (2)(g) clarifies the definition of “dental practitioner” and “ophthalmic optician” for the purposes of this section.

166. Subsection (3) widens the scope of subsection 49(1) of the 2000 Act to ensure that health professionals do not treat a patient where they know that an application for an intervention order or guardianship order has been made to the sheriff and has not been determined.

167. Subsection (4) widens the scope of section 50 of the 2000 Act to include all health professionals who are empowered to sign certificates of incapacity.

APPEALS UNDER PUBLIC HEALTH (SCOTLAND) ACT 1897

Section 30A – Amendment of Public Health (Scotland) Act 1897: appeal against certain orders etc.

168. This section inserts new sections 156A-156D into the Public Health (Scotland) Act 1897 to allow a right of appeal against detention under sections 54, 55 and 96 of that Act. The new sections make provision for appeals against an order (of a sheriff or justice under section 54), a direction (of a sheriff or justice under section 55), or a decision (of a local authority under section 96), to remove to hospital, detain in hospital, or transfer to another hospital, persons suffering from an infectious disease.

169. Section 157 of the Act currently excludes any right of appeal against orders, directions or decisions taken under sections 54, 55, or 96. The provision of a right of appeal in respect of these
provisions is necessary to ensure that they are compatible with Article 5(4) of the European Convention on Human Rights.

170. New Section 156A provides for appeals to the sheriff or sheriff principal against an order under section 54, a direction under section 55, or a decision under section 96. It sets out who may appeal, to whom the appeal should be made, the grounds for appeal, the timescales within which the appeal should be made, and the means by which it should be made. It also sets out the three options available to the sheriff or sheriff principal in dealing with the appeal.

171. New section 156B deals with further appeal to the sheriff principal, specifically against a section 96 decision. It again sets out who may appeal, the grounds, timescales for appeal, and the options available to the sheriff principal.

172. New section 156C enables further appeal to the Court of Session, again setting out the grounds for appeal.

173. New section 156D enables the provisions of sections 54, 55, and 96 to operate if an appeal is in progress. A person can therefore be removed to hospital, and/or detained in hospital while an appeal against, or in relation to, the order, direction or decision is underway.

JOINT VENTURES

Section 31 – Joint ventures

174. Subsection (1) inserts a new section 84B after section 84A of the National Health Service (Scotland) Act 1978 and gives new powers for Scottish Ministers to form or participate in forming joint ventures for the provision of facilities or services. This will provide the basis for the long term delivery of facilities that meet the needs of local communities, as well as encouraging more joint working, for example between the NHS, local authorities and the voluntary sector.

175. Subsection (1) of 84B defines the nature and extent of the involvement of Scottish Ministers in such companies.

176. Subsection (2) of 84B allows facilities and services to be provided to those persons or bodies exercising functions under the 1978 Act.

177. Subsection (3) of 84B provides the definitions of “companies” and “facilities” as applied under section 31(1).

178. Subsection (2) amends section 7 of the Health and Medicines Act 1988 to give Scottish Ministers powers to exploit intellectual property. The amendment inserts a new subsection (7C) to allow Scottish Ministers to form or participate in forming companies, or to participate in companies. It also allows Ministers to make financial provision to or in respect of companies, including by means of loans, guarantees and investments.
This document relates to the Smoking, Health and Social Care (Scotland) Bill as amended at Stage 2 (SP Bill 33A)

179. Subsection (2) also introduces a new subsection (7D) to the 1988 Act to provide a definition of “companies” for the purpose of subsection (7C), and provides that the new subsection (7C) is without prejudice to the powers already made available in subsection (2).

SCOTTISH HOSPITAL ENDOWMENTS RESEARCH TRUST

Section 32 – Scottish Hospital Endowments Research Trust

180. The Scottish Hospital Endowments Research Trust is a self-financing Non Departmental Public Body and a registered charity established, in 1953 by Act of Parliament, to receive and hold endowments, donations and bequests and to make grants from these funds to support medical research in Scotland. Subsection (2) repeals the Scottish Ministers’ responsibility for the Research Trust.

181. Subsection (3) substitutes paragraphs concerning the membership of the Research Trust.

182. New paragraph 3A provides for the continuation of existing members of the Research Trust, and makes them subject to the new terms and conditions of appointment of members determined by the Research Trust when those new terms and conditions are determined, or after a period of 90 days, whichever occurs first. This provision seeks to provide sufficient time within which the Research Trust can draft and agree its new terms and conditions.

183. New paragraph 3B sets out the terms of office of the membership of the Research Trust, the tenure of office - specifying that a single term of appointment shall not exceed 4 years - and vacation from office.

184. New paragraph 3C provides for single term of reappointment.

185. New paragraph 3D replaces section 12 (3(d)) of the National Health Service (Scotland) Act 1978 with new provisions for the reimbursement of expenses of the membership of the Research Trust.

186. New paragraph 3E provides for the Research Trust to appoint staff on such terms and conditions as they think appropriate.

187. New 3F provides the necessary provisions for the self regulation of the Research Trust, and requires standing orders to be made within a 90 day period.

188. New 3G provides for the Research Trust to be able to do anything necessary or expedient to enable them to exercise their functions.
PART 6: GENERAL

Section 33 – Ancillary provisions

189. This section enables the Scottish Ministers to make further provision, by order, which is incidental to or consequent on the Bill and to allow transitional or savings provisions as required in implementing the Bills’ provisions.

Section 34 – Regulations or orders

190. This section provides that powers to make orders or regulations in the Bill shall be exercisable by statutory instrument. Subsection (2) provides that except where otherwise provided, the statutory instruments containing such orders or regulations shall be subject to negative procedure in the Scottish Parliament. Subsection (3) provides that the following orders or regulations shall be the subject of affirmative resolution:

(a) regulations under sections 3(3) or 4(2) or (7) or paragraph 2, 4(1), 5(2), 12 or 13 of Schedule 1;

(b) an order under section 28(4)(e); and

(c) an order under section 33 which contains provisions which alter the text of an Act.

Subsection (4) provides that Scottish Ministers must consult such persons as they consider appropriate before laying a draft of a statutory instrument containing regulations under sections 3(3) or 4(2) or (7).

Section 35 – Interpretation

191. This section defines terms used throughout the Bill and is self-explanatory.

Section 36 – Minor and consequential amendments and repeals

192. Section 36 introduces schedule 2 (which makes minor and consequential amendments) and schedule 3 (which contains consequential repeals).

Section 37 – Short title and commencement

193. This section provides for the short title of the Bill. Further, the section allows the Scottish Ministers to bring the provisions of the Bill into force by order, except for sections 28, 29, 35 and (insofar as it relates to paragraph 1(1A) and (1C) of schedule 2) 36 and in schedule 2 paragraphs 1(1A) and 1(1C) which will come into force on the day after Royal Assent, and sections 33, 34 and 37 which will come into force on Royal Assent. Different days may be appointed in the order for different provisions.

194. In subsection (3) provision is made for any order made appointing a day for commencement of the provisions of sections 1 to 8 or schedule 1 (the prohibition of smoking provisions) for a time of day for the commencement to also be specified.
SCHEDULE 1 - FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2 AND 3

195. Paragraph 1(1) and (2) provides power for an authorised officer of a council or a constable to issue a fixed penalty notice, whilst paragraph 1(3) provides the definition of a “fixed penalty notice” for the purposes of Schedule 1.

196. Paragraph 2 provides the Scottish Ministers with the power to set via regulations a time limit between an offence being committed and an authorised officer being able to give a fixed penalty notice.

197. Paragraph 3 sets out the contents of the fixed penalty notice. It must identify the offence to which it relates and give reasonable particulars of the circumstances alleged to commit that offence. It must also state: the amount of the penalty and the period within which it may be paid; the discounted amount and the period within which it may be paid; the person to whom and the address at which payment may be made; the method or methods by which payment may be made; the person to whom and the address at which any representations relating to the notice may be made; and the consequences of not making a payment at which any representations relating to the notice may be made.

198. Paragraph 4 provides for the level of the fixed penalty notice to be prescribed and the period within which payment of the notice should be made. The council has a discretionary power to extend the period of payment.

199. Paragraph 5 enables offenders to pay a lesser amount in respect of the fixed penalty notice if they make an earlier payment.

200. Paragraph 6 sets out the effect of a fixed penalty notice, providing that no proceedings may be commenced before the end of the period for payment of the penalty, or if payment of the penalty is made before the end of that period or is accepted by the council after that time. Payment of the discounted amount will only count in that regard if it is made before the end of the period for payment for that discounted amount.

201. Paragraph 7 enables a person in receipt of a fixed penalty notice to request a hearing in respect of the offence for which they have been given notice provided that that request is made within 29 days of receipt of the notice. The request must be made in writing to the designated person at the address shown on the fixed penalty notice. The council will hold the meeting and the procurator fiscal will be notified that a hearing is to be held. The period between a person requesting a hearing and being notified of the hearing’s decision will not count towards the 29 days for the payment of the penalty.

202. Paragraph 8 provides for a power of the council to withdraw notices, in cases where they have been erroneously issued or consider if there are extenuating circumstances. Sub-paragraph 3 provides that a council is bound to consider any representations made by or on behalf of a person given a notice, and that they must decide in all circumstances whether to withdraw the notice.
203. Paragraph 9 provides for the withdrawal of a fixed penalty notice where proceedings for an offence are commenced.

204. Paragraph 10 provides for the recovery of unpaid fixed penalty fines. After the expiry of 29 days the council is able to enforce the unpaid penalty as if it were an extract registered decree arbitral. In practice this means that the unpaid penalty can be recovered in the same way as a sum of money due under a civil court decree.

205. Paragraph 11 provides a mechanism under which disputes as to whether or not a fixed penalty has been paid or a hearing sought within the period for paying can be resolved by the courts. Subparagraph (1) enables a person who is in dispute with a council to apply to the sheriff by summary application for a declaration that the fixed penalty cannot be enforced under paragraph 10 either because the fixed penalty has been paid or a request for a hearing has been made within the period for paying.

206. Paragraph 11(2) provides that the sheriff may declare that the person has or has not paid the penalty or requested a hearing within the period for paying and that the fixed penalty is or is not enforceable under paragraph 10.

207. Paragraph 12 allows the Scottish Ministers to make regulations about the application by councils of fixed penalties under Schedule 1 and also about the keeping of accounts and the preparation and publication of statements of account, relating to fixed penalties under Schedule 1.

208. Paragraphs 13(1) and (2) provide the Scottish Ministers with powers to make regulations prescribing the circumstances in which a fixed penalty notice may or may not be given and the methods for the payment of penalties.

SCHEDULE 2 – MINOR AND CONSEQUENTIAL AMENDMENTS

209. The following provisions clarify existing legislation by providing that Scottish Ministers may confer on Health Boards, Special Health Boards and the Common Services Agency by order any of their functions relating to the health service, rather than any of their functions under the National Health Service (Scotland) Act 1978 ("the 1978 Act").

210. Paragraph 1(1A) amends section 2(1) of the 1978 Act to provide that the reference there to Scottish Ministers’ functions specifically under that Act is changed to refer instead to their functions relating to the health service. As amended, the section will make clear that the functions that Scottish Ministers may provide by order to be exercisable by Health Boards and Special Health Boards are their functions related to the health service generally, rather than being limited to their functions under the 1978 Act.

211. Paragraph 1(1C) amends section 10(3) of the 1978 Act to provide that the reference to Scottish Ministers’ functions under the 1978 Act is changed to refer instead to their functions relating to the health service. As amended, the section will make clear that the functions that
Scottish Ministers may by order delegate to the Common Services Agency are their functions relating to the health service rather than their functions under the 1978 Act.

212. Sub-paragraph (11) of paragraph 1 to schedule 2 lists amendments to section 85AA of the 1978 Act that have the effect of placing the financial resources for meeting the remuneration element of providing pharmaceutical care services (PCS) with Health Boards, as part of their unified budgets. Currently the cost of the national contract is paid by Health Boards but funded centrally; additional services are funded locally. Given the intention to make Health Boards responsible in future for planning and securing or providing all PCS requirements (under both national and local contract arrangements) it is appropriate to make them responsible for the financial management of the process too.

SCHEDULE 3 - REPEALS

213. The following provisions amend the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp13).

214. At present, paragraph 4(3)(b) of schedule 2 of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides that a member of the Mental Health Tribunal for Scotland must vacate office on the day on which the member reaches the age of 70. The repeal of paragraph 4(3)(b) of schedule 2 removes this requirement.

The repeal of paragraph 4(6)(b) of schedule 2 removes reference to the Tribunal members’ age as one of the circumstances by which they would not be reappointed after a current 5 year appointment has ended.
INTRODUCTION

1. Following the completion of the Stage 2 Committee process, the Smoking, Health and Social Care (Scotland) Bill has been amended. The vast majority of the amendments do not make any difference to the financial impact of the provisions. However, in two sections, amendments will give rise to additional costs and these are noted below:

- payments to certain persons developing hepatitis C as a result of NHS treatment (section 24);
- authorisation of medical treatment (section 30).

PAYMENTS TO CERTAIN PERSONS INFECTED WITH HEPATITIS C AS A
RESULT OF NHS TREATMENT

Introduction

2. The provisions to allow Scottish Ministers to make a scheme for payments to certain persons infected with Hepatitis C as a result of NHS treatment were amended at Stage 2. The effect of the amendment is to allow claims for ex gratia payments from dependants of people who were infected as a result of NHS treatment and died before 29 August 2003, or died after 5 July 2004 without making a claim. Claims in these categories were not permitted previously under the scheme.

3. It is estimated that 4,000 people may have been infected in Scotland with the Hepatitis C virus through NHS treatment, of whom around 1,200 may still be alive and 2,800 deceased. These figures are based on epidemiological research and were published in the report of the Lord Ross Expert Group.

Costs on the Scottish Administration

4. It is difficult to estimate what the costs of extending the scheme to cover the additional categories of claim might be. The Executive recognises that many of the deceased are people who received blood transfusions when they were already elderly or seriously ill, and may have died before they developed symptoms of Hepatitis C. Take-up from this group, however, does have the potential to add significantly to the costs of the scheme at the expense of the overall health budget.
5. The current scheme is expected to cost some £15 million. Payments are made in two stages. The first is a payment of £20,000 for those who have acquired the Hepatitis C virus. A further payment of £25,000 is for those infectees who go on to develop cirrhosis of the liver, liver cancer or require a liver transplant as a consequence of the infection.

6. If there were a take-up rate of 25% - consistent with the estimates published in the Expert Group Report - from relatives or dependants of the deceased, the costs of the scheme could more than double, with additional expenditure of some £20 million.

7. The changes to the scope of the scheme brought about by the amendments raise the risk that Scottish Ministers will no longer be able to participate in the Skipton Fund scheme and will require to establish a separate Scottish scheme. Although it is not possible at present to identify the costs associated, it is clear that the economies of scale achieved through running a single UK-wide scheme would be lost and that as a consequence there would be additional costs on the Scottish Administration.

Costs on local authorities

8. The hepatitis C provisions of the Bill have no financial implications for local authorities.

Costs on other bodies, individuals and businesses

9. An important aspect of the practical working of the UK Skipton Fund Scheme is that payments are not taken into account for the purpose of assessing social security entitlement. This is achieved through regulations which are made by the UK government specifically for this purpose – included in the Social Security (Miscellaneous Amendments) (No 2) and (No 3) Regulations 2004. Social security is a reserved function and if significant changes are made to the Skipton Fund, there is concern that the existing regulations would no longer apply. This would have the potential to significantly disadvantage all claimants and there is no guarantee that new regulations could be made to apply to Scotland only.

10. It is not possible to identify the potential costs to individuals if the social security waiver no longer applied as this would be dependent on an individuals circumstances.

AUTHORISATION OF MEDICAL TREATMENT

Introduction

11. The provisions for authorisation of medical treatment for adults with incapacity were amended at the Stage 2 Committee process of the Bill. The amendments added a requirement for the categories of healthcare professional who would be allowed to issue a certificate to satisfy requirements as may be prescribed. The intention is that these healthcare professionals will be required to undergo relevant training before they can issue certificates.
**Costs on the Scottish Administration**

12. The Scottish Executive has already provided additional funding to NHS Education Scotland of approximately £30,000 for the development of a suitable training programme for healthcare professionals. There are no further financial implications for the Scottish Administration.

**Costs on local authorities**

13. The authorisation of medical treatment provisions of the Bill have no financial implications for local authorities.

**Costs on other bodies, individuals and businesses**

*NHS Education Scotland*

14. NHS Education Scotland (NES) will develop a suitable training programme that healthcare professionals will be able to access through their continuing and professional development. NES will require to work with the agencies responsible for the training of health professionals to develop a suitable programme. The initial development costs of approximately £30,000 have already been provided by the Executive. There are no further financial implications for NES.

*Healthcare Professionals*

15. The delivery of the training of individual healthcare professionals will fall largely on the bodies responsible for professional education. It is expected that uptake of the training will be done as part of the professionals’ continuing and professional development which is a mandatory requirement and that there will consequently be no additional cost to them. It is possible that the cost for attending the course will be in the order of £120 per person.
Subordinate Legislation Committee

28th Report, 2005 (Session 2)

Smoking, Health and Social Care (Scotland) Bill as amended at Stage 2
Subordinate Legislation Committee

Remit and membership

Remit:

1. The remit of the Subordinate Legislation Committee is to consider and report on-

   (a) any-

   (i) subordinate legislation laid before the Parliament;

   (ii) Scottish Statutory Instrument not laid before the Parliament but classified as general according to its subject matter,

   and, in particular, to determine whether the attention of the Parliament should be drawn to any of the matters mentioned in Rule 10.3.1;

   (b) proposed powers to make subordinate legislation in particular Bills or other proposed legislation;

   (c) general questions relating to powers to make subordinate legislation; and

   (d) whether any proposed delegated powers in particular Bills or other legislation should be expressed as a power to make subordinate legislation.

   *(Standing Orders of the Scottish Parliament, Rule 6.11)*

Membership:

Dr Sylvia Jackson (Convener)
Mr Adam Ingram
Gordon Jackson (Deputy Convener)
Mr Stewart Maxwell
Christine May
Mike Pringle
Murray Tosh
Committee Clerking Team:

Clerk to the Committee
Ruth Cooper

Senior Assistant Clerk
David McLaren

Support Manager
Catherine Fergusson
Subordinate Legislation Committee

28th Report, 2005 (Session 2)

Smoking, Health and Social Care (Scotland) Bill as amended at Stage 2

The Committee reports to the Parliament as follows—

Introduction

1. At its meeting on 21 June 2005, the Committee considered the inserted or substantially amended delegated powers provisions in the Smoking, Health and Social Care (Scotland) Bill as amended at stage 2. The Committee reports to the Parliament on such provisions under Rule 9.7.9 of Standing Orders.

2. Under Rule 9.7.10, the Executive provided a supplementary subordinate legislation memorandum to the Committee, which is published at Annex A to this report.

Section 4 - Meaning of “smoke” and “no-smoking premises”

3. Section 4 defines what is meant by “smoking” and “no-smoking premises”. The terms are to be defined in regulations made by Ministers under this section.

4. In line with the concerns that this Committee expressed to the Minister for Health, the bill has been amended to require that future regulations made under section 4(2) or (7) will be subject to consultation in draft form. This section as amended will allow the Parliament to scrutinise draft regulations. The Committee welcomed the amendments made to section 4, which improve the level of consultation required for future regulations.

5. The Committee considered that it was not clear whether although made under section (4) regulations under subsection (8) which relate back to the requirements of section 3(1)(b) would be caught by the prohibitions under section 1. The Committee considered that the amendments made to section 3 might cast doubt on the enforceability of regulations made under subsection (8). The Committee has raised this issue with the Executive and the lead Committee, and understands that the Executive has lodged an amendment to clarify this matter at stage 3.
Section 7A - sale of tobacco to under-age persons: variation of age limit

6. This section would enable Ministers to modify section 18 of the Children and Young Persons (Scotland) Act 1937, to change the minimum legal age to smoke.

7. Although it is currently subject to negative procedure, the Executive has undertaken to change this to affirmative procedure at stage 3. The Committee was content to note this new power, and the Executive’s undertaking to amend this to affirmative procedure at Stage 3.

Section 15 – List of persons undertaking to provide or approved to assist in the provision of general dental services

Section 17 – List of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

8. Amendments were made to further sub-divide the list of relevant healthcare professionals. The Committee was content with these powers.

Section 19A – Drug Tariff

9. This section gives the Scottish Ministers power to prescribe the information relating to pharmaceutical care services that must be included in the drug tariff. The Committee was content with this amendment.

Section 26A – Frequency of inspection of care services under the 2001 Act

10. This section inserts new subsections into the Regulation of Care (Scotland) Act 2001. The proposed power would allow Scottish Ministers to amend the minimum frequency at which care services must be inspected by the Care Commission. This would be done by Order following consultation with the Care Commission.

11. The Committee sought clarification of the purpose and effect of the words “and thereafter” in the Bill. The Committee understands that it reflects the Executive’s intention to undertake a two stage consultation whereby the Care Commission will be consulted first and wider consultation will be undertaken thereafter. The Committee draws this matter to the attention of the Parliament.

Section 30 – Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

12. As amended at Stage 2, section 30(2)(b) enables Scottish Ministers to prescribe, by regulations, requirements that must be met in relation to health professionals to be able to certify for incapacity. The Committee was content with this amendment.

Section 37(2) – Short title and commencement

13. Section 37(2) of the Bill originally provided for amongst other sections, sections 1 to 8 and schedule 1 to come into force on the day after Royal Assent.
This was amended at Stage 2 to omit the references to sections 1 to 8 and schedule 1. The result of this is that these provisions will come into force on such day as the Scottish Ministers may appoint by order.

14. In addition section 37(3) was amended to enable an order appointing a day for the commencement of sections 1 to 8 or schedule 1 to specify the time in the day for their commencement. The Committee was content with the amendments to the commencement power.
ANNEX A

SUPPLEMENTARY MEMORANDUM TO THE SUBORDINATE LEGISLATION COMMITTEE BY THE SCOTTISH EXECUTIVE

SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) BILL

PURPOSE

15. This supplementary memorandum has been prepared by the Scottish Executive in accordance with Rule 9.7.10 of the Parliament’s Standing Orders, to assist consideration by the Subordinate Legislation Committee in accordance with Rule 9.7.9. It addresses changes to provisions of the Smoking, Health and Social Care (Scotland) Bill conferring power to make subordinate legislation and the inclusion of new powers as a result of amendments at Stage 2 of the Bill. It describes the purpose of each additional provision and explains why the matter is to be left to subordinate legislation.

16. Part 1 of this supplementary memorandum explains changes made to subordinate legislation powers that were included in the Bill at introduction. Part 2 discusses new subordinate legislation powers introduced at Stage 2.

PART 1 – CHANGES TO EXISTING PROVISIONS

17. Section 4 has subordinate legislation making powers in relation to the prohibition of smoking in certain wholly enclosed places. Subsection (2) of section 4 enables Scottish Ministers to prescribe by means of regulations certain kinds of premises or classes of premises as “no-smoking premises” for the purposes of Part 1 of the Bill. Subsection (7) enables Scottish Ministers to modify, by means of regulations, section 4(4) so as to add or remove a kind of premises from the kinds of premises which can be prescribed as “no-smoking premises” under section 4(2). The Bill has been amended to require that any changes to regulations made under section 4(2) or (7) will be subject to consultation in draft form. The consultation requirements in relation to regulations made under not only section 4(2) and (7) but also section 3(3) are currently contained in section 34(4) of the Bill. As a consequence of these amendments, section 34(4) is redundant and the Executive will move a further technical amendment at Stage 3 to omit it from the Bill.

18. Sections 15 and 17 of the Bill include amendments to the provisions in the National Health Service (Scotland) Act 1978 (the 1978 Act) for subordinate legislation relating to the listing of relevant healthcare professionals. These amendments have been further amended at Stage 2 to provide for further subdivision of the lists. Further amendments to subsection (2B) of sections 25 and 26 of the 1978 Act add an extra provision to these subsections so that regulations made under the powers may provide that the relevant family health service practitioners may not provide services under arrangements with a Health Board unless they are named in the relevant part of the Health Board’s list. It is considered that these amendments do not affect the appropriateness of such regulations being made by negative resolution procedure.
19. A new section 19A of the Bill inserts new section 17VA into the 1978 Act. Section 17VA(2)(a) gives the Scottish Ministers power to prescribe the information relating to pharmaceutical care services that must be included in the Drug Tariff. The power is to be exercised by regulations subject to negative resolution procedure (sections 105(2) and 108(1) of the 1978 Act).

20. Section 30(2)(b) of the Bill was amended at Stage 2 to extend the subordinate legislation making power inserted into section 47 of the Adults with Incapacity (Scotland) Act 2000 (“the 2000 Act”). Section 30(2)(b) as introduced gave powers to allow Scottish Ministers to prescribe the requirements that must be met in order for the prescribed description of persons to certify for incapacity under section 47 of the 2000 Act. It is believed that the negative resolution procedure is still appropriate in respect of the extended powers.

21. Section 37(2) of the Bill was amended at Stage 2 to omit the references in it to sections 1 to 8 and schedule 1. The result of this is that these provisions will come into force on such day as the Scottish Ministers may appoint by order. In addition section 37(3) was amended to enable an order appointing a day for the commencement of sections 1 to 8 or schedule 1 to specify the time in the day for their commencement (so that they do not need to come into force at the beginning of that day).

SECTION 30 – AMENDMENT OF ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000: AUTHORISATION OF MEDICAL TREATMENT

Relevant provision: Section 30(2)(b) inserting section 47(1A) of the 2000 Act;
Power conferred on: The Scottish Ministers.
Power exercisable by: Regulations made by Statutory Instrument.

22. These are additional provisions in section 30 to enable Scottish Ministers to prescribe the requirements that the persons defined in section 47(1A) must meet in order to be entitled to issue certificates of incapacity. This would allow Scottish Ministers to, for example, prescribe appropriate accredited training that must be undertaken by these people.

23. The Bill, as introduced, did not therefore insert into section 47 a requirement for the specified groups of health professionals (dental practitioners, ophthalmic opticians and registered nurses) to have undergone training on the assessment of incapacity. As amended at Stage 2, section 30(2)(b) of the Bill now enables Scottish Ministers to prescribe by regulations requirements that must be met in relation to all of those health professionals in addition to those who may later be prescribed to be able to certify for incapacity.

24. It is considered that subordinate legislation is the most appropriate approach due to the flexibility of such a power to take account of changing circumstances. Regulations will be by negative resolution in accordance with section 86 of the 2000 Act, which should allow the appropriate degree of Parliamentary scrutiny.
PART 2 – NEW SUBORDINATE LEGISLATION MAKING POWERS

25. A new section 7A introduces a power to allow Scottish Ministers to vary by order the three separate age limits in section 18 of the Children and Young Persons (Scotland) Act 1937 relating to the sale of tobacco products and other preventative measures relating to young people smoking. It is believed that affirmative resolution procedure is appropriate for these powers and the Scottish Executive will bring forward an amendment at Stage 3 to require this.

26. New section 26A of the Bill inserts into section 25 of the Regulation of Care (Scotland) Act 2001 (“the 2001 Act”) new powers to make subordinate legislation. The new powers enable Scottish Ministers to vary the minimum inspection frequency for certain categories of registered care services (to below but not above the current statutory levels). These powers would be subject to affirmative resolution procedure.

SECTION 7A – SALE OF TOBACCO TO UNDER-AGE PERSONS: VARIATION OF AGE LIMIT

<table>
<thead>
<tr>
<th>Relevant provision:</th>
<th>Section 7A.</th>
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<tbody>
<tr>
<td>Power conferred on:</td>
<td>The Scottish Ministers.</td>
</tr>
<tr>
<td>Power exercisable by:</td>
<td>Order.</td>
</tr>
<tr>
<td>Parliamentary procedure:</td>
<td>Negative resolution procedure of the Scottish Parliament (Note – The Executive intends to bring forward an amendment at Stage 3 to require an affirmative resolution procedure).</td>
</tr>
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27. Under section 18 of the Children and Young Persons (Scotland) Act 1937 (c.37) (offence of selling tobacco etc. to under-age persons and other preventative measures), subsection (1) makes it an offence to sell tobacco to persons under 16; subsection (2) allows the court to order the person in charge of premises to take precautions to stop those under 16 from using a cigarette machine – and/or to order its removal; and subsection (3) places a duty on constables and park-keepers to seize any tobacco or cigarette papers from those under 16 if found in their possession whilst smoking in the street/public place.

28. The provisions in section 7A would enable Scottish Ministers, by order, to modify section 18 of the 1937 Act so as to substitute for the age specified in any of its provisions such other age or ages as they consider appropriate. Scottish Ministers believe that where there is evidence that varying the minimum age in section 18 would contribute to reducing smoking rates in Scotland then this power may be exercised.

29. The Scottish Ministers may make an order under this section only after consulting such persons as they consider appropriate on a draft of the order. As the powers will enable Scottish Ministers to amend primary legislation it is felt that affirmative resolution is considered to be the appropriate procedure and the Scottish Executive will bring forward an amendment to section 34 at Stage 3 to address this.
SECTION 26A – FREQUENCY OF INSPECTION OF CARE SERVICES UNDER THE 2001 ACT

Relevant provision: Section 26A inserts a new Section 25(5A) into the 2001 Act.

Power conferred on: The Scottish Ministers
Power exercisable by: Order made by Statutory Instrument
Parliamentary Procedure: Affirmative Resolution of the Scottish Parliament

30. At present, the Care Commission is required by section 25 of the 2001 Act to inspect all care services at least once every 12 months (or twice every 12 months, in the case of certain services). In respect of inspections Section 25 distinguishes between the first 12 months after registration with the Care Commission and subsequent 12 month periods.

31. The new section 25(5A) gives the Scottish Ministers the power, after consulting the Care Commission and other appropriate persons, to amend by Order the minimum frequency at which care services must be inspected by the Care Commission. More specifically, the power enables the Scottish Ministers to vary the length of the periods specified in sections 25(3) and 25(5) of the 2001 Act (to a frequency below but not above the current statutory levels) and therefore reduce the minimum frequency of mandatory inspections. The power is capable of being exercised in different ways in respect of different care services.

32. As the Care Commission’s experience of regulating particular sectors grows, it may be necessary over time to change the frequencies in different ways in respect of different services. Subordinate legislation is considered appropriate for this purpose because it affords the Scottish Ministers flexibility to respond quickly to changes in circumstances, the power to amend is subject to affirmative resolution procedure (in accordance with section 78(2)(b) of the 2001 Act as amended at Stage 2 by new section 26A(3) of the Bill) and, thirdly, the Scottish Ministers will be required to consult first the Care Commission and, thereafter, other appropriate persons before a draft can be laid before the Scottish Parliament.
Smoking, Health and Social Care (Scotland) Bill

Marshalled List of Amendments selected for Stage 3

The Bill will be considered in the following order—

Sections 1 to 37
Schedules 1 to 3
Long Title

Amendments marked * are new (including manuscript amendments) or have been altered.

Section 1

Mr Brian Monteith
33 In section 1, page 1, line 25, at beginning insert <Subject to subsection (1A),>

Mr Brian Monteith
34 In section 1, page 1, line 25, at beginning insert <Subject to subsection (1B),>

Mr Brian Monteith
35 In section 1, page 1, line 25, at beginning insert <Subject to subsections (1A) and (1B),>

Mr Brian Monteith
36 In section 1, page 1, line 26, at end insert—

<(1A) This section does not apply to a person who has the management or control of a theatre or other venue where the person knowingly permitted to smoke is taking part in a bona fide performance or organised rehearsal of a dramatic or lyric theatrical production.>

Mr Brian Monteith
37 In section 1, page 1, line 26, at end insert—

<(1B) This section does not apply to a person having the management or control of a retail establishment dedicated to or predominantly for the sale of tobacco or tobacco products in respect of smoking in such premises.>

Mr Brian Monteith
38 In section 1, page 1, line 30, leave out from beginning to <that> in line 1 on page 2 and insert—

<(3) An accused charged with an offence under this section is not guilty of an offence if—
(a)>

Mr Brian Monteith
39 In section 1, page 2, line 3, leave out <that>
Section 2

Mr Brian Monteith
40 In section 2, page 2, line 8, at beginning insert <Subject to subsection (1A), >

Mr Brian Monteith
41 In section 2, page 2, line 8, at beginning insert <Subject to subsection (1B), >

Mr Brian Monteith
42 In section 2, page 2, line 8, at beginning insert <Subject to subsections (1A) and (1B),>

Mr Brian Monteith
43 In section 2, page 2, line 8, at end insert—
   <(1A) This section does not apply to smoking by an actor or other performer taking part in the
   bona fide performance or organised rehearsal of a dramatic or lyric theatrical production
   in a theatre or other venue being used for such a production.>

Mr Brian Monteith
44 In section 2, page 2, line 8, at end insert—
   <(1B) This section does not apply to smoking by a customer of a retail establishment dedicated
   to or predominantly for the sale of tobacco or tobacco products while in the premises of
   such an establishment.>

Mr Brian Monteith
Supported by: Mrs Nanette Milne
45 In section 2, page 2, line 9, leave out from beginning to <that> and insert <An accused charged
with an offence under this section is not guilty of an offence if>

Section 3

Mr Brian Monteith
46 In section 3, page 2, line 15, at beginning insert <Subject to subsection (1A), >

Mr Brian Monteith
47 In section 3, page 2, line 15, at beginning insert <Subject to subsection (1B), >

Mr Brian Monteith
48 In section 3, page 2, line 15, at beginning insert <Subject to subsections (1A) and (1B),>

Mr Brian Monteith
49 In section 3, page 2, line 21, at end insert—
<(1A) Nothing in subsection (1) requires a notice to be displayed in a theatre or other venue being used for a dramatic or lyric theatre production in a location where the notice would detract from the performance of the production or the artistic integrity of the set.>

Mr Brian Monteith

50 In section 3, page 2, line 21, at end insert—
<(1B) Nothing in subsection (1) requires a notice to be displayed in a retail establishment dedicated to or predominantly for the sale of tobacco or tobacco products.>

Mr Brian Monteith

Supported by: Mrs Nanette Milne

51 In section 3, page 2, line 22, leave out from beginning to <that> and insert <An accused charged with an offence under this section is not guilty of an offence if>

Section 4

Mr Brian Monteith

52 In section 4, page 2, line 37, after third <premises> insert—
<(  ) not being exempt places listed in schedule (Exempt places); and
(  )>

Irene Oldfather

53 In section 4, page 3, line 1, leave out from <prescribe> to <are> in line 2 and insert <provide for some (but not most) wholly enclosed spaces within such no-smoking premises or classes of no-smoking premises as may be prescribed by the regulations to be>

Mr Brian Monteith

54 In section 4, page 3, line 2, after <which> insert <, in addition to the exempt places listed in schedule (Exempt places),>

Irene Oldfather

55 In section 4, page 3, line 3, at end insert—
<(  ) Regulations under subsection (2) need not, insofar as they relate to premises of the type mentioned in subsection (4)(ya), provide for the whole of such an outside space to be included in the definition of “no-smoking premises”; but must provide for at least one area within each such outside space to be so included.>

Irene Oldfather

56 In section 4, page 3, line 4, after <is> insert—
<(ya) any outside space which forms part of premises—
(i) to which the public or a section of the public has access; and
(ii) which are used exclusively or mainly for the sale and consumption of food or drink; or
Mr Brian Monteith

In section 4, page 3, line 11, at end insert—

<( ) For the purposes of subsection (4)—
  (a) a place is to be regarded as wholly enclosed if it is completely enclosed on all sides by solid floor-to-ceiling walls, windows, or solid floor-to-ceiling partitions with the exception of doors and passageways; and
  (b) a place is to be regarded as substantially enclosed if it is at least partially covered by a roof and has walls such that the total area of the roof and wall surfaces exceeds 70 per cent of the total notional roof and wall area.>

Mr Brian Monteith

In section 4, page 3, leave out line 17

Mr Brian Monteith

In section 4, page 3, line 23, at end insert—

<(6A) The Scottish Ministers may, by regulations, after consulting such persons as they consider appropriate, modify schedule (Exempt places) so as to—
  (a) add to a kind of premises to; or
  (b) remove a kind of premises from,
those in that schedule.>

Rhona Brankin
Supported by: Mr Andy Kerr

In section 4, page 3, line 32, at end insert <and that any such provision is to be treated, for the purposes of that section, as if incorporated in it>

After section 4

Mr Brian Monteith
Supported by: Mrs Nanette Milne

After section 4, insert—

<Defences: burden of proof

(1) This section applies where an accused charged with an offence under this Part relies on a defence under any of sections 1(3)(a) and (b), 2(2) and 3(2).

(2) Where evidence is adduced which is sufficient to raise an issue with respect to that defence, the court or jury is to assume that the defence is satisfied unless the prosecution proves beyond reasonable doubt that it is not.>
Section 7A

Mr Stewart Maxwell

1 In section 7A, page 5, line 22, after <other> insert <higher>

Before section 9

Kate Maclean

63 Before section 9, insert—

<Eye examinations and sight tests of school pupils>

In section 39 (medical and dental inspection, supervision and treatment of pupils and young persons) of the 1978 Act—

(a) after subsection (2) insert—

“(2A) It is also the duty of the Scottish Ministers to provide, to such extent as they consider necessary to meet all reasonable requirements—

(a) for the carrying out of eye examinations and sight tests for such pupils and young persons as are mentioned in subsection (1); and

(b) for their ophthalmic treatment.

(2B) The Scottish Ministers must, in carrying out their duties under subsection (2A), ensure that a screening programme is provided to include a minimum of an eye examination for all pupils on entry to the first year of primary education and a sight test for all pupils on entry to the first year of secondary education.”;

(b) in subsection (3), after “subsection (2)”, insert “and ophthalmic treatment made available for the purpose of subsection (2A)”;

(c) in subsection (4), after “subsection (2)”, insert “and for the eye examination and ophthalmic treatment described in subsection (2A).”.

Mr Duncan McNeil

64 Before section 9, insert—

<Detection of vision problems in children>

After section 38A of the 1978 Act, insert—

“38B Detection of vision problems in children

(1) It is the duty of the Scottish Ministers, to such extent as they consider necessary to meet all reasonable requirements, to provide for the detection of vision problems in children.

(2) In this section, “children” means persons under the age of 16 years.”.

After section 10

Mrs Nanette Milne

17 After section 10, insert—
Uptake of oral health assessments and eye examinations

(1) In making any kind of arrangements under the 1978 Act or arrangements for pilot schemes under Part 1 of the National Health Service (Primary Care) Act 1997 (c.46) which include the provision of oral health assessments and dental examinations or eye examinations and sight tests free of charge, every Health Board must ensure that those categories of persons who would, before 1st April 2006, have been entitled to receive dental examinations or sight tests free of charge are encouraged to attend at appropriate intervals for oral health assessments and dental examinations and eye examinations and sight tests.

(2) The Scottish Ministers may, for the purpose of ensuring that the duty imposed by subsection (1) continues to apply only in respect of vulnerable categories of persons where uptake of oral health assessments and dental checks or eye examinations and sight tests is low, by order amend that subsection.

Section 14

Rhona Brankin
Supported by: Mr Andy Kerr

18 Move section 14 to after section 21

Section 15

Mrs Nanette Milne

19 In section 15, page 8, line 33, after <regulations> insert—

<( ) shall include provision for the same disclosure of information to be required and on the same timescale in respect of the persons mentioned in subsection (2C)(a) as is required in respect of the persons mentioned in subsection (2C)(b); and

( )>

Mrs Nanette Milne

20 In section 15, page 9, line 27, at end insert—

<(2C) The persons are—

(a) persons included in any list of persons undertaking to provide general dental services prepared and published by virtue of subsection (2)(a) of this section as in force immediately before the coming into force of section 15 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00);

(b) applicants for inclusion in the list prepared, maintained and published by virtue of subsection (2) of this section as inserted by that section of that Act.>
Section 17

Mrs Nanette Milne

21 In section 17, page 10, line 39, after <regulations> insert—

<(  ) shall include provision for the same disclosure of information to be required and on the same timescale in respect of the persons mentioned in subsection (2C)(a) as is required in respect of the persons mentioned in subsection (2C)(b); and

( )>

Mrs Nanette Milne

22 In section 17, page 11, line 31, at end insert—

<(2C) The persons are—

(a) persons included in any list of persons undertaking to provide general ophthalmic services prepared and published by virtue of subsection (2)(a) of this section as in force immediately before the coming into force of section 17 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00);

(b) applicants for inclusion in the list prepared, maintained and published by virtue of subsection (2)(a) of this section as inserted by that section of that Act.>

Section 24

Rhona Brankin
Supported by: Mr Andy Kerr

24 In section 24, page 22, line 12, at end insert <and

( ) did not die before 29th August 2003;>

Shona Robison

65 In section 24, page 22, line 20, leave out from <; and> to end of line 21

Rhona Brankin
Supported by: Mr Andy Kerr

25 In section 24, page 23, line 11, after <claims;> insert—

<(  ) provide for a right of appeal against a decision refusing a claim under the scheme;>

Rhona Brankin
Supported by: Mr Andy Kerr

26 In section 24, page 23, line 16, leave out <(1)(za)> and insert <(1)>
Section 30

Rhona Brankin
Supported by: Mr Andy Kerr

27  In section 30, page 29, line 40, after <adult> insert <(in a case where the person who so issued the certificate was someone other than that practitioner)>  

Section 31

Carolyn Leckie

2  Leave out section 31

Section 34

Mr Brian Monteith

66  In section 34, page 37, line 7, after <section> insert <4(6A) or>

Rhona Brankin
Supported by: Mr Andy Kerr

28  In section 34, page 37, line 7, after <section > insert <7A or>

Rhona Brankin
Supported by: Mr Andy Kerr

29  In section 34, page 37, line 12, leave out subsection (4)

Before schedule 1

Mr Brian Monteith
Supported by: Mrs Nanette Milne

62  Before schedule 1, insert—

<SCHEDULE
(introduced by section 4)
EXEMPT PLACES

Domestic premises.
Short and long-term adult residential care premises and hospices.
Psychiatric hospitals and psychiatric units.
Any offshore installation.
Such hotel bedrooms as are designated by the person having the management or control of the hotel as being bedrooms in which smoking is permitted.
Any dedicated interview room, detention room or cell accommodation within a police station.
Any legalised police cell within the meaning of section 14 of the Prisons (Scotland) Act 1989 (c.45) or prison cell.

Any retail establishment dedicated to or predominantly for the sale of tobacco or tobacco products.

The stage area of any enclosed theatrical production site, where smoking is an integral part of the production.

Any club premises to which the public does not have access as of right.

Medical research and treatment sites forming part of any educational establishment or healthcare facility, where smoking is integral to the research being conducted.

Private vehicles.

Any designated smoking area within an airport departure lounge.

Public houses where no hot food is served.

Schedule 2

Rhona Brankin
Supported by: Mr Andy Kerr
30 In schedule 2, page 41, line 14, after <157> insert <(no appeal otherwise)>  

Rhona Brankin
Supported by: Mr Andy Kerr
31 In schedule 2, page 44, line 39, after <(8)> insert <, at end>  

Long Title

Rhona Brankin
Supported by: Mr Andy Kerr
32 In the long title, page 1, line 2, after <places;> insert <to enable the Scottish Ministers by order to vary the minimum age limit of those to whom tobacco may be sold;>  

Mr Duncan McNeil
67 In the long title, page 1, line 3, leave out <services and> and insert <services,>  

Mr Duncan McNeil
68 In the long title, page 1, line 3, after second <services> insert <and detection of vision problems in children>  

Carolyn Leckie
69 In the long title, page 1, line 16, leave out from first <to> to <Scotland;> in line 19
Smoking, Health and Social Care (Scotland) Bill

Groupings of Amendments for Stage 3

Note: The time limits indicated are those set out in the timetabling motion to be considered by the Parliament before the Stage 3 proceedings begin. If that motion is agreed to, debate on the groups above each line must (subject to Rules 9.8.4A and 9.8.5A of Standing Orders) be concluded by the time indicated, although the amendments in those groups may still be moved formally and disposed of later in the proceedings.

Group 1: Exempt places and exclusion of tobacco retailers, theatre performances and rehearsals
33, 34, 35, 36, 37, 40, 41, 42, 43, 44, 46, 47, 48, 49, 50, 52, 54, 59, 66, 62

Group 2: Defences
38, 39, 45, 51, 60

Group 3: Restriction of smoking in exempt places
53

Group 4: No-smoking areas in outside premises
55, 56

Debate to end no later than 55 minutes after proceedings begin

Group 5: Definition of wholly or substantially enclosed
57, 58

Group 6: Part 1 regulation making powers – miscellaneous
7, 29

Group 7: Sale of tobacco to under-age persons
1, 28, 32

Debate to end no later than 1 hour 20 minutes after proceedings begin

Group 8: Eye examinations, sight tests and oral health assessments
63, 64, 17, 67, 68

Group 9: Minor and technical amendments
18, 27, 30, 31

Group 10: Disclosure of information by those already on NHS lists
19, 20, 21, 22

Debate to end no later than 2 hours after proceedings begin
Group 11: Skipton fund – eligibility date
24, 65

Group 12: Skipton fund – appeals and eligibility
25, 26

Group 13: Joint ventures
2, 69

Debate to end no later than 3 hours after proceedings begin
Dear Roseanna

THE SMOKING, HEALTH AND SOCIAL CARE (SCOTLAND) ACT 2005
(PROHIBITION OF SMOKING IN CERTAIN PREMISES) REGULATIONS 2005

I undertook to provide the Health Committee with a copy of these updated regulations in time for the Stage 3 debate on the Smoking Bill tomorrow. The attached draft reflects discussion at earlier Parliamentary Stages of the Bill and takes into account issues raised by respondents during the recent public consultation. I should point out that they are still ‘work in progress’, albeit largely on issues of drafting refinement, rather than of substance.

I should like to bring some of the key changes to the Committee’s attention:

Exemptions

Exemptions for adult care homes and psychiatric facilities now only apply to ‘designated rooms’ within these facilities. ‘Designated room’ has been defined to ensure that it must have a ventilation system which does not ventilate into any other part of the no-smoking premises. By adopting this approach, I hope to strengthen our message about the importance of protecting staff, visitors and non-smoking residents of these facilities from the harmful effects of second hand smoke. As I have already indicated elsewhere, it is open to all such establishments to adopt a fully no-smoking policy and I would strongly encourage them to do so wherever possible.

Signage

Further clarification has been provided on the signage to be displayed in no-smoking premises. Proprietors are required to have one sign of the specified size, displaying the required text conspicuously visible inside their premises. They would then have flexibility on the size and shape of other signs in the premises, as long as the international no smoking symbol is used and is of a specified minimum size. Less stringent signage requirements are also set out for vehicles.
No-smoking premises

An amendment made to the Bill at Stage 2 defined no-smoking premises as those which are 'wholly or substantially enclosed'. These premises are now further defined within the regulations so that premises without a roof, or those with an opening which constitutes 50% or more of the perimeter (excepting doors, windows, passageways etc) are not caught by the legislation. This is broadly in line with the effect of the definitions in the similar Irish legislation.

Definitions

A number of definitions have been strengthened to take on board suggestions made by respondents to the consultation and to ensure clarity.

I trust the Committee will welcome these changes. A copy of this letter and the updated regulations are also being made available on SPICE. Copies of the finalised regulations will be sent to all those who responded to the consultation exercise when they are available. They will be laid, with the Commencement Order for the Act, when Parliament resumes in September.

ANDY KERR
2005 No. [ ]

PUBLIC HEALTH

The Smoking, Health and Social Care (Scotland) Act 2005
(Prohibition of Smoking in Certain Premises) Regulations 2005

Made - - - -

Laid before the Scottish Parliament

Coming into force

The Scottish Ministers, in exercise of the powers conferred by sections 3(3), 4(2), 4(7) of, and paragraphs 2, 5(1), 6(2), 13 and 14 of Schedule 1 to, the Smoking, Health and Social Care (Scotland) Act 2005 and all other powers enabling them in that behalf, after consulting such persons as they consider appropriate in accordance with section 34(4) of that Act, hereby make the following Regulations, a draft of which has, in accordance with section 34(3) of that Act, been laid before and approved by a resolution of the Scottish Parliament:

Citation, interpretation and commencement

1.—(1) These Regulations may be cited as the Smoking, Health and Social Care (Scotland) Act 2005 (Prohibition of Smoking in Certain Premises) Regulations 2005.

(2) In these Regulations—

“the Act” means the Smoking, Health and Social Care (Scotland) Act 2005;

“adult” means a person who has attained the age of 16 years;

“adult care home” means an establishment providing a care home service exclusively for adults;

“adult hospice” means a hospice providing care exclusively for adults;

“bar” means any premises exclusively or mainly used for the sale and consumption of beverages, whether alcoholic or not;

“care home service” means a care home service within the meaning of section 2(3) of the Regulation of Care (Scotland) Act 2001(b);

“club premises” means any premises which are used by and for the purposes of a club or other unincorporated association, whether for profit or not;

“council” means a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994(a);

(a) 2005 asp [ ]
(b) 2001, asp 8
smoking rega 2806-jk
"designated hotel bedroom" means a room in a hotel which –

(a) is set apart exclusively for the sleeping accommodation of travellers;
(b) has been designated by the person having the management or control of the hotel as being a room in which smoking is permitted;
(c) has a ceiling and, except for doors and windows, is completely enclosed on all sides by solid floor-to-ceiling walls;
(d) has a ventilation system that does not ventilate into any other part of the hotel (except any other designated hotel bedrooms); and
(e) is clearly marked as a bedroom in which smoking is permitted;

"designated room" means a room which –

(a) has been designated by the person having the management or control of the no-smoking premises in question as being a room in which smoking is permitted;
(b) has a ceiling and, except for doors and windows, is completely enclosed on all sides by solid floor-to-ceiling walls;
(c) has a ventilation system that does not ventilate into any other part of the no-smoking premises in question (except any other designated rooms); and
(d) is clearly marked as a room in which smoking is permitted;

"detention or interview room" means a room -

(a) within a police station which is used for the purposes of interviewing or detaining persons;
(b) within a police station which is used for the purposes of cell accommodation;
(c) which is a legalised police cell;
(d) within premises used by a person commissioned, appointed or authorised under [section 6(3) of the Customs and Excise Management Act 1979(b)] for the purposes of interviewing or detaining persons;
(e) within premises used by an authorised person within the meaning of [section 96(1) of the Value Added Tax Act 1994(c)] for the purposes of interviewing or detaining persons;

"domestic premises" means premises occupied as a private dwelling (including any garage, outhouse, or other appurtenance of such premises which is not used in common by the occupants of more than one such dwelling), and “non-domestic premises” shall be construed accordingly;

"educational institution" means –

(a) a school within the meaning of section 135(1) of the Education (Scotland) Act 1980(d);
(b) a school care accommodation service within the meaning of section 2(4) of the Regulation of Care (Scotland) Act 2001;
(c) a college or other institution providing further education within the meaning of section 1 of the Further and Higher Education (Scotland) Act 1992(e) and section 1(5)(b) of the Education (Scotland) Act 1980;
(d) a university or other institution providing higher education within the meaning of section 38 of the Further and Higher Education (Scotland) Act 1992; and
(e) any other educational and vocational institution;

"health care premises" means any premises provided by the Scottish Ministers in accordance with the provisions of section 36(1)(b) of the National Health Service (Scotland) Act 1978(f) and any other premises which are not a hospital which are used for the purpose of providing medical, dental, pharmaceutical, ophthalmic or chiropody services to non-resident persons;

(a) 1994, c.29
(b) 1979, c.2
(c) 1994, c.23
(d) 1980, c.44
(e) 1992, c.37
(f) 1978, c.29

smoking regs 2806v2-jk
"hospice" means an establishment the whole or main purpose of which is to provide palliative care for persons resident there who are suffering from a progressive disease in its final stages;

"hospital" means -

(a) any institution for the reception and treatment of persons suffering from illness;
(b) any maternity home; and
(c) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and any institution for providing dental treatment maintained in connection with a dental school,

and includes clinics, dispensaries and out-patient departments which are not health care premises which are maintained in connection with any such home or institution;

"hospital unit" means any part of a hospital which is treated as a separate unit;

"hotel" means a hotel, boarding house, guest house, inn or hostel containing at least two apartments set apart exclusively for the sleeping accommodation of travellers;

"illness" includes mental disorder within the meaning of the Mental Health (Care and Treatment) (Scotland) Act 2003(a) and any injury or disability requiring medical or dental treatment or nursing;

"legalised police cell" means a police cell within the meaning of section 14 of the Prisons (Scotland) Act 1989(b);

"no-smoking notice" means a notice displayed in accordance with section 3(1) of the Act;

["offender accommodation service" means an offender accommodation service within the same meaning of section 2(10) of the Regulation of Care (Scotland) Act 2001;]

"offshore installation" means any offshore installation within the meaning of regulation 3 of the Offshore Installations and Pipeline Works (Management and Administration) Regulations 1995(c);

"premises" includes -

(a) any building or part of a building;
(b) any structure or part of a structure, whether moveable or otherwise;
(c) any installation on land (including the foreshore and other land intermittently covered by water), any offshore installation, and any other installation (whether floating, or resting on the seabed or the subsoil thereof, or resting on other land covered with water or the subsoil thereof); and
(d) any tent, marquee or stall;

"private hire car" means a hire car other than a taxi within the meaning of section 23(1) of the Civic Government (Scotland) Act 1982(d);

"private vehicle" means any vehicle which is used primarily for the private purposes of the person who owns it or of a person otherwise having the right to use it, provided always that such right to use a vehicle does not, in relation to a motor vehicle, include a reference to a person whose right to use the vehicle derives only from having paid, or undertaken to pay, for the use of the vehicle and its driver for a particular journey;

"psychiatric hospital" means a hospital the whole or main purpose of which is to treat persons with a mental disorder within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003, and includes a state hospital;

(a) 2003,asp 13
(b) 1989, c.45
(c) S.I. 1995/738
(d) 1982, c.45

smoking regs 2806v2-jk
“psychiatric unit” means a hospital unit the whole or main purpose of which is to treat persons with a mental disorder within the meaning of section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003;

"public house" includes an inn, ale-house, victualling house or other premises in which alcoholic drink is sold by retail for consumption either on or off the premises;

“public transportation facilities” includes waiting rooms, ticket offices and terminal buildings provided in connection with any public transportation vehicle;

“public transportation vehicle” means any vehicle available to the public as a means of transportation;

"residential accommodation" means so much of any premises as is for the time being occupied or used by any person for residential purposes or otherwise as living accommodation, (including hotel accommodation that is occupied or used as a person's principal place of residence), but not including a reference to so much of any premises as constitutes any common area to which the person has or is allowed access in connection with the person's use or occupation of any accommodation, nor including a reference to an adult care home, an adult hospice, a psychiatric hospital, a psychiatric unit or premises providing a secure accommodation service;

“restaurant” means -

(a) a café, coffee shop, bistro, fast food establishment or snack bar; and
(b) any other premises exclusively or mainly used for the sale and consumption of food;

“secure accommodation service” means a secure accommodation service within the same meaning of section 2(9) of the Regulation of Care (Scotland) Act 2001;

“sports centre” means any gymnasium, health spa, swimming pool, roller or ice rink, bowling alley and other similar premises used to engage in sports, athletics or recreational activities or to witness sports, athletics, recreational or similar activities;

“state hospital” means a state hospital provided under section 102(1) of the National Health Service (Scotland) Act 1978;

“taxi” means a hire car within the meaning of section 23(1) of the Civic Government (Scotland) Act 1982; and

"vehicle" includes any train, bus, taxi and any vessel (whether navigable or not), boat or hovercraft.

(3) A reference to premises may include premises within premises.

(4) These Regulations shall come into force on [    ] 2006.

Display of no-smoking notices

2.—(1) At least one no-smoking notice displayed in no-smoking premises that are not a vehicle shall --
(a) be a minimum size of 230mm by 160mm;
(b) display the international “no smoking” symbol, consisting of a graphic representation of a burning cigarette enclosed in a red circle with a red bar across it, at least 85mm in diameter; and
(c) display the name of the person to whom a complaint may be made by any person who observes another person smoke in the no-smoking premises in question and state that a complaint may be so made.

(2) The remainder of no-smoking notices displayed in no-smoking premises that are not a vehicle and any no-smoking notices displayed on or near no-smoking premises that are not a vehicle shall display the international “no smoking” symbol, consisting of a graphic representation of a burning cigarette enclosed in a red circle with a red bar across it, at least 85mm in diameter.
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(3) A no-smoking notice displayed in no-smoking premises that are a vehicle shall –

(a) display the international “no smoking” symbol, consisting of a graphic representation of a burning cigarette enclosed in a red circle with a red bar across it; and

(b) display the holder of a particular post to whom a complaint may be made by any person who observes another person smoke in the no-smoking premises in question and state that a complaint may be so made.

(4) A no-smoking notice shall be displayed by the person having the management or control of the no-smoking premises in such a manner that it is protected from tampering, damage, removal or concealment.

“No-smoking premises”

3.—(1) The premises or classes of premises prescribed(a) under section 4(2) of the Act as being “no-smoking premises” for the purposes of Part 1 of the Act are the premises or classes of premises specified in Schedule 1 to these Regulations, being premises or classes of premises which are wholly enclosed.

(2) The premises or parts of premises or classes of premises or parts of premises prescribed under section 4(3) of the Act which are excluded from the definition of “no-smoking premises” are the premises or parts of premises or classes of premises or parts of premises specified in Schedule 2 to these Regulations.

(3) For the purposes of section 4(2) of the Act –

(a) “premises” includes -

(i) any building or part of a building;

(ii) any structure or part of a structure, whether moveable or otherwise;

(iii) any installation on land (including the foreshore and other land intermittently covered by water), any offshore installation, and any other installation (whether floating, or resting on the seabed or the subsoil thereof, or resting on other land covered with water or the subsoil thereof);

(iv) any tent, marquee or stall; and

(v) any vehicle.

(b) “wholly enclosed” means –

(i) for premises other than a vehicle or part of a vehicle, having a ceiling or roof and, except for doors, windows and passageways, wholly enclosed, whether permanently or temporarily; or

(ii) for premises that are a vehicle, or part of a vehicle, having a top or roof and, except for doors, windows or exits, wholly enclosed, whether permanently or temporarily;

(c) “substantially enclosed” means –

(i) for premises other than a vehicle or part of a vehicle, having a ceiling or roof and, except for doors, windows and passageways, substantially enclosed, whether permanently or temporarily; or

(ii) for premises that are a vehicle, or part of a vehicle, having a top or roof and, except for doors, windows or exits, substantially enclosed, whether permanently or temporarily, and in determining whether premises are “substantially enclosed”, no account is to be taken of openings in which there are doors, windows or other fittings that can be opened or shut;

(a) Section 35 of the Act defines “prescribed” as meaning prescribed by regulations made by the Scottish Ministers

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(d) premises shall be taken to be “substantially enclosed” if-
   (i) the opening in the premises has an area; or
   (ii) if there is more than one, both or all those openings have an aggregate area,
       which is less than half of the area of the walls, including any other structures serving the
       purpose of walls, which constitute the perimeter of the premises;

(e) where an opening is in, or consists of the absence of, such walls or other structures or a part of
    them, their area shall be measured for the purposes of paragraph (d) as if it included the area of the
    opening; and

(f) “has access” means has access whether on payment or otherwise, and whether as of right or by
    virtue of express or implied permission.

Fixed penalty time limits, amounts and payments

4. — (1) The time limit prescribed under paragraph 2 of Schedule 1 to the Act relating to the offence after
which a fixed penalty notice may not be given shall be 7 days.

(2) The amount of the fixed penalty prescribed under paragraph 4(1) of Schedule 1 to the Act is –

   (a) £200 for an offence under section 1 of the Act;
   (b) £50 for an offence under section 2 of the Act; and
   (c) £200 for an offence under section 3 of the Act.

(3) The discounted amount prescribed under paragraph 5(2) of Schedule 1 to the Act for a fixed
    penalty is -

   (a) £150 for an offence under section 1 of the Act;
   (b) £30 for an offence under section 2 of the Act; and
   (c) £150 for an offence under section 3 of the Act.

Application by councils of fixed penalties and account keeping

5. (1) Paragraphs (4) and (5) apply in relation to the application by councils of fixed penalties paid under
   Schedule 1 to the Act.

(2) Paragraphs (3) and (6) apply in relation to the keeping of accounts, and the preparation and
    publication of statements of account, by councils in relation to fixed penalties under Schedule 1 to the Act.

(3) Councils shall keep an account of their income and expenditure in respect of the administration
    and enforcement of section 5 of, and Schedule 1 to, the Act.

(4) At the end of each financial year any deficit in the account shall be made good out of the council’s
    general fund, and (subject to paragraph 5 below) any surplus shall be applied to purposes connected with
    the improvement of the amenity of the area of the council or any part of that area.

(5) If the council so determines, any amount not applied in any financial year, instead of being or
    remaining so appropriated, may be carried forward in the account kept under paragraph 1 above to the next
    financial year.

(6) Each council shall, as soon as possible after the end of each financial year, prepare and send to
    the Scottish Ministers a statement of account to include the account of their income and expenditure kept
    under paragraph (3) above and an account of any action taken by them, pursuant to paragraph 4 or 5 above,
    in respect of any deficit or surplus in their account for the year.

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Regulation 3(1)

SCHEDULE 1

NO-SMOKING PREMISES

1. Restaurants.
2. Bars and public houses.
3. Shops and shopping centres.
4. Hotels.
6. Cinemas, concert halls, theatres, bingo halls, gaming and amusement arcades, casinos, dance halls, discotheques and other premises used for the entertainment of members of the public.
7. Premises used as a broadcasting studio or film studio or for the recording of a performance with a view to its use in a programme service or in a film intended for public exhibition.
8. Halls and any other premises used for the assembly of members of the public for social or recreational purposes.
11. Club premises.
12. Offices, factories and other premises that are non-domestic premises in which one or more persons work.
14. Premises providing care home services, sheltered housing, secure accommodation services [and offender accommodation services/bail hostels].
15. Hospitals, hospices, psychiatric hospitals, psychiatric units and health care premises.
16. Crèches, day nurseries, day centres and other premises used for the day care of children or adults.
17. Premises used for, or in connection with, public worship or religious instruction, or the social or recreational activities of a religious body.
19. Airport passenger terminals and any other public transportation facilities.
20. Public transportation vehicles.
21. Vehicles which one or more persons use for work.
22. Public telephone kiosks.
SCHEDULE 2

Regulation 3(2)

EXEMPTIONS

1. Residential accommodation.
2. Designated rooms in adult care homes.
3. Adult hospices.
4. Designated rooms in psychiatric hospitals and psychiatric units.
5. Designated hotel bedrooms.
6. Detention or interview rooms which are designated rooms.
7. [Designated rooms in offender accommodation service premises (bail hostels)]
8. Offshore installations.
EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make further provision under Part 1 of, and Schedule 1 to, the Smoking, Health and Social Care (Scotland) Act 2005 ("the Act") in relation to the prohibition of smoking in certain wholly and substantially enclosed premises.

Regulation 1 contains the citation, commencement and interpretation provisions to be applied to the Regulations, and gives the date (xxxxx 2006) on which they will come into force.

Regulation 2 makes provision in relation to the display of no-smoking notices, providing further requirements in addition to those already stipulated under section 3(1) of the Act. Paragraph (1) of regulation 2 sets out the requirement that at least one no-smoking notice within no-smoking premises that are not a vehicle must be a minimum size and must display certain specified details. Paragraph (2) provides that all other no-smoking notices on no-smoking premises that are not a vehicle, as well as any no-smoking notices on or near no-smoking premises that are not a vehicle, must still display the international no-smoking symbol. Paragraph (3) makes separate provision in relation to no-smoking premises that are vehicles by requiring certain specified details to be displayed.

Regulation 3(1) gives effect to Schedule 1, which sets out the premises or classes of premises which are prescribed under section 4(2) of the Act to be no-smoking premises for the purposes of Part 1 of the Act, being premises or classes of premises which are wholly enclosed. These are: restaurants; bars and public houses; shops and shopping centres; hotels; libraries, archives, museums and galleries; cinemas, concert halls, theatres, bingo halls, gaming and amusement arcades, casinos, dance halls, discotheques and other premises used for the entertainment of members of the public; premises used as a broadcasting studio or film studio or for the recording of a performance with a view to its use in a programme service or in a film intended for public exhibition; halls and any other premises used for the assembly of members of the public for social or recreational purposes; conference centres, public halls and exhibition halls; public toilets; club premises; offices, factories and other premises that are non-domestic premises in which one or more person works; educational institutions; premises providing care home services, sheltered housing, secure accommodation services [and offender accommodation services/bail hostels]; hospitals, hospices, psychiatric hospitals, psychiatric units and health care premises; crèches, day nurseries, day centres and other premises used for the day care of children or adults; premises used for, or in connection with, public worship or religious instruction, or the social or recreational activities of a religious body; sports centres; airport passenger terminals and any other public transportation facilities; public transportation vehicles; vehicles which one or more person uses for work; and public telephone kiosks, the majority of which terms are defined in regulation 1(2).

Regulation 3(2) gives effect to Schedule 2, which sets out the premises or parts of premises or classes of premises or parts of premises which are prescribed under section 4(3) of the Act to be excluded from the definition of "no-smoking premises", that is those which are excluded from the list of "no-smoking premises" in Schedule 1. These are: residential accommodation; designated rooms in adult care homes; adult hospices; designated rooms in psychiatric hospitals and psychiatric units; designated hotel bedrooms; detention or interview rooms which are designated rooms; [designated rooms in offender accommodation service premises/bail hostels]; offshore installations; and private vehicles, all of which terms are defined in regulation 1(2).

Regulation 3(3) defines and elaborates the meaning of certain expressions ("premises"; "wholly enclosed"; "substantially enclosed"; and "has access") used in section 4(4) of the Act, as provided for under section 4(5).

Regulation 4 prescribes time limits, amounts and payments in relation to fixed penalties under Schedule 1. Paragraph (1) prescribes the time limit under paragraph (1) of Schedule 2 to the Act after which a fixed penalty notice may not be given as being 7 days. Paragraph (2) prescribes the amount of the fixed penalty under paragraph 4(1) of Schedule 1 to the Act for offences under section 1 (£200), section 2 (£50) and
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section 3 (£200). Paragraph (3) prescribes the discounted amount of the fixed penalty under paragraph 5(2) of Schedule 1 to the Act for offences under section 1 (£150), section 2 (£30) and section 3 (£150).

Regulation 5 provides for the application by councils of fixed penalties and account keeping.
Smoking, Health and Social Care (Scotland) Bill: George Lyon, on behalf of the Parliamentary Bureau, moved S2M-3062—That the Parliament agrees that, during Stage 3 of the Smoking, Health and Social Care (Scotland) Bill, debate on groups of amendments shall, subject to Rule 9.8.4A, be brought to a conclusion by the time limits indicated (each time limit being calculated from when the Stage begins and excluding any periods when other business is under consideration or when the meeting of the Parliament is suspended or otherwise not in progress):

- Groups 1 to 4 – 55 minutes
- Groups 5 to 7 – 1 hour and 20 minutes
- Groups 8 to 10 – 2 hours
- Groups 11 to 13 – 3 hours

The motion was agreed to.

Smoking, Health and Social Care (Scotland) Bill - Stage 3: The Bill was considered at Stage 3.

The following amendments were disagreed to (by division)—

- 33 (For 13, Against 93, Abstentions 1)
- 38 (For 15, Against 91, Abstentions 1)
- 40 (For 15, Against 92, Abstentions 1)
- 44 (For 13, Against 93, Abstentions 1)

The following amendments were moved and, with the agreement of the Parliament, withdrawn: 53 and 55.

The following amendments were not moved: 34, 35, 36, 37, 39, 41, 42, 43, 45, 46, 47, 48, 49, 50, 51, 52, 54 and 56.

Smoking, Health and Social Care (Scotland) Bill - Stage 3: The Parliament resumed consideration of the Bill at Stage 3.

The following amendments were agreed to without division: 7, 64, 18, 25, 26, 27, 28, 29, 30, 31, 32, 67 and 68.

The following amendments were agreed to (by division)—

- 1 (For 75, Against 1, Abstentions 17)
24 (For 56, Against 52, Abstentions 0)

The following amendments were disagreed to (by division)—

60 (For 16, Against 82, Abstentions 1)
63 (For 30, Against 75, Abstentions 0)
65 (For 51, Against 57, Abstentions 0)
62 (For 16, Against 87, Abstentions 0)

The following amendments were moved and, with the agreement of the Parliament, withdrawn: 57 and 19.

The following amendments were not moved: 58, 59, 17, 20, 21, 22, 2, 66 and 69.

**Smoking, Health and Social Care (Scotland) Bill - Stage 3:** The Minister for Health and Community Care (Mr Andy Kerr) moved S2M-2985—That the Parliament agrees that the Smoking, Health and Social Care (Scotland) Bill be passed.

After debate, the motion was agreed to ((DT) by division: For 97, Against 17, Abstentions 1).
Smoking, Health and Social Care (Scotland) Bill: Stage 3

10:45

The Deputy Presiding Officer (Trish Godman): We now move to stage 3 of the Smoking, Health and Social Care (Scotland) Bill. First, we will deal with amendments to the bill and then we will move to the debate on the motion to pass the bill. For the first part, members should have the bill, as amended at stage 2; the marshalled list, which contains all the amendments that I have selected for debate; and the groupings that I have agreed. I will allow an extended voting period of two minutes for the first division. Thereafter, I will allow a voting period of one minute for the first division after a debate on a group and 30 seconds for all other divisions.

Section 1—Offence of permitting others to smoke in no-smoking premises

The Deputy Presiding Officer: Group 1 deals with exempt places and the exclusion of tobacco retailers, theatre performances and rehearsals. Amendment 33, in the name of Brian Monteith, is grouped with amendments 34 to 37, 40 to 44, 46 to 50, 52, 54, 59, 66 and 62.

Mr Brian Monteith (Mid Scotland and Fife) (Con): There is no doubt that smoking features in the canon of Scottish plays, such as John Byrne’s “The Slab Boys”, and in plays by writers such as Terence Rattigan that portray the 1930s, 1940s, 1950s and even 1960s. In “Private Lives”, Noel Coward holds a cigarette and stands conversing with Amanda and Elyot Chase, not necessarily smoking that cigarette but simply holding it. Amendment 33 seeks to ensure that we separate public health concerns, which are a legitimate aspect of the bill, from the artistic performance that takes place on a theatre stage. We shall debate the principle of the bill at a later stage today. However, it strikes me and many other people as particularly odd that, in pursuit of public health goals, it is necessary to ban the smoking of tobacco or any other product such as herbal tobacco on stage.

I point out that amendment 53 in group 3 will pre-empt amendment 54 in this group.

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I point out that amendment 53 in group 3 will pre-empt amendment 54 in this group.
Stewart Stevenson: He cannot even get that right.

Mr Monteith: I will not take the member’s interventions. I certainly do not appreciate his heckling—he will have the opportunity to speak.

In India, not only is smoking being taken out of films, but smoking scenes in old movies are being extricated. The messianic belief and the political correctness of those who wish to impose such censorship have nothing to do with public health.

We must accept that a case can be made for some exemptions, for example for specialist cigar retailers. Only 18 specialist cigar retailers operate in Scotland, although probably only 12 would fall under the terms of amendment 37. On behalf of those retailers, I point out that, for the conduct of their business, it is necessary to test products, not just for quality, but to check that they are not counterfeit. There is a difference between cigarette and cigar smoking. A market exists for counterfeit high-quality cigars, so retailers must check whether the goods that they receive are proper. I appeal for an exemption for that small number of retailers in the industry.

I am interested in members’ responses, because I believe that the debate is detached from the genuine concerns about public health.

I move amendment 33.

Mr Stewart Maxwell (West of Scotland) (SNP): Rarely have I heard such a litany of complete and utter nonsense. If actors are on stage performing a play, perhaps by Irvine Welsh, should they inject heroin or take other illegal drugs because that would be realistic and correct? Just perhaps, they should act and pretend that they are doing that. The audience, using their imagination, would understand and the theatrical impact and artistic integrity of the acting would not be disputed. It is unbelievable that it is beyond the wit and wisdom of the acting would not be disputed. It is clear that nobody lives there. In the case of the residence; it is not a care home and it is clear that nobody lives there. In the case of the residence, it is not a care home and it is not a care home and it is not a place of residence; it is not a place of residence; it is not a place of residence; it is not a place of residence; it is not a place of residence; it is not a place of residence.

Mr Maxwell: That is beyond belief. I am opposed to censorship of the arts, but we should at least allow the arts to use—

Alex Johnstone (North East Scotland) (Con): Will the member take an intervention?

Mr Maxwell: Allow me to respond to Phil Gallie’s points.

We should at least allow the arts to use a small white tube such as the one that I am holding now, which is a theatrical prop that produces smoke. Its effect looks realistic to me and it does not take away from the integrity of the play to use a theatrical prop rather than a real cigarette. I do not know where Phil Gallie is going with that argument.

The main reason for rejecting the amendments is that they are nothing more than subterfuge and an attempt to hide behind an argument about artistic integrity. The cry of artistic freedom from the Tories is a cover for punching holes right through the bill, when it is in fact a bill about protecting public health. To be polite, I think that it is unreasonable of the Tories to try to use artistic freedom in that way. Artistic freedom is not the issue and it is in no way damaged by the bill. There is no censorship of the arts, which can carry on as normal.

On the amendments seeking to exclude more premises than are currently listed in the bill, I point out that the bill excludes certain premises on humanitarian grounds. A tobacco shop is not a place of residence; it is not a place of residence; it is not a place of residence. In the case of the illicit trade in expensive cigars—I am sure that Brian Monteith knows more about such cigars than I do—if the owner of a cigar shop needs to test a cigar, why would it be beyond their wit and wisdom to step outside to smoke that cigar and test whether it is real? It seems perfectly reasonable to do that.

The Tory party has tried to wreck this bill and the Prohibition of Smoking in Regulated Areas (Scotland) Bill right from the start. It has never been interested in artistic integrity and artistic freedom, or the rights of workers and of the vast majority of the population who believe that their health should be protected. This is about wrecking the bill and punching holes in it. The Tories failed to do that with my bill; they failed to do it at stage 2 of this bill because they had no support from any member of the Health Committee; and they will fail to do it today. I urge members to reject the amendments.
Donald Gorrie (Central Scotland) (LD): I would like some clarity from the minister on the issue that Brian Monteith has raised. Although I am not in favour of punching holes in the bill, I am in favour of sensible dramatic representation. Section 4(1) states:

“In this Part, ‘smoke’ means smoke tobacco, any substance or mixture which includes it or any other substance or mixture; and a person is to be taken as smoking if the person is holding or otherwise in possession or control of lit tobacco, of any lit substance or mixture which includes tobacco or of any other lit substance or mixture which is in a form or in a receptacle in which it can be smoked.”

My interpretation of that, which may be wrong because I am coming fresh to the bill, is that a person simulating smoking in the way indicated by Stewart Maxwell could be caught by the legislation. I would like the minister to make it absolutely clear that that is not the intention.

Mr Maxwell indicated disagreement.

Donald Gorrie: If there is a better interpretation, I would like to hear it from the minister. I think that I understand English and that is what the bill says. That gives some substance to Brian Monteith’s point on dramatic issues.

11:00

Mr Maxwell: Will the member take an intervention?

Donald Gorrie: If Stewart Maxwell knows better than the minister, I will give way.

Mr Maxwell: The section that Donald Gorrie just read out says that there has to be a “lit substance”. The prop that I am holding is not lit. It is clear that smoke can be produced from something that accurately resembles a cigarette but which is not lit. The prop would not be caught by the bill, as it poses no health risk, so there is no problem.

Donald Gorrie: The section does not say anything about health risks; it talks about smoking any substance whatsoever. There may be occasions in plays when it is an important part of the drama that the actor puffs away at something. If the minister can make it quite clear that the actor and the manager will not be put in jail because of that, I will accept that. However, we need that clarification. As Brian Monteith has said, there is concern among people in theatrical circles who have nothing to do with Tory plots but who just want to put on plays in an effective and convincing manner. I would like that assurance.

The Minister for Health and Community Care (Mr Andy Kerr): I am disappointed by the start of the debate. This is the most major piece of public health legislation in a generation, but we have heard nothing but trivialisation and a fairly blatant attempt to undermine a bill that is well supported in Scotland. The bill is comprehensive and is based on the principle of protecting people from environmental tobacco smoke in enclosed public places. The Executive has been clear, consistent and fair in its consideration of exemptions from the smoking prohibition. We have made it clear that exemptions will be limited and granted only on humanitarian grounds. These amendments are completely unnecessary, as the bill already makes adequate provision for the definition of no-smoking premises.

I fail to understand why Brian Monteith believes that his approach could be any better. Yet again, he is advocating exemptions from the prohibition for a highly selective group of premises—his personal wish-list. Mr Monteith fails to grasp the fundamental point of the bill, which is to address a very real public health issue and to protect the public from the harmful effects of second-hand smoke. That includes theatre audiences and employees of theatres and retail premises, as well as passengers in airport departure lounges.

During the stage 1 debate, Mr Monteith warned of the development of so-called smokeasies—a subject to which he returned earlier today. It seems that he is now seeking to create those smokeasies to meet his own agenda, under the guise of specialist tobacco retailers. I am sure that he will protest that the exemption is merely to allow customers to test cigars before buying them. However, as Stewart Maxwell has pointed out, it would be simple for a customer to step outside the shop to test the product. I am concerned that, in the future, such retailers might decide to bring in a couple of comfortable chairs and perhaps provide some refreshments for customers who came to test the products, which would result in the type of smokeasy that Mr Monteith warned us about. How could we protect the staff and non-smoking customers who walked in off the street? Where would the protection of public health be in that scenario?

As was said in reply to Mr Monteith’s amendments on theatres at stage 2—and as has been ably demonstrated today—it is not beyond the wit and wisdom of those who are involved in the dramatic arts to come up with an alternative to smoking on stage, which addresses the points that Mr Monteith has made about the prohibition somehow shackling and undermining our arts community. It must be remembered that we are seeking to present smoking—including smoking in a dramatic performance—as not being a normal social activity, so I ask our arts community to think again about that. We are trying to denormalise smoking, and—as has been demonstrated—there are alternatives to the smoking of real cigarettes on stage.
The issue has been raised of what we should use on stage instead of whisky. Should we use cold tea? Of course we should, or we could use another similar product. That is what we do; we get round these issues by being creative. That is what the arts industry is about and it will of course get round them. I hope that we proceed with the rest of the amendments in a slightly more mature way that represents to Scotland why the Parliament is so confident that the bill is so important to our communities. I therefore ask Brian Monteith to withdraw amendment 33.

Mr Monteith: I have absolutely no intention of withdrawing amendment 33. People who are portrayed as smoking dope in a play quite often have to roll it up and then light it. Stewart Maxwell’s example of a prop would not apply in that case. People getting together to light a cigarette could not use that prop, because they would create smoke by lighting it, which is the point that Donald Gorrie made. People wishing to portray a cigar or pipe would not be able to use that prop. Stewart Maxwell could not speak in a play while puffing on that prop to create the smoke. On the consumption of heroin, or tea that is meant to be whisky, the point is that holding a prop would not create smoke by lighting it, which is the point that Donald Gorrie made. People wishing to portray a cigar or pipe would not be able to use that prop. Stewart Maxwell could not speak in a play while puffing on that prop to create the smoke. On the consumption of heroin, or tea that is meant to be whisky, the point is that holding a prop would not apply in that case. People getting together to light a cigarette could not use that prop, because they would create smoke by lighting it, which is the point that Donald Gorrie made. People wishing to portray a cigar or pipe would not be able to use that prop. Stewart Maxwell could not speak in a play while puffing on that prop to create the smoke. On the consumption of heroin, or tea that is meant to be whisky, the point is that holding a prop would not apply in that case. People getting together to light a cigarette could not use that prop, because they would create smoke by lighting it, which is the point that Donald Gorrie made. People wishing to portray a cigar or pipe would not be able to use that prop. Stewart Maxwell could not speak in a play while puffing on that prop to create the smoke. 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Not allowing the exemptions that I am suggesting is draconian and disproportionate. We have heard no argument that shows what effect allowing the exemption for theatres will have on public health, except that we want to denormalise smoking. If that is not censorship, what is? The Parliament wants to denormalise smoking on the stage; it wants to censor it from the stage. That is why amendment 33 should be supported.

The Deputy Presiding Officer: The question is, that amendment 33 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For
Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gillie, Phil (South of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)

AGAINST
Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Bairlie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Bain, Andrew (South of Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craige, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Frances (West of Scotland) (SSP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Mrs Margaret (Moray) (SNP)
Fabiani, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fox, Colin (Lothians) (SSP)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kane, Rosie (Glasgow) (SSP)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingston, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
Mccabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeill, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
that they took reasonable precautions to ensure that the offence was not committed or that they could not reasonably prevent someone from smoking in the premises. However, that suggests that the defendant is already guilty. We seek simply to change the tone of those words so that it is clear that the defendant is innocent until proven guilty. The amendment’s purpose is to ensure that clear language is used. The bill says:

“It is a defence for an accused charged with an offence under this section to prove”

that they took reasonable precautions to ensure that the offence was not committed or that they could not reasonably prevent someone from smoking in the premises. However, that suggests that the defendant is already guilty. We seek simply to change the tone of those words so that it is clear that the defendant is innocent. I seek to hear what arguments the Executive has for enforcing the bill ever to win a case in court. I do not want to waste Parliament’s time any further by explaining the defences that there are in part 1 of the bill. Suffice it to say that the amendment seeks to make it even easier to prove the defences and, in so doing, move the balance back towards encouraging evasion, which clearly would undermine the public health benefits that the bill will provide. I appeal to Brian Monteith to withdraw the amendment.

Mr Maxwell: If only that were the case. The amendment—which, again, met with no support on the Health Committee—is not about clarifying the bill or making it fairer for those who might be prosecuted under this law; it is a wrecking amendment. Its intention is to make it much more difficult to carry out a prosecution. Indeed, it is clear that it is designed to make it almost impossible for enforcement authorities to achieve a successful prosecution, which would completely undermine the purpose of the legislation. I ask the chamber to reject the amendment.

Mr Kerr: The only commendable thing about amendment 38 is the member’s persistence in bringing the matter that it relates to back to us for our consideration despite the fact that, as has been mentioned, he received no support for his position at stage 2.

Mr Monteith: Is the minister aware that there were no votes on the amendments that dealt with this matter at stage 2, which means that there is no record of whether there was support for them or not? In fact, at least one member of the committee supported my position. To say that there was no support is highly inaccurate.

Mr Kerr: The point is that nobody pressed the amendments on this subject, which means that there was no support for them other than from the Conservatives, who have been unique in their approach to this legislation.

As we made clear during the stage 2 consideration of the amendments relating to Mr Monteith’s position, amendment 38 is a full attack on the enforcement of the bill. It would undermine the provisions by making it more difficult for those enforcing the bill ever to win a case in court. I do not want to waste Parliament’s time any further by explaining the defences that there are in part 1 of the bill. Suffice it to say that the amendment seeks to make it even easier to prove the defences and, in so doing, move the balance back towards encouraging evasion, which clearly would undermine the public health benefits that the bill will provide. I appeal to Brian Monteith to withdraw the amendment.

Mr Monteith: The minister is loose with his words, as I clearly indicated in my intervention, and I must say that loose words make bad law. Amendment 38 seeks to tighten up the bill and ensure that it is clear that people are innocent before being proven guilty. Stewart Maxwell is right to say that the amendment might make it more difficult to obtain a prosecution, but that reasoning could apply to every crime. Why not make everybody guilty until they prove their innocence? That way, there would certainly be many more convictions. However, that is not desirable.

It is quite clear that, unless the burden of proof is reversed in the bill, questions are raised about the bill’s compatibility with the right to a fair trial under article 6.1 of the European convention on human rights and the right to a presumption of innocence under article 6.2. For that reason, the minister should be aware that the United Kingdom
Government has dealt with similar situations in other pieces of legislation by the use of amendments that are similar to amendment 38. There is a precedent for it. There must be a concern that people will be presumed guilty until they are proved innocent. That is the wrong way round in Scots law. Whether it means that there are more or fewer convictions, a fair trial is concerned that people will be presumed guilty until they are proved innocent. That is the wrong way round in Scots law. Whether it means that there are more or fewer convictions, a fair trial is important. 

11:15

The Deputy Presiding Officer: The question is, that amendment 38 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)

Against

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Bailie, Mike (South of Scotland) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Branch, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Edie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Paisley North) (SNP)
Fabian, Linda (Central Scotland) (SNP)
Fergusson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)

Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kane, Rosie (Glasgow) (SSP)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Steward (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Muldorn, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allan (Cunninghame North) (Lab)

Abstentions

Tosh, Murray (West of Scotland) (Con)

The Deputy Presiding Officer: The result of the division is: For 15, Against 91, Abstentions 1.

Amendment 38 disagreed to.

Amendment 39 not moved.
### Section 2—Offence of smoking in no-smoking premises

**Amendment 40 moved—[Mr Brian Monteith].**

**The Deputy Presiding Officer:** The question is, that amendment 40 be agreed to. Are we agreed?

**Members:** No.

**The Deputy Presiding Officer:** There will be a division.

#### FOR
- Aitken, Bill (Glasgow) (Con)
- Brodie, Derek (South of Scotland) (Con)
- Davidson, Mr David (North East Scotland) (Con)
- Douglas-Hamilton, Lord James (Lothians) (Con)
- Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Galloway, Mike (Highlands and Islands) (Con)
- Johnstone, Alex (North East Scotland) (Con)
- Brown, Robert (Glasgow) (LD)
- Butler, Bill (Glasgow Anniesland) (Lab)
- Canavan, Dennis (Falkirk West) (Ind)
- Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
- Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
- Crawford, Bruce (Mid Scotland and Fife) (SNP)
- Cunningham, Roseanna (Perth) (SNP)
- Curran, Ms Margaret (Glasgow Baillieston) (Lab)
- Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
- Edie, Helen (Dunfermline East) (Lab)
- Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
- Ewing, Mrs Margaret (Moray) (SNP)
- Fabiani, Linda (Central Scotland) (SNP)
- Ferguson, Patricia (Glasgow Maryhill) (Lab)
- Finnie, Ross (West of Scotland) (LD)
- Gibbon, Rob (Highlands and Islands) (SNP)
- Gillon, Karen (Clydesdale) (Lab)
- Glen, Marilyn (North East Scotland) (Lab)
- Graham, Christine (South of Scotland) (SNP)
- Harvie, Patrick (Glasgow) (Green)
- Henry, Hugh (Paisley South) (Lab)
- Home Robertson, John (East Lothian) (Lab)
- Hughes, Janis (Glasgow Rutherglen) (Lab)
- Hyslop, Fiona (Lothians) (SNP)
- Jackson, Dr Sylvia (Stirling) (Lab)
- Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
- Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
- Kane, Rosie (Glasgow) (SSP)

#### AGAINST
- Gallie, Phil (South of Scotland) (Con)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
- Douglas-Hamilton, Lord James (Lothians) (Con)
- Davidson, Mr David (North East Scotland) (Con)
- Brownlee, Derek (South of Scotland) (Con)
- Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
- Aitken, Bill (Glasgow) (Con)

#### ABSTENTIONS
- Gorrie, Donald (Central Scotland) (LD)

**The Deputy Presiding Officer:** The result of the division is: For 15, Against 92, Abstentions 1.

**Amendment 40 disagreed to.**

**Amendments 41 to 43 not moved.**

**Amendment 44 moved—[Mr Brian Monteith].**

**The Deputy Presiding Officer:** The question is, that amendment 44 be agreed to. Are we agreed?

**Members:** No.
The Deputy Presiding Officer: There will be a division.

**FOR**

Aitken, Bill (Glasgow) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Lab)
Mline, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)

**AGAINST**

Adam, Brian (Aberdeen North) (SNP)
Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baird, Sharp (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Butler, Bill (Glasgow Anniesland) (Lab)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Fabian, Linda (Central Scotland) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Glen, Marilyn (North East Scotland) (Lab)
Gorrie, Donald (Central Scotland) (LD)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kane, Rosie (Glasgow) (SSP)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Leckie, Carolyn (Central Scotland) (SSP)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radclife, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan ( Roxburgh and Berwickshire) (LD)
Rumbles, Mike( West Aberdeenshire and Kincardine) (LD)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Barf and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Swinson, Mr John (North Tayside) (SNP)
Tosh, Murray (West of Scotland) (Con)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Whitefield, Karen (Airdrie and Shotts) (Lab)
Wilson, Allian (Cunninghame North) (Lab)

**ABSTENTIONS**

Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)

The Deputy Presiding Officer: The result of the division is: For 13, Against 93, Abstentions 1.

Amendment 44 disagreed to.

Amendments 45 not moved.

**Section 3—Display of warning notices in and on no-smoking premises**

Amendments 46 to 51 not moved.

**Section 4—Meaning of “smoke” and “no-smoking premises”**

Amendment 52 not moved.

The Deputy Presiding Officer: Group 3 is on the restriction of smoking in exempt places. Amendment 53, in the name of Irene Oldfather, is in a group on its own. If amendment 53 is agreed to, I will not be able to call amendment 54 because it will have been pre-empted.
Irene Oldfather (Cunninghame South) (Lab): Amendment 53 was lodged on Friday with the intention of protecting staff and residents of adult care homes and psychiatric hospitals from the implications of a blanket exemption, albeit one on humanitarian grounds.

In discussions between the minister and the cross-party group on tobacco control, concern was expressed that it should be clear that exemption is not a presumption for smoking. Consequently, establishments should have designated smoking rooms and decisions should not be left to the discretion of exempt establishments.

I am delighted that in publishing draft regulations last night, the minister has made it clear that, following discussion, he has decided that the exemption will apply only to designated rooms and not to whole premises. The minister will appreciate that, although he agreed in discussions with the cross-party group to consider the matter, the position was unclear in the absence of the regulations.

I would welcome clarification from the minister on a couple of points about implementation. I ask him to be vigilant about smoke drift from smoking rooms to non-smoking environments. Does he see scope to work with establishments on implementation guidance to minimise the health hazards from smoke drift for employees and others? Will he give an assurance that he will put in place a review process for exempt premises or designated rooms to consider the implications further down the line? Will he also give an assurance that he will back the exemptions with strong cessation measures, to encourage best practice in developing tobacco control policy?

I move amendment 53.

Mr Maxwell: As Irene Oldfather knows, I sympathise with amendment 53. I support the presumption of no smoking throughout premises and I responded to the consultation along those lines. I had concerns about some premises having a blanket exemption. Nevertheless, I understand some of the complications that would arise if we agreed to the amendment, which might be complicated to implement. It might be better to cover the issue in tightly drawn regulations that make absolutely clear the necessity of having strong smoking policies in exempt premises.

The proposal would be complicated to implement and it has been suggested rather late in the day, at stage 3. It might have been better to lodge such an amendment at stage 2, when we could have discussed it more. I am not sure about the amendment’s wording.

I would like the minister to confirm that the regulations on the matter will be tightly drawn and that the Executive will push for strong smoking policies in exempt premises, so that, as Irene Oldfather said, even such premises will make a presumption in favour of no smoking and protecting the health and well-being of residents of such premises who do not smoke.

Karen Gillon (Clydesdale) (Lab): I draw members’ attention to my entry in the register of members’ interests, to my membership of Unison and to the fact that my husband is a psychiatric nurse.

I have some sympathy with Irene Oldfather’s points. As the minister knows, I represent the area that includes the state hospital at Carstairs. Particular issues relate to people with psychiatric illness and the management of that illness. Will the minister assure us that any room will not be designated at the expense of a common room that is generally available to people and that a separate smoking room will be available? In general hospitals, such as Wishaw general hospital, where problems exist at the moment, will it be possible to do that in a ward setting? Will he assure us that any designation to allow smoking in such settings will not be at the expense of facilities that are available to all residents who do not smoke?

Mr Kerr: As Irene Oldfather said, amendment 53 addresses an issue that the cross-party group on tobacco control raised with me. The bill provides ministers with powers to exempt premises, parts of premises and classes of premises from its provisions. That flexibility is important in dealing with circumstances that pose practical or humanitarian issues, and the draft regulations that I have sent to the Health Committee reflect that point.

However, I have always made it clear that the protection of staff, visitors and non-smoking residents of exempt premises from other peoples’ smoke is equally important. Following my discussions with the cross-party group on the matter, I have decided that it is not appropriate to exempt adult care homes and psychiatric hospitals in their totality from the bill’s provisions. Therefore, the draft regulations have been amended so that care homes and places of residential psychiatric care will now be defined as no-smoking premises. However, the exemptions will allow for specific smoking rooms to be designated within those places for the use of those smokers for whom it is their permanent or temporary home. I hope that Ms Oldfather and the cross-party group agree that that approach strikes a better balance between the rights of smokers and of non-smokers in those places.

I reiterate that an exemption in no way constitutes a right to smoke and I strongly urge the management of premises that are currently smoke free to maintain that status. We will continue to
discuss with Parliament issues such as smoke drift, guidance and smoking policies as we develop the regulations. I want all those institutions to have strong no-smoking policies to ensure that non-smokers’ rights are protected.

Although we will advocate making the regulations as comprehensive as possible, I am not able to talk about particular locations or premises. I share the view that the cessation measures in which we have invested considerable additional resources will assist the situation in the different environments that members have highlighted.

We want to add to the collective knowledge of the influence of no-smoking policies, which I hope will be adopted today, because we want to be part of the worldwide effort to ensure that other nations develop no-smoking policies. As a result, we must ensure not only that we take very positive steps today but that we continue to review particular exemptions as the matter progresses.

Phil Gallie: I respect and accept the minister’s aims. However, does he agree that some people in care homes have reached a considerable age, have lost mobility and are more or less confined to their own rooms, which have effectively become their homes? Is the minister able to ensure that the regulations will allow such individuals to have the opportunity to smoke, even if it imposes on the care home a requirement to provide adequate ventilation?

Mr Kerr: As we discussed earlier, we will have to rely on the regulations. In the process of agreeing those regulations and consulting those who run care homes, we will try to achieve the best possible result. Although I sympathise with Phil Gallie’s point, we want the legislation and the supporting regulations to be as comprehensive and as clear as possible in order to protect non-smokers’ rights. Unravelling such matters might simply open the legislation to abuse.

Brian Adam (Aberdeen North) (SNP): As the minister is aware, during discussions with the cross-party group on tobacco control, I raised concerns that some care homes will not be smoke free and that a number of adults in those homes will want to have a smoke-free environment. Is he able to assure us that the regulations will address the concerns and protect the rights of adults and others who do not smoke? Will he encourage care home providers to ensure that people who might be exposed to secondary tobacco smoke, no matter how good the ventilation is, have genuine choices?

Mr Kerr: I reassure the member that, through the process of agreeing the regulations and carrying out consultation in many parts of Scotland, that will indeed be the case. I look forward to discussing with the cross-party group and others how the regulations will work effectively for non-smokers.

The Deputy Presiding Officer: I call Irene Oldfather to wind up and to indicate whether she will press or withdraw amendment 53.

Irene Oldfather: The minister’s positive comments clearly show that the regulations will do exactly what amendment 53 calls for. The move from a blanket exemption to having designated rooms represents significant progress.

I also welcome the minister’s commitment to ensuring that the legislation will have the widest possible coverage while still being workable.

I am content with the minister’s comments on tobacco control and his commitment to continued dialogue on smoke drift. I welcome the opportunity for the minister and the cross-party group to discuss that further.

Amendment 53, by agreement, withdrawn.

Amendment 54 not moved.

11:30

The Convener: Group 4 is on no-smoking areas in outside premises. Amendment 55 is grouped with amendment 56.

Irene Oldfather: Amendment 56 seeks to extend the definition of “premises” to outdoor areas, to bring pavement cafes and beer gardens within the scope of the legislation. Amendment 55 calls for designated no-smoking areas in such premises. My fear is that, without the amendments, the legislation, when it comes into force, will force smokers outside, so that pavement cafes and beer gardens become visible smoking areas. There are a number of problems with that. First, it means that families with children and non-smokers—some of whom may be asthmatic—who want to enjoy a meal, snack or drink outside in good weather will have to do so surrounded by smokers. That is unpleasant for the seven people in every 10 who do not smoke.

Another point concerns normalisation and the prevailing culture. The legislation is absolutely groundbreaking in what it does. In my opinion, the further we push the boundaries on no-smoking environments—along the lines of having designated areas even outside—the more we encourage young people to see non-smoking as the norm. It sends out the wrong signal to children and young people if they walk past pavement cafes that are full of smokers, so there is an argument about the visibility of smoking and normalisation.

Having considered the evidence that has been provided in the past couple of days, I recognise
that my proposed extension might create some uncertainties about enforcement. I would be interested in the minister’s comments on that, and I seek a reassurance from him on how some of the difficulties might be addressed. I look forward to his comments and clarification.

I move amendment 55.

The Deputy Presiding Officer: This part of the debate has to end by 11.40, so I will give the next three members two minutes each.

Shona Robison (Dundee East) (SNP): I will be brief. I oppose amendments 55 and 56 for two reasons. First, the bill’s whole purpose is to take public health measures based on concerns about the health impact of environmental tobacco smoke in enclosed public spaces. To try to extend that to outside areas undermines the argument.

The second issue is almost as important. As far as possible, we must try to take the public with us. We know that the move is controversial and that views on it are mixed, but I believe that a majority of people in Scotland support the bill and that we would lose public support by trying to extend the ban into outside areas. That would be a step too far. It would be overly zealous, it is not required and the SNP will certainly not support the amendments.

Mr Monteith: I welcome Shona Robison’s words in opposition to the amendments. I feel that the bill is already disproportionate in its efforts to—as the minister put it—denormalise smoking. It is quite clear from the evidence that the committee took that the ban worked in Ireland partly because smokers could go outside to smoke, with heaters, awnings and suchlike to protect them from the elements. My fear about Irene Oldfather’s amendments is that even that opportunity would be denied, making a disproportionate measure even more disproportionate. For that reason, the amendments should be opposed.

Tricia Marwick (Mid Scotland and Fife) (SNP): Throughout the progress of the bill, we have been told that it is a public health measure. Although we all now accept the facts about the effect of tobacco smoke in enclosed public spaces, there is, to my mind, no evidence at all to support the view that tobacco smoke is harmful in outside public spaces.

There has been much discussion of the Irish experience of which I have had great experience over the past three or four months. In response to Brian Monteith’s point, I can say that it is true that publicans in Ireland have been extremely creative in creating outside spaces with awnings and the like for smokers. However, by moving the argument, at stage 3, from one of public health to an attack on people who smoke serves only to undermine the bill. Frankly, that argument will lose public support for the bill.

Mr Kerr: I share many of the views that members have expressed on the amendments in the group.

I am sympathetic to what Ms Oldfather is trying to achieve and her desire to reduce exposure to environmental tobacco smoke. However, I believe that to agree to her amendments would be a step too far. The provisions in the bill are evidence based and there is not enough evidence to support the argument that environmental tobacco smoke in an unenclosed setting is harmful. Clearly, as with all our legislation, the Executive will continue to monitor the situation. However, without evidence, I cannot support the amendments.

The bill reflects the Executive’s intention to protect members of the public in wholly or substantially enclosed premises in relation to which the evidence of harm from second-hand smoke is overwhelming. I hope that at some stage in the future evidence may become available to justify taking other steps, but I cannot support such measures at this time.

It is extremely important that the legislation is consistent, fair and easily enforceable by proprietors of establishments and environmental health officers. Any legislation for outdoor areas would need to be carefully defined to provide the same clarity. The bill does not provide for that.

As they stand, the amendments in the group risk compromising the enforcement measures that are contained in the bill. Although I understand where the member is coming from with the amendments, I echo the comments that were made about their complexity and about the fact that the member did not signal early enough her intention to lodge them.

Amendments 55 and 56 would undermine the enforcement measures in the bill. I hope that Irene Oldfather will consider withdrawing amendment 55.

Irene Oldfather: Some of the arguments that we have heard this morning would have been used five years ago in a debate on banning smoking entirely.

I welcome the minister’s comments on the intention behind amendments 55 and 56 and I hear what he and other members said about enforcement. We have made much progress and I do not want to compromise the bill or to bring any lack of clarity to its enforcement. I hope that the Parliament will revisit the issue. I think that I heard in what the minister said a commitment to consider the issue at some point in the future, as and when evidence develops. If so, that is welcome.

I seek leave to withdraw amendment 55.

Amendment 55, by agreement, withdrawn.
Amendment 56 not moved.

The Deputy Presiding Officer: That ends the debate on group 4, which brings us to the end of this part of the debate on the bill.
On resuming—

Presiding Officer’s Ruling

The Presiding Officer (Mr George Reid): What we witnessed earlier from some members of the Scottish Socialist Party was an absolute disgrace. For elected members to act in such a grossly undemocratic fashion shows an absolute contempt for Parliament. Those members have compounded that contempt by refusing to leave the chamber. They cannot hope to be simultaneously on the barricades and on the benches of this Parliament.

My powers as Presiding Officer are limited to suspending the offending members up to the end of the next sitting day. I so now suspend them. It may be that Parliament judges that penalty to be insufficient, given the gravity of the offence. I shall convene the Parliamentary Bureau and invite my colleagues to consider sanctions that will make it very clear that the business of democracy will continue in this place without let, without hindrance and without disorder.

This is a matter of democracy. Those who claim to speak for others should never deny that right and that privilege to other elected members. [Applause.]
On resuming—

Smoking, Health and Social Care (Scotland) Bill: Stage 3

Resumed debate.

The Deputy Presiding Officer (Trish Godman): We resume consideration of stage 3 amendments to the Smoking, Health and Social Care (Scotland) Bill. I will allow an extended voting period of two minutes for the first division this afternoon. Thereafter, I will allow a voting period of one minute for the first division after the debate on the group. All other divisions will last for 30 seconds.

Group 5 is on the definition of wholly or substantially enclosed. Amendment 57, in the name of Brian Monteith, is grouped with amendment 58. [Interruption.] It would be helpful if we could hear Mr Monteith. Members who are carrying on conversations should do so outside the chamber. I say that to Mr Smith in particular.

Mr Monteith: It may seem strange to lodge a probing amendment at stage 3, but such will be the nature of the regulations that will accompany the bill when it becomes an act that it is worth exploring a number of points at this stage to find out what the Executive’s views are and to allow it to consider whether it should make any further changes. Amendment 57 seeks to change the bill, but I will not put it to a vote because I am more interested in hearing the Executive’s views on the matter.

There is still confusion about the phrase “wholly or substantially enclosed” in relation to premises. For that reason, amendment 57 seeks to point out that the approach in England under the Department of Health’s white paper, which is out for consultation, includes a clear definition that seems to be different from the definition that has been used in Scotland. That may be wholly intentional on the part of the Department of Health in London and the Health Department in Edinburgh, but I would like to hear from the minister why the definitions of “enclosed” might be different, because that could bring about unintentionally different results in different parts of the United Kingdom. It is important at this stage—before we deal with the regulations—to ascertain what the Executive’s aims are.

I move amendment 57.
Mr Kerr: As I have said, our approach to the smoking provisions in the bill is relatively simple. The intent and scope of the provisions must be clear; the provisions should be readily enforceable; and there should be as few loopholes for evasion as possible. Brian Monteith’s amendment 57 would provide an additional opportunity for loopholes to be found.

One of the key concepts in the bill is the kind of premises that may be prescribed as no-smoking premises under the regulations. At stage 2, in response to comments that were made in our consultation on the draft smoking regulations, we amended the bill to make it more specific and flexible on the definition of wholly enclosed spaces to allow opportunities to create non-wholly enclosed spaces in line with established practices under the Irish smoking ban. We have learned from that process rather than from anything that is happening south of the border, because we view the Irish model as very successful in its implementation and enforcement. No-smoking premises will now be defined as premises that are “wholly or substantially enclosed” and which also fall within one of four specified categories. The phrase “wholly or substantially enclosed” is of paramount importance in the designation of no-smoking premises.

We have further defined the phrase “wholly or substantially” in the revised draft regulations, as the member said. We have not yet finalised the regulations, but the drafting clearly sets out our direction of travel, which is consistent with the Irish approach and which may be broadly stated as follows. When a premises either has no roof or has a roof but no walls on 50 per cent of its perimeter, it cannot be considered enclosed. Our view is that such a definition makes our policy intention clear, reduces the possibilities for evasion and is readily enforceable by environmental health officers on the ground. Our proposed changes will add clarity and allow us to be specific but flexible, which is what was asked of us by respondees to the consultation.

Brian Monteith seeks to restrict the type of premises that will be caught by the legislation by narrowing the definition of those premises in the bill. However, we believe that a more flexible approach is needed to ensure that the bill can deliver this important and far-reaching health measure. I hope, therefore, that Brian Monteith will seek to withdraw amendment 57.

Mr Monteith: I know that my reputation for intrigue and trying to make things happen goes before me, but I assure the minister that, in lodging amendment 57, I did not seek to reduce the scope of the bill. I do not have a scooby what difference the amendment would make to the bill. I have no idea what the difference would be between 70 per cent of the total notional roof and wall area and 50 per cent, which is what the bill currently specifies; I am simply trying to ascertain why the Executive arrived at that different figure.

The minister explained that the Executive has learned from the Irish model. When a bill is finally introduced in England, Westminster, too, may well choose to learn from the Irish model as well as from what is happening in Scotland. I make no judgment on that, but I will take further advice on the minister’s remarks. I seek leave to withdraw amendment 57.

Amendment 57, by agreement, withdrawn.

Amendments 58 and 59 not moved.

The Deputy Presiding Officer: Group 6 is on part 1 regulation making powers. Amendment 7, in the name of the minister, is grouped with amendment 29.

Mr Kerr: Amendment 7 is a technical amendment to section 4(8). Following the Subordinate Legislation Committee’s observation on the lack of clarity, the Executive believes that section 4(8) should be amended to make it clear that any failure to comply with any additional signage requirements that are specified in regulations that are made under that section will constitute an offence under section 3(1) in the same way that failure to comply with the signage requirements under section 3(1) will be an offence. Section 4(8) would then mirror section 3(3), which was amended at stage 2 to make a similar point about additional signage requirements for buildings.

Amendment 29 will remove redundant section 34(4), following stage 2 amendments to require ministers to consult on any future regulations that are made under either section 4(2) or section 4(7).

I move amendment 7.

Mr Maxwell: As a member of the Subordinate Legislation Committee, I welcome the proposed changes. There was some debate in the committee about the possible problem with the two sections and whether a loophole would inadvertently be created so that it would be difficult to prosecute the offence in certain circumstances. I welcome amendment 7. Amendment 29 is merely a technical amendment that is consequential to amendment 7. We welcome both amendments and will support them.

Dr Sylvia Jackson (Stirling) (Lab): As the convener of the Subordinate Legislation Committee, I reiterate what Stewart Maxwell said. I have no reservation about his saying it, because he has taken great interest in the bill.

Amendment 7 agreed to.
After section 4

Amendment 60 moved—[Mr Brian Monteith].

The Deputy Presiding Officer: The question is, that amendment 60 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

For

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
Mile, Mrs Nanette (North East Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
McGhee, Mr Andrew (Mid Scotland and Fife) (Con)

AGAINST

Arbuckle, Mr Andrew (Mid Scotland and Fife) (Lab)
Baillie, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballard, Mark (Lothians) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eddie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Graham, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)

Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeill, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Ailisadair (South of Scotland) (SNP)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunningham South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Wilson, Allan (Cunningham North) (Lab)

ABSTENTIONS

Tosh, Murray (West of Scotland) (Con)

The Deputy Presiding Officer: The result of the division is: For 16, Against 82, Abstentions 1.

Amendment 60 disagreed to.

Section 7A—Sale of tobacco to under-age persons: variation of limit

The Deputy Presiding Officer: Group 7 is on the sale of tobacco to underage persons. Amendment 1, in the name of Stewart Maxwell, is grouped with amendments 28 and 32.

Mr Maxwell: Amendment 1 is intended to help clarify the policy intention behind the amendment at stage 2 that inserted section 7A. I am sure that Duncan McNeil’s intention was not that ministers could take the power to lower the age for buying cigarettes to below 16. Section 7A(1) states that ministers may substitute for the age specified in the Children and Young Persons (Scotland) Act 1937 such other age or ages as they consider
appropriate. I am sure that the current Executive would not do this, but the danger is that it cannot tie the hands of any future Executive, which could, using that power, reduce the legal age for buying cigarettes or other tobacco products to below 16. I am sure that that was not the policy intention behind Duncan McNeil’s amendment at stage 2.

By inserting the word “higher” between the words “other” and “age”, we would keep the power but ensure that the age could be raised or left at 16, but not lowered. The amendment is merely a technical one that attempts to clarify the original intention behind Mr McNeil’s amendment, which was supported by the Health Committee at stage 2. Amendments 28 and 32 are consequential on the insertion of section 7A and we support them as well.

I move amendment 1.

The Deputy Minister for Health and Community Care (Lewis Macdonald): This is my first contribution to this debate, so it is appropriate for me to acknowledge Stewart Maxwell’s support for the bill throughout its parliamentary stages and the contribution that his member’s bill made in terms of flushing out a number of the key issues and concerns surrounding the introduction of legislation on smoking. His bill allowed evidence to be taken that established beyond doubt the harmful effects of environmental tobacco smoke and helped to move on the argument to where we are today.

The amendments in group 7, including Mr Maxwell’s amendment, recognise that a key objective of the bill is to discourage young people from starting to smoke in the first place. Duncan McNeil and his colleagues on the Health Committee deserve a good deal of credit for the progress of the bill and Mr McNeil’s stage 2 amendment gave Scottish ministers powers to vary the legal age for buying tobacco. Duncan McNeil made a powerful case that that could be an important contribution to the process of reducing the numbers of young smokers.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Does the Scottish Executive have any intention of using that power?

Lewis Macdonald: From the beginning, we have made it clear that we first want to be sure that there is strong evidence that varying the legal age of tobacco purchase will be effective in its stated aims. We have also been clear that any order to give effect to such a change will be subject to the affirmative resolution procedure in the Parliament. That is the effect of amendment 28, which meets our commitment at stage 2 to take this course.

Building on Duncan McNeil’s stage 2 amendment, Stewart Maxwell’s amendment 1 will allow ministers, responding to further research on the issue, to send a strong message by raising and maintaining the legal age of tobacco purchase if—but only if—such a measure is to shown to offer an effective way of discouraging young people from taking up smoking.

Depending on the further research that we have commissioned in this area, the provision is an important and valuable tool that might help to reduce the high level of young people who take up smoking. I am therefore happy to commend Mr Maxwell’s amendment 1, as well as amendments 28 and 30.

Nora Radcliffe (Gordon) (LD): The Liberal Democrats are quite happy to support Stewart Maxwell’s amendment. I have certain reservations relating to the question whether the fact that we view people as being adult enough to marry at 16 might make it difficult to raise the age of consent for other things. However, I welcome the fact that further research will be commissioned into why young people take up smoking or why they do not. That research will be valuable and if the evidence suggests that we should raise the age at which people can buy tobacco, that will be all fair and good. The research is the bonus that comes out of this process and it is fair enough to include in the bill the ability to act on that research.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I welcome the amendments that have been lodged by the Executive and Stewart Maxwell, because they give us an opportunity to review the age restriction on the sale of tobacco that dates back to the previous century, when smoking was viewed as harmless and glamorous. That was before the availability of scientific evidence that demonstrated the health impact of smoking. Knowing what we know now about the dangers of smoking, it is our duty to protect young people from them.

In 2005, is it correct to leave to 16-year-olds the decision about whether to buy cigarettes? According to a BBC healthy Britain survey, the majority of the public—particularly those between the ages of 18 and 34—supports the raising of the age limit. Furthermore, I am pleased to be able to announce that the British Medical Association conference decided today that the Government should be more effective in denying the supply of alcohol and tobacco to minors and that the minimum legal age for the sale of cigarettes should be raised to 18—that is now BMA policy.

Several European countries, including Sweden, Ireland, Finland, Iceland, Malta, Norway and Poland have set the minimum age for tobacco sales at 18. As we know, the age restrictions in North America are even stricter; some American states have set the age limit at 21. Recently, Nova Scotia and Ontario increased the age limit to 19.
Of course, there is no need to look across the world for good examples when there is a good example under our noses. Guernsey, with its devolved Government, has introduced a package of measures to reduce smoking. It has increased to 18 the age at which people may buy tobacco and the island is now credited as a world leader in reducing smoking among young people. The number of young people who report that they smoke has reduced by half and only 3 per cent of 11-year-olds think that they will smoke when they are older. Nearly twice as many young people smoke in the UK as in Guernsey.

If amendment 1 leads to an increase in the legal age for tobacco sales from 16 to 18, we will not be a world leader. We will not even be the first part of the British isles to introduce such legislation. We will simply be modernising our laws to give children the protection that is the norm throughout the modern world.

15:15

Mr Monteith: I was interested to hear the minister say that research had already been commissioned. Will he confirm whether the Executive has commissioned research on this issue that could lead to affirmative action, which he mentioned in response to Mike Rumbles's question, being taken through the Parliament?

Stewart Maxwell’s amendment 1 will mean that the Parliament will still have the opportunity to have a full debate about the issue, based on evidence, before it makes a decision. That is a proper approach, with which we have no difficulty, although it is interesting that the amendment prejudices the evidence by suggesting that the age would be increased. That raises the question what we would do if the evidence showed that the age should be left alone or reduced. However, my main concern is to hear from the minister what action has already been taken that will help us to reach a view on the amendment.

Mike Rumbles: On many issues, the Liberal Democrats place the age of responsibility at 16, so I find it rather strange that we are asked to support an amendment that seeks to increase the age to 18. I would like to hear from the minister how the measure, if it was implemented, would be effective. In my view, the most important thing is to prevent our 12 to 14-year-olds from smoking—that is the key, surely, and not the 16 to 18-year-olds. As I understand it, there have only ever been two prosecutions in relation to under-16s, so is the proposal not just a fig leaf?

Mr John Home Robertson (East Lothian) (Lab): I am keen to support the proposed change, but I emphasise the need to enforce the legislation. The Protection of Children (Tobacco) Act 1986 was a private member’s bill that I put through the House of Commons to deal with a tobacco product called Skoal Bandits, which was a threat at that time—it was a sucking tobacco. The 1986 act was intended, by shifting the onus of proof, to make it easier to get prosecutions against shopkeepers and retailers who sell tobacco products to children. The Government of the United Kingdom at that time, to its eternal shame, failed to do anything proactive to enforce that legislation. I want the legal age to be increased; above all, I want the legislation to be enforced. That is essential for the safety of children and young people in Scotland.

Irene Oldfather: It is striking to note the extent to which smoking is rooted in youth. Some 90 per cent of smokers start smoking before they reach the age of 18. If someone has not started smoking by the time they reach the age of majority, it is unlikely that they will start thereafter. Increasing the age to 18 will therefore make a substantial difference. Some 30 per cent of our 15-year-olds smoke. Those figures are approximate, but they suggest that a large majority of smokers start before the age of 15, which is one year short of the present legal age.

I identify with John Home Robertson’s comments on enforcement and prosecution. Problems with prosecution have occurred in the past. In fact, no prosecutions, convictions or fines were recorded for underage tobacco sales from 1996 to 1997. I know that the Lord Advocate is considering how to advance the position, but children’s charities have been unfavourable towards the idea of using children to gather evidence. Increasing the age to 18 might allow charities to come on board with us on enforcing the law and prosecuting those who sell tobacco to young people.

Lewis Macdonald: As announced at stage 2, we have asked a group under Laurence Gruer to examine such matters and we have commissioned research to start in September. Unfortunately, I cannot provide Mr Monteith with the results of that. If we were in such a position, we would take a slightly different view today. We have made it clear that the intention is to undertake that research.

Mr Rumbles suggested that amendment 1 would increase the minimum age to 18. It would not. The amendment would give ministers the power to raise the age if the research showed that doing so would be effective. Effectiveness, which is critical, was at the heart of the speeches by John Home Robertson and Irene Oldfather.

Provision has been made for action when shopkeepers or others sell tobacco or tobacco products to underage people. Fines of up to £2,500—level 4 on the standard scale—are
possible; the same applies to those who permit smoking in no-smoking premises.

Mike Rumbles asked how we could make a change in the age limit effective. Duncan McNeil’s comments on the effectiveness of age limitations elsewhere were telling.

Before we take any measures that use the proposed powers, we will return to the Parliament under the affirmative resolution procedure.

**Mr Maxwell:** I welcome the support for my amendment 1 from various sections of the Parliament. I was going to say that it is obvious that nobody supports lowering the minimum age below 16, but after Brian Monteith spoke, I was not absolutely sure whether we all agreed on that.

John Home Robertson was right about enforcement. Enforcing the legislation is critical. There would be no point in making the changes if we did not enforce them. We should enforce the current laws and if we decide to change the law to raise the age, we should enforce that.

I agree absolutely with what the minister said about the group of amendments. All that I add is that when the order is made under the affirmative resolution, we will need not only the consultation. The Parliament will have to abide by and agree with what we want to do, because the Parliament will have the power to vote down the order, if it so wishes.

Many of the comments about whether we should raise the age are for debate at another time, because that is not the issue. The point is to ensure that the power is correct. My amendment would restrict the Executive’s power so that it could not lower the age below 16. That is perfectly sensible. The evidence from Guernsey and elsewhere that Duncan McNeil cited made the point well. I hope that the Parliament will support my amendment.

**The Deputy Presiding Officer:** The question is, that amendment 1 be agreed to. Are we agreed?

**Members:** No.

**The Presiding Officer:** There will be a division.

**For**

Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baille, Jackie (Dumbarton) (Lab)
Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Ballard, Mark (Lothians) (Green)
Boyack, Sarah (Edinburgh Central) (Lab)
Brown, Robert (Glasgow) (LD)
Canavan, Denis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gibson, Rob (Highlands and Islands) (SNP)
Gillan, Karen (Clydesdale) (Lab)
Graham, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Faisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Gorbals) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenny (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mathew, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAveety, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Wilson, Allan (Cunninghame North) (Lab)

**AGAINST**

McIntyre, Des (Clydebank and Milngavie) (Lab)

**ABSTENTIONS**

Aitken, Bill (Glasgow) (Con)
Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (West of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
Tosh, Murray (West of Scotland) (Con)

The Presiding Officer: The result of the division is: For 75, Against 1, Abstentions 17.

Amendment 1 agreed to.

Before section 9

The Deputy Presiding Officer: Group 8 is on eye examinations, sight tests and oral health assessments. Amendment 63, in the name of Kate Maclean, is grouped with amendments 64, 67 and 68.

Kate Maclean (Dundee West) (Lab): I can deal quickly with Duncan McNeil’s amendments 64, 67 and 68. I cannot disagree with them, because they essentially replicate the first part of my amendment 63. However, as I continue, it will become obvious that I think that amendments 64, 67 and 68 do not go far enough.

There is evidence of—and a consensus on—the fact that perhaps as many as one in five young people in our schools have undetected sight problems. Such problems can lead to poor academic and sporting achievement and behavioural difficulties. For example, I heard about a girl in a Glasgow school who was in a special unit for children with learning disabilities and behavioural problems until a simple eye test showed that she could barely see beyond the end of her arm. After she got the spectacles that she required, she was able to return to mainstream education.

Although it would not be ethical to conduct scientific research into the link between poor vision and poor academic performance and behaviour, common sense seems to dictate that there is a link between being unable to see properly and being unable to learn to one’s full potential.

The Executive will argue that there is insufficient evidence to support amendment 63. However, I dispute that. I feel that I have presented to the Executive and all MSPs evidence both of the existence of significant undetected sight loss among school pupils and of the efficacy of sight screening. In particular, I e-mailed to everyone a peer-reviewed, published article entitled “School vision screening, ages 5 to 16 years: the evidence-base for content, provision and efficacy”, which I think contains all the proof that is needed.

As for the Executive’s criticism that amendment 63 is inflexible, I would argue that it is very flexible. I am asking for the very minimum: an eye examination on entry into primary school and a sight test on entry into secondary school. A body of opinion holds that further screenings in between those two examinations would be useful but, as I have said, I am asking only for the minimum. If further research proved that further screenings would be beneficial, they could obviously be introduced.

I realise that the Executive and the majority of the ophthalmology lobby support the recommendation in the Royal College of Paediatrics and Child Health’s fourth edition of “Health for all children”—or Hall 4—that there should be an eye examination at the age of four or five. I agree absolutely with that, because there is no doubt that such a provision would allow problems that are mainly or solely treatable before the age of five or six to be identified and treated. Indeed, I think that the recommendation has universal support. With amendment 63, I seek to enshrine that provision in legislation.

The disagreement comes with the provision that children should have a sight test on entry into secondary school. I agree that, on a purely medical screening model, such a provision would be unnecessary. However, the sight test would show not only disease and pathologies but visual disorders, particularly myopic conditions, many of which develop between the ages of eight and 12.

Although the Executive does not support my amendment, it is supported by a large number of organisations, whose statements of support have been forwarded to all members. I hope that members have had a chance to look at those and at the copy of the article that I mentioned earlier.

Members might also be interested to know that the World Health Organisation’s VISION 2020: The Right to Sight initiative has identified as one of its major priorities uncorrected refractive disorders. I understand that the Scottish Executive might now offer to commission research into the need for and the efficacy of the type of sight screening that is set out in amendment 63. I am concerned that, if that research is once again informed largely by one area of medical opinion, it will reach the same conclusion that Hall 4 reached and children will continue to suffer because of undetected and untreated sight loss. Indeed, one of the people who contacted me about amendment 63 and who could feed into the process said in an e-mail that it did not matter if children got spectacles later than they need them. Well, it matters to me, which is why I will press the amendment and why I urge every MSP to support it.
I move amendment 63.

Mr McNeil: It is difficult to disagree that health problems, including sight problems, have to be identified. However, it is also important to point out, as Kate Maclean said, that children already receive free sight tests, although we might have to address certain issues with regard to take-up.

As Kate Maclean pointed out, the current policy is that all children aged four to five will receive a sight test as part of comprehensive vision screening in their pre-school year. No one is complacent, of course. Built into the current policy is the recognition that there must be on-going review, and that is necessary. It is important to point out that the current childhood vision screening policy is supported by a large body of professional consensus and scientific research from the United Kingdom and North America. I suggest that further advances on, or a review of, current policy will be successful only if we proceed by consensus. Continued consensus must be based on robust evidence, and the professional consensus for routine sight testing as outlined in Kate Maclean’s amendment is simply not there. There is a debate about that, as we have seen in the e-mails from people who have contacted us, and I believe that my amendment 64 can resolve some of the issues that arise from that debate.

Amendment 64 would place a duty on Scottish ministers

"to meet all reasonable requirements, to provide for the detection of vision problems in children."

It would allow for a flexible approach, so that experts could assess the optimal age for screening, the most appropriate screening technique and the most suitable personnel to undertake and supervise the screening. Most important, it would allow the assessment and clear definition of the health impact of that intervention.

I hope that there will be as inclusive and broad a consultation as possible and that RNIB Scotland will be involved in that. I hope that there will be a timeframe to push on that consultation study and that some of that work will include pilot schemes in certain areas to address that unmet need in our most vulnerable groups across Scotland.

Mrs Nanette Milne (North East Scotland)

(Con): Amendment 17 is straightforward. It would provide for the Executive to place a duty on health boards to ensure that people who are currently eligible for free eye and dental checks are targeted more effectively. The people to whom I refer are the most vulnerable in society, yet their health is most at risk because they escape the net and therefore fail to have the checks carried out. Even if free checks become available to everyone, those people will still need to be targeted. It is well known that the Conservative group considered that to provide free eye and dental checks for everyone by 2007 would not be the best use of public resources. Free checks are already available for people who need them and the difficulty lies in persuading those who are eligible to come forward and, in the case of dentistry, in finding sufficient national health service dentists to carry out checks.

With regard to amendments 63 and 64, no one could deny that it is important to pick up eye problems in children as early as possible. That is why I previously indicated my support for the screening of schoolchildren at primary and secondary levels. Since then, however, I have looked at the matter in some detail and have found that the situation is more complex than I had thought. There is little doubt that screening at age four to five is desirable, and I am glad that that will be carried out, but more research is probably needed before sensible recommendations can be made about screening for impaired visual acuity at secondary school level. As Duncan McNeil said, according to professional advice, the optimal age for screening, the most appropriate technique and the most suitable personnel to undertake it, as well as other factors, must all be investigated before a screening programme can be recommended by the national screening committee. However, I have a great deal of sympathy with Kate Maclean’s amendment 63, and I share her concern that sight testing is apparently not currently taken into consideration in the medical model that influences the national screening committee. Duncan McNeil’s amendment 64 to place a duty on ministers

"to provide for the detection of vision problems in children"

should ensure that future recommendations made as a result of research will be carried out. I understand that the Executive plans to instigate more research. If I receive an assurance from the minister that the need for sight testing for children before they enter secondary school will be assessed as part of that research, that would help me to decide which amendment to support.

Eleanor Scott (Highlands and Islands)

(Green): I have much sympathy with Kate Maclean’s amendment 63. I will support it, on balance, although that was not an automatic decision. I speak as a former school doctor who was brought up not only with Hall 4, but with Hall 1, 2 and 3 beforehand and very much in the medical model.

I am reassured that the amendment does not in any way take away from the pre-school vision screening, which I believe is the crucial one for picking up any eye conditions that could, if undetected, lead to permanent poor sight in later
life. However, I take the point that children may fail educationally not because of an eye pathology of that nature, but because of a refractive error that is not corrected by glasses.

When I first started as a school doctor we tested vision at regular intervals. That was gradually whittled down in response, I believe, to evidence that was examined in the compilation of the Hall reports.

There is an argument for testing vision on school entry, but there is an issue about who does it. The letter that Kate Maclean circulated said quite a lot about optometrists doing it, but I think that school nurses are in a very good position to do it because they can capture all children. There are unresolved issues but, on balance, I will support amendment 63 because this is a very important issue.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I passionately believe that children should have eye tests before they go to primary school, during primary school and before they go to secondary school. I come into the category of people who want the extra test. The test in the middle would be done to pick up all the things that were missed by the first test. People often go through the medical sieve—they do not get picked up—and it is very important for children's education that eye problems are picked up. Kate Maclean and Eleanor Scott have said it all. I am definitely in favour of amendment 63.

We must bear it in mind that another group of people are often forgotten about. If a child has poor eyesight and is deaf—I do not mean stone deaf—they cannot even see what people are saying. We realise what a different world people who are exceptionally short-sighted live in when we listen to their descriptions of what they see. I have had friends—including a relative—who have been extremely short-sighted. It is terrible to isolate those people and it is wrong to prevent them from making the best of their schooling.

I will vote for Kate Maclean's amendment 63. I would like the provision to be coupled with regular hearing tests.

Shona Robison: I will make a short speech in support of amendment 63. It is totally unacceptable—I was not previously aware of the fact—that 20 per cent of primary and secondary school pupils have an undiagnosed sight problem. Of course, the problem is that that can severely impact on their education. The system fails to screen children consistently after age four and five. There are very patchy sight-screening programmes in some schools. That is not good enough. We need a comprehensive school-age screening programme. I believe that Kate Maclean's amendment 63 will ensure that.

Duncan McNeil’s amendment 64 is much weaker and non-specific. For that reason, we hope that members will support Kate Maclean's amendment 63.

Nora Radcliffe: I agree with Kate Maclean about the importance of picking up poor eyesight. She is right that there are horror stories. Jean Turner also emphasised that point.

My difficulty with Kate Maclean's amendment 63 is that it is too prescriptive—it confines people to those two eye examinations when the evidence may show that that is not enough or that it is too much. There is general agreement that there should be pre-school screening. That is fine and that will happen. We should not confine people to two eye checks if more than that turns out to be the better option. I favour amendment 64, because it does not restrict us to two eye examinations: it opens up the possibility of more.

I will briefly comment on Nanette Milne’s amendment 17. People who are eligible for free eye and dental checks do not come forward for their checks because they do not know that they are eligible. When free eye and dental checks are universal, there will be no confusion about who is eligible. That will go a long way towards ending people's reluctance to come forward for checks.

Roseanna Cunningham (Perth) (SNP): I register a personal interest in the matter. I was one of the children whose eyesight problems were picked up in the standard school test that used to be carried out. My eyesight problems were the reason why my work was falling behind at the time—I suffer from quite severe short-sightedness.

Amendment 63 reflects the unanimous view of the Health Committee, which is stated in paragraphs 90 and 91 of the committee's stage 1 report. The Health Committee strongly recommended that the Executive lodge suitable amendments at stage 2 to address the issue. I acknowledge that amendment 64, which Duncan McNeil lodged, represents an attempt to find a compromise position, but it is no more than a compromise and does not reflect what I thought was the unanimous view of the committee. I hope that Kate Maclean will press amendment 63 and I invite members to support it. Amendment 63 is clear and unambiguous and wholly superior to amendment 64. We ought to support clarity rather than vagueness.

Mr Kerr: I acknowledge Kate Maclean's commitment to sight screening, her work with the Scottish Parliament cross-party group on visual impairment and her connections with the RNIB and other such organisations, and I commend her passion and commitment.

The Executive endorses measures to ensure the early identification and treatment of health
problems in children, but amendment 63 would create an inflexible framework for childhood vision screening policy, which would be inappropriate. As we have said throughout the passage of the bill, we want to ensure that legislation is evidence based. During the debate on amendment 55, I said to Irene Oldfather that there is no evidence to support the view that smoke has an effect on people’s health outdoors, and I say to Kate Maclean that there is no substantial, peer-reviewed evidence on the matter that she raises. According to the RNIB:

“The role of vision screening after school entry remains controversial, as there is a paucity of evidence to support the benefits of screening in this age group. The degree of disability caused, at this age, by uncorrected refractive errors is unknown.”

Kate Maclean has pushed the Executive extremely hard on the matter, but policy needs a rational evidence base.

It has been suggested that the United Kingdom national screening committee is focused only on medical matters, but that is not the case. The committee informs its proposals by drawing on the latest research evidence and the skills of specifically convened multidisciplinary expert groups, which always include patients and service users. The committee’s expert group on childhood vision screening involved all three eye care professional groups: optometrists; orthoptists; and ophthalmologists. Of course, the Hall 4 recommendations on vision screening reflect the recommendations of the national screening committee. Accusations that the committee’s approach does not address vision screening are therefore unfounded.

Amendment 64 helps us out in relation to research. There is an evidence base for the orthoptist-led vision screening programme for children in their pre-school year, when they are between four and five years old. As a result of the programme sight problems will be detected, as will medical conditions such as amblyopia, when sufferers are at an age at which there is evidence that their problems are most amenable to treatment. I share members’ concerns that we must identify sight problems early, to ensure that they do not impact on children’s learning. For that reason we published guidance that recommends a sight test for any child who appears to be struggling at school. The approach is linked to the measures that are being implemented as a result of the Education (Additional Support for Learning) (Scotland) Act 2004, to support children and enable them to learn effectively.

The Executive’s approach to vision screening is based on the recommendations of the Royal College of Paediatrics and Child Health, which emerged after an extensive review of available evidence on vision screening practice, which members mentioned and is commonly known as Hall 4. The review involved all three eye care professions and its recommendations have the backing of the respective professional bodies. The chair of the Scottish branch of the British and Irish Orthoptic Society wrote to ministers to highlight the fact that efforts should focus on the implementation of the Hall 4 pre-school programme, for which there is a strong evidence base. In particular it was highlighted that she was unable to endorse proposals for additional tests which were rejected by the national screening group and ophthalmic professional bodies on the ground of lack of robust evidence.

15:45

Decisions about our children’s health and health care are not to be taken lightly and must be based on sound evidence. We seek to do research that will determine whether the routine sight testing of schoolchildren identifies previously undetected significant sight problems. I reassure all members that the Executive is committed to doing that research, which will also investigate the optimal intervals for testing, who should undertake the tests and which tests should be used.

An eye care review, led by an expert group, is currently under way. Optometrists, orthoptists and ophthalmologists are all involved in the review and they can progress the vision screening of schoolchildren. They will determine how best to undertake the research and I will certainly ask the review group for further information on timescales and publication of the report. I hope that members will understand that the Executive is serious; if we find evidence that we should do this, we will do it.

That is the point of Duncan McNeil’s amendment 64 and I hope that members will consider supporting it, because it is about what we have tried to achieve through the bill and it is about providing that evidence base. Members can rest assured that the Executive is committed to doing that. I would be happy to hear from members about the content of the review and the research. Amendment 64 will create a specific duty on Scottish ministers in respect of vision screening for children while providing flexibility to adapt the approach as new evidence appears. That is why the Executive supports the amendment.

As was explained at stage 2, the prescriptive nature of Mrs Milne’s amendment 17 would place an unreasonable duty on health boards. In particular, health boards would in future always be required to refer to categories of people who were entitled to receive free eye tests and dental examinations before 1 April 2006. That would become extremely burdensome to our health boards. We take very seriously the responsibility
of ensuring that vulnerable groups can access the health services to which they are entitled. The Executive is currently undertaking a number of initiatives such as the well man initiative and the unmet needs pilots, to consider how to improve access to health services among vulnerable groups across Scotland.

Our health improvement policy has an overarching aim of reducing health inequalities and it is good practice for health boards to focus on tackling health inequalities and adapting local services in order to engage with vulnerable people and those in more deprived communities. We have made it clear that we support measures to increase the uptake of free checks and have made a commitment to work with health boards to target those vulnerable groups who are already eligible. So, while I support the principle of encouraging the uptake of free eye and dental checks, I believe that amendment 17 is unduly restrictive. I therefore invite Mrs Milne not to move it.

I reassure members—particularly in relation to Duncan McNeil’s amendment 64—that we are committed to carrying out the research. If it shows us the way forward for screening tests, the Executive will deliver on that commitment.

Kate Maclean: I want to address a couple of points that members made. Nora Radcliffe said that the consequences of my amendment 63 would be too restrictive if more sight tests were required in the future. However, the amendment calls for “a minimum of an eye examination for all pupils on entry to the first year of primary education and a sight test for all pupils on entry to the first year of secondary education.” That does not in any way exclude the possibility of another sight test being given at age seven or eight when young people become literate and it is easier to test their visual acuity than it is when they are four or five.

The Minister for Health and Community Care and I will just have to agree to differ about the evidence. I feel that I have presented evidence in support of the fact that there are significant but undetected sight problems in school pupils and problems with the efficacy of screening. If we move away from screening more regularly than just the once at age four or five, we will be going against what is happening in other countries.

On Duncan McNeil’s point about the fact that there are free eye tests, the provision is being brought in by the bill and while we might all think that it is a very good idea, there is no scientific research base to show that there is any public health benefit in giving people access to free eye tests. If we look at the statistics for areas where all children are entitled to free eye tests and free dental checks and where there is easy access to those—Dundee, for example—we find a higher incidence of sight loss and dental disease. That shows that, if free access is not organised into a screening programme, its existence will not necessarily mean its uptake.

I have presented enough evidence for the Parliament to support amendment 63 and I will press it.

The Deputy Presiding Officer: The question is, that amendment 63 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.

Ms Wendy Alexander (Paisley North) (Lab): On a point of order, Presiding Officer.

The Deputy Presiding Officer: I am sorry, but we are in the middle of a vote.

Ms Alexander: It is to do with the vote.

The Deputy Presiding Officer: We are in the middle of a vote.

Ms Alexander: I tried three times to insert my card.

The Deputy Presiding Officer: I cannot take a point of order during a vote.

FOR

Baird, Shiona (North East Scotland) (Green)
Ballance, Chris (South of Scotland) (Green)
Canavan, Dennis (Falkirk West) (Ind)
Crawford, Bruce (Mid Scotland and Fife) (SNP)
Cunningham, Roseanna (Perth) (SNP)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Gibson, Rob (Highlands and Islands) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Hyslop, Fiona (Lothians) (SNP)
Lochhead, Richard (North East Scotland) (SNP)
MacAskill, Mr Kenny (Lothians) (SNP)
Maclean, Kate (Dundee West) (Lab)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
McFee, Mr Bruce (West of Scotland) (SNP)
Morgan, Alasdair (South of Scotland) (SNP)
Neil, Alex (Central Scotland) (SNP)
Robison, Shona (Dundee East) (SNP)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Stevenson, Stewart (Barff and Buchan) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Swinburne, John (Central Scotland) (SSCUP)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)

AGAINST

Aitch, Bill (Glasgow) (Con)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
The Deputy Presiding Officer: The result of the division is: For 30, Against 75, Abstentions 0.

Amendment 63 disagreed to.

Amendment 64 moved—[Mr Duncan McNeill]—and agreed to.

**After section 10**

Amendment 17 not moved.

**Section 14—Provision of certain services under NHS contracts**

The Deputy Presiding Officer: Group 9 is minor and technical amendments. Amendment 18, in the name of the minister, is grouped with amendments 27, 30 and 31.

Lewis Macdonald: Amendment 18 is merely technical and moves section 14 of the bill to after section 21 to reflect its widened scope.

Amendment 27 concerns the right of appeal under section 50(3) of the Adults with Incapacity (Scotland) Act 2000, which provides a right of appeal for "any person having an interest in the personal welfare of the adult" with incapacity in relation to any treatment that has been decided on between a medical practitioner and the adult’s proxy decision maker. That gives extra protection to the adult on decisions that are made about his or her medical treatment.

Section 30 of the bill introduces into the Adults with Incapacity (Scotland) Act 2000 a new, additional right of appeal for the medical professional who has primary responsibility for the medical treatment of the adult. That recognises that a person’s general practitioner may have cause to question a decision that is made by another relevant professional person, such as a dentist. Amendment 27 makes it clear that the new right of appeal for the GP applies in cases in which discussions about treatment take place between one of the other new categories of people who can issue a certificate and the proxy decision maker. In such cases, the medical practitioner will be able to intercede on behalf of the adult if one of those other professionals and the adult’s proxy decision maker have made a decision on treatment with which the GP does not agree.

Amendment 30 is a technical amendment that tidies up an inaccurate reference elsewhere to the Public Health (Scotland) Act 1897 as a consequence of amendment at stage 2, and amendment 31 is a minor formatting amendment.

I move amendment 18.
Amendment 18 agreed to.

Section 15—Lists of persons undertaking to provide or approved to assist in the provision of general dental services

The Deputy Presiding Officer: Group 10 concerns the disclosure of information by those already on NHS lists. Amendment 19, in the name of Nanette Milne, is grouped with amendments 20 to 22.

Mrs Milne: I can be brief on this group. The amendments are intended to ensure that those who already provide dental or ophthalmic services are subject to the same disclosure checks in the same timeframe as those who are being added to the registered list.

If disclosure checks are necessary for new practitioners before they can be listed, they are necessary for all registered practitioners. That is only fair and it should be made clear on the face of the bill.

I move amendment 19.

Lewis Macdonald: Professionals who are applying to join a list will be required to disclose the necessary information before their application for inclusion on a list by an NHS board is considered. It will be up to the individual concerned to obtain and provide that information, and there is no prescribed timescale as such.

The amendments in this group are similar to amendments that Nanette Milne lodged at stage 2, when they were debated in committee. For the avoidance of doubt, I make it clear, as ministers did then, that it is our policy intention that a requirement for disclosure of information will apply equally to relevant professionals who are applying to join a list and practising professionals who are already on such a list. The provisions of the bill are drafted in such a way as to lead to that outcome.

Professionals who are applying to join a list will be required to disclose the necessary information before their application for inclusion on a list by an NHS board is considered. It will be up to the individual concerned to obtain and provide that information, and there is no prescribed timescale as such.

For those professionals already on an NHS board list, arrangements will be put in place to define a reasonable period within which they should submit relevant information when required to do so by the NHS board. However, it is simply not appropriate to define such a period in the bill. The issue must be discussed with the relevant professional bodies.

Nanette Milne does not advocate putting such a precise timescale on the face of the bill, but she does seek to require the same timescale to apply to existing and new practitioners. Since there is no timescale as such for new applicants in the bill, there cannot be one for existing practitioners. Therefore, her amendments could not achieve the result that she intends.

We want to ensure continuity of patient services and to make certain that practitioners and their patients are not disadvantaged by the requirements. I cannot be precise on the timescale for implementing the requirement for persons who are already listed. Those details have still to be discussed—and are best discussed—with the relevant professional bodies. However, I can assure Nanette Milne and other members that that will be completed as quickly as possible, without creating unnecessary additional burdens on any of those involved.

Nanette Milne’s purpose can be achieved without amendments 19 to 22. Therefore, the amendments are not necessary and I hope that, in light of my assurances, she will withdraw amendment 19.

The Deputy Presiding Officer: I invite Nanette Milne to wind up and to press or withdraw amendment 19.

Mrs Milne: I felt it important to flag up the issue. Disclosure checks should be carried out as quickly as possible both on existing and on new practitioners. However, after listening to the minister’s assurance, I seek leave to withdraw amendment 19.

Amendment 19, by agreement, withdrawn.
Amendment 20 not moved.

Section 17—Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

Amendments 21 and 22 not moved.

Section 24—Payments to certain persons infected with hepatitis C as a result of NHS treatment etc

The Deputy Presiding Officer: Group 11 is on the Skipton Fund eligibility date. Amendment 24, in the name of the minister, is grouped with amendment 65.

Mr Kerr: The basis of making ex gratia payments to those who have been infected with hepatitis C following NHS treatment is to help to alleviate the suffering and the life changes that people experience as a result of living with the infection. Our hearts go out to the individuals, and their families, who have had to undergo such a change in their lifestyles.
This is an issue on which Scotland has led the way in the United Kingdom, leading to the establishment of the UK-wide Skipton Fund scheme. However, I emphasise that the payments are not compensation; they are ex gratia payments that reflect the Executive’s recognition that, although it has no legal liability, there is a genuine need to provide help to people who are facing hardship and distress as a result of contracting the disease.

What we seek to do is to provide help with the extra costs that can arise over a period of years from living with hepatitis C. However, there is a need to strike a balance between funding ex gratia payments to those affected and funding other demands on the health budget. On that basis, payments under the Skipton Fund will be made only to those who were alive on 29 August 2003, when the scheme was announced. Extending payments to people who died before that date would take us away from the key principle of this being an ex gratia payment scheme that ministers have offered and implemented. For those reasons, I do not believe that there is a strong enough case for extending payments to dependants of those who died before the announcement of the payment scheme.

16:00

The Executive accepts that payments could be made to dependants of eligible persons, where the persons died after the scheme was announced and before a claim was made. In those circumstances, an expectation may have been created that a payment would consequently be made. Therefore, I do not intend to seek to undo the stage 2 amendment that gave effect to that provision.

I would like to explain some of the factors that are built into the existing ex gratia payment Skipton Fund scheme. Under the current scheme, derogation has been granted by the UK Government specifically in relation to Skipton Fund payments in respect of the assessment of assets for social security benefits, which is a reserved issue. That means that payments made to a person from the Skipton Fund are disregarded when the person’s capital in relation to social security benefits such as housing benefit, income support, jobseekers allowance and state pension credits is calculated. The arrangements would not apply in the case of any extension of payments beyond the Skipton Fund criteria, which could significantly disadvantage those who receive payments, depending on individual circumstances.

At stage 2, the Health Committee agreed an amendment, lodged by Shona Robison, that removed from section 24 the eligibility date of 29 August 2003. As I have said, the purpose of the ex gratia payments under the Skipton Fund scheme—which were intended for those who were alive when the scheme was announced on 29 August 2003—was always to alleviate the suffering and life changes that people experience as a result of living with the infection. I believe that the scheme as established is based on a set of fair principles and priorities and balances the interests of those who have a real need for assistance against the wider interests of patients and the delivery of health services. That is why I have had to lodge amendment 24, which would restore to the bill the commencement date of the scheme in relation to primary infectees.

Amendment 65, in the name of Shona Robison, would remove the cut-off date of 29 August 2003 for secondary infectees. In effect, it would permit claims to be made on behalf of secondary infectees who died before the scheme was introduced on 29 August 2003. For the reasons that I have explained, I cannot support an amendment of that nature, as it is not commensurate with an ex gratia payment scheme to help support the living.

I urge members to support the Executive’s amendment and invite Shona Robison not to move hers.

I move amendment 24.

Shona Robison: I rise to speak in favour of amendment 65 and against amendment 24.

Amendment 65 would remove the arbitrary date of 29 August 2003 in relation to those infected through secondary transmission and would provide consistency with the rest of the bill, as amended at stage 2. Frankly, the issue comes down to justice, fairness and consistency. If the minister gets his way with amendment 24 and the date of 29 August 2003 is reinstated in the bill, the family of someone who died on 29 August 2003 will be entitled to receive financial assistance from the Skipton Fund, whereas the family of someone who died on 28 August 2003 will not. There is no consistency, fairness or justice in that.

Let us consider the significance of the date of 29 August 2003. It is the date on which the previous Minister for Health and Community Care, Malcolm Chisholm, happened to announce officially the establishment of the Skipton Fund by issuing a press release. It is an arbitrary date that is not meaningful in any way to the families of those who have died as a result of contracting hepatitis C through NHS treatment.

As Mike Rumbles said at the Health Committee’s meeting of 31 May 2005:

“As it stands, the bill is neither just nor fair.”—[Official Report, Health Committee, 31 May 2005; c 2001.]

The bill was not just or fair on 31 May, when the committee agreed with me and voted by five votes
to two to remove the date of 29 August 2003 from the bill. If that date was not just or fair on 31 May, it is not just or fair today. I urge those members—particularly the Liberal Democrats—who supported me on that day to remain consistent to fairness and justice and to ensure that that date does not return to the bill.

I touch on two of the minister’s arguments for proposing the date of 29 August 2003 that I notice he did not focus on today particularly, although he has done so in the press and in the letter to the Health Committee.

The first concerns the numbers. The minister has stated that 4,000 people in Scotland could have been infected with hepatitis C, that there would be hundreds of claims and that the cost could be £20 million. Those figures are totally inaccurate. I refer the minister to a 2002 minute from the expert group that emphasised the fact that the 4,000 figure that generated the estimates of the cost of the scheme in the preliminary report was a projection of the number of people who were likely to have been infected. The minute said that the actual number of people who had been identified was 568. That is a seventh of the number to which the minister referred, so the cost would be significantly lower than the minister has led people to believe.

The minister could look to other sources of information for the figures. The Skipton Fund has received only six applications from the families of those who died prior to 29 August 2003. He could look at the number of deaths reported to the procurator fiscal—the minister should have those to look at the number of deaths reported to the procurator fiscal in that period.

The second reason that the minister has given for why we cannot have such a change in Scotland is that it would undermine consistency with the UK scheme and that that would almost pap Scotland out of the scheme. However, his argument is undermined by the fact that he does not intend to put back into the bill the second date of 5 July 2004. Therefore, we will still have a different set of arrangements in Scotland from those down south.

However, all those arguments together are nothing compared with the issue of justice for the families who have had no public inquiry. I say to the minister that I know that compensation is not the issue, but financial assistance is so important because it would acknowledge the families’ loss as a result of their loved one contracting hepatitis C through NHS treatment.

On this last day of Parliament before recess, I urge members throughout the chamber please to do the right thing by the families of hep C sufferers and not to put the date of 29 August 2003 back into the bill. Members should support the Health Committee’s position by rejecting amendment 24 and supporting amendment 65.

Nora Radcliffe: I give credit to the previous Health Committee that fought so hard to get agreement on the principle that there should be ex gratia payments to people who contracted hepatitis C. That was tremendously good work. I also pay tribute to the current Health Committee for fighting to get the proposed improvements made to the scheme.

It is perfectly fair that 29 August 2003 should be the date from which people should expect to get ex gratia payments, not 5 July 2004, which is when the scheme was up and running. People should not be disadvantaged by administration in that way. I commend the Executive for coming back to the date of 29 August 2003.

Mrs Milne: I abstained on the issue at the Health Committee because I wanted to find out more about it. However, I now agree that the definition of eligibility for ex gratia payments from the Skipton Fund is unfair, because, as Shona Robison said, the cut-off date is arbitrary. The number of people who are involved is finite and not high. I have now made up my mind that I agree with the Health Committee’s decision to remove that arbitrary date from the bill.

Mr Maxwell: Will the member ask the Liberal Democrats to explain why the later date, which has been removed, is administrative, but the earlier date is not administrative or arbitrary? Will she ask them to explain why it is fair for the family of somebody who died at one minute past midnight on the appropriate date to receive an ex gratia payment, while the family of somebody who died at one minute to midnight will not get a payment? Frankly, I do not understand that.

Mrs Milne: If the Liberal Democrats do not already see that that is unfair, I might have the same difficulty as other members have had in persuading them that it is.

I will vote against the minister’s amendment 24 and for Shona Robison’s amendment 65.

Dr Turner: As members might expect given my background, I cannot accept the dates at all—people were either infected in Scotland by an NHS hospital or they were not; that is all that needs to be proved. I fully appreciate that the payments are ex gratia. It is generous that money will not be deducted in accounting for other benefits. The payment is just for the suffering and life changes of people who contracted hepatitis C, but the condition sometimes takes a long time to be
diagnosed—sometimes it is not even clear on the death certificate. Therefore, it might take a while for families to realise what was going on. I know from experience that patients' families spend a great deal of money and lose wages to look after them. For example, I have known people to spend a great deal of money on trying to persuade a patient to eat tasty meals. I cannot justify the inclusion of dates, so I will vote for Shona Robison's amendment 65.

I would love to think that, before the cost of the ex gratia payment was worked out, the worst scenario was considered. The figures that we have been given do not stack up. Even the Haemophilia Society believes that only a small number of people are involved. I hope that we can finish this term by agreeing to pay them and to scrub the dates.

**Mr John Swinney (North Tayside) (SNP):** As always, I came to Parliament this morning proud of the fact that I am a member. Today, I came with an extra special enthusiasm, because I was coming to vote for an excellent bill that will make an enormous difference to the lives of people in Scotland. I look forward to supporting it at 6 o'clock tonight. My views are somewhat tempered by the antics at lunch time, but that is enough said about that.

Parlament will excel itself today if it supports Shona Robison's amendment 65 and votes against the minister's amendment 24. Within days of my election to the House of Commons eight years ago I was asked to see a couple called John and Pat McAughey, from the village of Stanley in Perthshire. John McAughey was a haemophiliac who, along with many other people in our country, was infected with hepatitis C through contaminated blood products. For years, I saw John and Pat McAughey and other constituents and listened carefully to their concerns. I have found support and encouragement for them from members of the Parliament's Health Committee and from ministers, who have engaged on the issues and addressed some of its serious consequences.

**16:15**

Without going into too many details about the family's circumstances, it would be fair to say that John and Pat expected that John would die before Pat, but things did not work out like that. Pat died suddenly before John, who died around three weeks ago. For the eight years that I knew them as constituents, they were completely consumed by the issue. They and their families could think of almost nothing else.

Just before the debate, I received a letter from their son—John McAughey—that asked me to go to the Parliament today to make the case on behalf of his two deceased parents, one of whom had, as I said, contracted hepatitis C through contaminated blood products. The issue is not about administrative dates, but about the point that Jean Turner has just made. The problem begins to apply at the moment when the infection is contracted, which is an identifiable point, as health records will substantiate the position. Once evidence becomes clear, it is up to the Skipton Fund to make a judgment that is based on the totality of the issues and cases with which it will deal. Therefore, I cannot understand why the minister is bringing before us an issue that could result in his taking the gloss off what would be a super bill for the Parliament to pass. One chink of injustice will be left in it.

Some of the lines of defence that the minister has used are quite astonishing. He tried to suggest that there would be a massive increase in costs for the Skipton Fund. However, I understand that the Skipton Fund has an underspend in the order of £7 million. If the minister's proposition is valid, evidence must exist to demonstrate where all the cases that will suddenly cause financial strain on the Skipton Fund will come from. We are not waiting for evidence to emerge. That evidence must exist, as all cases should have been reported to procurators fiscal throughout the country—I think that Shona Robison made that point.

The minister's second line of defence has been that all the United Kingdom Administrations have agreed on the approach that will be taken. That approach has been agreed is undeniable, but is not devolution about doing things differently in Scotland? Is it not about finding Scottish solutions to Scottish problems? If we are not convinced by the arguments that are put forward in other parts of the United Kingdom, we will do things differently. Indeed, surely we are doing things differently with the Smoking, Health and Social Care (Scotland) Bill.

At 6 o'clock, I will vote enthusiastically for the remainder of the bill, which is superior to legislation in the rest of the United Kingdom. I am immensely proud of that. I loved hearing the Secretary of State for Health say on the radio the other day that she expected that the rest of the United Kingdom would catch up with Ireland's and Scotland's smoking legislation in the years to come—that made me feel proud of our Parliament and of the leadership that the minister and the First Minister have given on the issue. If we can do such things with respect to smoking, why cannot we legislate for the Skipton Fund to help individuals with hepatitis C contamination?

The issue is simple. We are sent here to do the right thing. There are four words on the mace that sits in front of us: "Wisdom. Justice. Compassion."
Integrity." I cannot think of four more relevant words that should determine how we should vote on the group of amendments that we are discussing. Those people need wisdom, justice, compassion and integrity to be used. We are talking about individuals such as John and John and Pat McAughey, whose lives have been completely consumed by a tragedy that befell them. We have not been able to deliver a public inquiry or compensation for such people. The Government has come up with the pragmatic solution of ex gratia payments. In fairness, we should ensure that that solution applies to everyone.

**Mr Kerr:** Scotland led the way on this scheme. Scotland drove it forward and it was adopted by the rest of the UK. With due respect to the members who have made passionate speeches, including John Swinney, the issue at stake is one of principle. We are not changing our principles. We have repeatedly emphasised that the scheme is about giving help to those who are living with hepatitis C and suffering hardship and about helping them to meet the extra costs that result from their condition; it is not about compensation. In general, the NHS does not pay compensation to patients for harm and injury in cases such as this, it is not about compensation. We have acknowledged the work that the Health Committee has done on the cut-off date. We have taken cognisance of that in the support that we are giving, and we are leaving that amendment in place. Nonetheless, we founded the Skipton Fund giving, and we are leaving that amendment in place. We have repeatedly emphasised that the scheme represents. That is the fact of the matter. I know that this is an extremely difficult matter and I understand the concern that is being expressed by members. Nevertheless, we must stick to the principle of the Skipton Fund scheme, which the Parliament agreed and on which the Parliament led the way in the UK. That principle is ex gratia payments, not compensation.

**The Deputy Presiding Officer (Murray Tosh):** The question is, that amendment 24 be agreed to. Are we agreed?

**Members:** No.

**The Deputy Presiding Officer:** There will be a division.

**For**

Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baillie, Jackie (Dumbarton) (Lab)
Baker, Richard (North East Scotland) (Lab)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
Eddie, Helen (Dunfermline East) (Lab)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gillon, Karen (Clydesdale) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lyon, George (Argyll and Bute) (LD)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
May, Christine (Central Fife) (Lab)
McAvey, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peattie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robson, Euan ( Roxburgh and Berwickshire) (LD)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Wallace, Mr Jim (Orkney) (LD)
Wilson, Allan (Cunninghame North) (Lab)
**AGA NIST**

- Aitken, Bill (Glasgow) (Con)
- Baird, Shonia (North East Scotland) (Green)
- Ballance, Chris (South of Scotland) (Green)
- Ballard, Mark (Lothians) (Green)
- Brodiebank, Mr Ted (Mid Scotland and Fife) (Con)
- Brownlee, Derek (South of Scotland) (Con)
- Canavan, Dennis (Falkirk West) (Ind)
- Crawford, Bruce (Mid Scotland and Fife) (SNP)
- Cunningham, Roseanna (Perth) (SNP)
- Davidson, Mr David (North East Scotland) (Con)
- Douglas-Hamilton, Lord James (Lothians) (Con)
- Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
- Ewing, Mrs Margaret (Moray) (SNP)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Gallie, Phil (South of Scotland) (Con)
- Gibson, Rob (Highlands and Islands) (SNP)
- Goldie, Miss Annabel (West of Scotland) (Con)
- Grahame, Christine (South of Scotland) (SNP)
- Harvie, Patrick (Glasgow) (Green)
- Hyslop, Fiona (Lothians) (SNP)
- Ingram, Mr Adam (South of Scotland) (SNP)
- Johnstone, Alex (North East Scotland) (Con)
- Lochhead, Richard (North East Scotland) (SNP)
- MacAskill, Mr Kenny (Lothians) (SNP)
- MacDonald, Margo (Lothians) (Ind)
- Maclean, Kate (Dundee West) (Lab)
- Marwick, Tricia (Mid Scotland and Fife) (SNP)
- Mather, Jim (Highlands and Islands) (SNP)
- Matheson, Michael (Central Scotland) (SNP)
- Maxwell, Mr Stewart (West of Scotland) (SNP)
- McFee, Mr Bruce (West of Scotland) (SNP)
- McGrigor, Mr Jamie (Highlands and Islands) (Con)
- McLetchie, David (Edinburgh Pentlands) (Con)
- Milne, Mrs Nanette (North East Scotland) (Con)
- Mitchell, Margaret (Central Scotland) (Con)
- Monteith, Mr Brian (Mid Scotland and Fife) (Con)
- Morgan, Alasdair (South of Scotland) (SNP)
- Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
- Neil, Alex (Central Scotland) (SNP)
- Robison, Shona (Dundee East) (SNP)
- Russell, Mr Mark (Mid Scotland and Fife) (Green)
- Scanlon, Mary (Highlands and Islands) (Con)
- Scott, Eleanor (Highlands and Islands) (Green)
- Scott, John (Ayr) (Con)
- Stevenson, Stewart (Banff and Buchan) (SNP)
- Surgeon, Nicola (Glascow) (SNP)
- Swinburne, John (Central Scotland) (SSCUP)
- Swinney, Mr John (North Tayside) (SNP)
- Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
- Watson, Mike (Glasgow Cathcart) (Lab)
- Welsh, Mr Andrew (Angus) (SNP)
- White, Ms Sandra (Glasgow) (SNP)

**FOR**

- Aitken, Bill (Glasgow) (Con)
- Baird, Shonia (North East Scotland) (Green)
- Ballance, Chris (South of Scotland) (Green)
- Ballard, Mark (Lothians) (Green)
- Brodiebank, Mr Ted (Mid Scotland and Fife) (Con)
- Brownlee, Derek (South of Scotland) (Con)
- Canavan, Dennis (Falkirk West) (Ind)
- Crawford, Bruce (Mid Scotland and Fife) (SNP)
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- Davidson, Mr David (North East Scotland) (Con)
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- Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
- Ewing, Mrs Margaret (Moray) (SNP)
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- Grahame, Christine (South of Scotland) (SNP)
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- Marwick, Tricia (Mid Scotland and Fife) (SNP)
- Mather, Jim (Highlands and Islands) (SNP)
- Matheson, Michael (Central Scotland) (SNP)
- Maxwell, Mr Stewart (West of Scotland) (SNP)
- McFee, Mr Bruce (West of Scotland) (SNP)
- McGrigor, Mr Jamie (Highlands and Islands) (Con)
- McLetchie, David (Edinburgh Pentlands) (Con)
- Milne, Mrs Nanette (North East Scotland) (Con)
- Mitchell, Margaret (Central Scotland) (Con)
- Monteith, Mr Brian (Mid Scotland and Fife) (Con)
- Morgan, Alasdair (South of Scotland) (SNP)
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- Robison, Shona (Dundee East) (SNP)
- Russell, Mr Mark (Mid Scotland and Fife) (Green)
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- Scott, Eleanor (Highlands and Islands) (Green)
- Scott, John (Ayr) (Con)
- Stevenson, Stewart (Banff and Buchan) (SNP)
- Surgeon, Nicola (Glascow) (SNP)
- Swinburne, John (Central Scotland) (SSCUP)
- Swinney, Mr John (North Tayside) (SNP)
- Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
- Watson, Mike (Glasgow Cathcart) (Lab)
- Welsh, Mr Andrew (Angus) (SNP)
- White, Ms Sandra (Glasgow) (SNP)

**AGAINST**

The Deputy Presiding Officer: The result of the division is: For 56, Against 52, Abstentions 0.

Members: The SSP members are not here.

The Deputy Presiding Officer: Order.

Amendment 24 agreed to.

Amendment 65 moved—[Shona Robison].

The Deputy Presiding Officer: The question is, that amendment 65 be agreed to. Are we agreed?

Members: No.

The Deputy Presiding Officer: There will be a division.
Amendment 65 disagreed to.

The Deputy Presiding Officer: Group 12 is on the Skipton Fund—appeals and eligibility. Amendment 25, in the name of the minister, is grouped with amendment 26.

Mr Kerr: Amendment 25 introduces to section 24 a right of appeal for applicants whose claim under the Skipton Fund scheme is refused. The Executive undertook at stage 2 to lodge such an amendment. It has always been the intention of Scottish ministers for there to be a right of appeal against decisions taken about the acceptance of claims made under the Skipton Fund scheme and the amendment consolidates that intention.

Amendment 26 addresses an inconsistency in the provisions of section 24. At stage 2, the bill was amended to allow for claims to be made by certain persons who had been infected with hepatitis C through contact with persons who had previously been infected by NHS treatment. That was required so that the scheme meets the policy requirement of ensuring that ex gratia payments can be made to all eligible people—both primary and secondary infectees—in order to help to alleviate their suffering. One of those stage 2 amendments modified the provisions to enable the scheme to specify conditions of eligibility in respect of claims on behalf of potentially eligible secondary infectees who died before making a claim. Amendment 26 will secure that, in the interests of fairness and equity, there is consistency with the different types of infectees who are eligible under the scheme by ensuring that the scheme can similarly specify conditions of eligibility in respect of claims on behalf of potentially eligible primary infectees who died before making a claim.

I move amendment 25.

Amendment 25 agreed to.

Amendment 26 moved—[Mr Andy Kerr]—and agreed to.

Section 30—Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

Amendment 27 moved—[Mr Andy Kerr]—and agreed to.

Section 31—Joint ventures

The Deputy Presiding Officer: Group 13 is on joint ventures. Amendment 2, in the name of Carolyn Leckie, is grouped with amendment 69, also in the name of Carolyn Leckie. Given that Ms Leckie is not present to move her amendments, the debate on them cannot take place unless another member wishes to move amendment 2. Does anyone wish to do so?

Amendment 2 not moved.

Section 34—Regulations or orders

Amendment 66 not moved.

Amendments 28 and 29 moved—[Mr Andy Kerr]—and agreed to.

Before schedule 1

Amendment 62 moved—[Mr Brian Monteith].

The Deputy Presiding Officer: The question is, that amendment 62 be agreed to. Are we agreed?

The Deputy Presiding Officer: There will be a division.

For

Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
Brownlee, Derek (South of Scotland) (Con)
Davidson, Mr David (North East Scotland) (Con)
Douglas-Hamilton, Lord James (Lothians) (Con)
Fraser, Murdo (Mid Scotland and Fife) (Con)
Gallie, Phil (South of Scotland) (Con)
Goldie, Miss Annabel (South of Scotland) (Con)
Johnstone, Alex (North East Scotland) (Con)
McGrigor, Mr Jamie (Highlands and Islands) (Con)
McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)
AGAINST
Alexander, Ms Wendy (Paisley North) (Lab)
Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
Baird, Shiona (North East Scotland) (Green)
Baker, Richard (North East Scotland) (Lab)
Ballance, Chris (South of Scotland) (Green)
Barrie, Scott (Dunfermline West) (Lab)
Boyack, Sarah (Edinburgh Central) (Lab)
Brankin, Rhona (Midlothian) (Lab)
Brown, Robert (Glasgow) (LD)
Canavan, Dennis (Falkirk West) (Ind)
Chisholm, Malcolm (Edinburgh North and Leith) (Lab)
Cunningham, Roseanna (Perth) (SNP)
Curran, Ms Margaret (Glasgow Baillieston) (Lab)
Deacon, Susan (Edinburgh East and Musselburgh) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
Ewing, Mrs Margaret (Moray) (SNP)
Ferguson, Patricia (Glasgow Maryhill) (Lab)
Finnie, Ross (West of Scotland) (LD)
Gibson, Rob (Highlands and Islands) (SNP)
Gillon, Karen (Clydesdale) (Lab)
Godman, Trish (West Renfrewshire) (Lab)
Graham, Christine (South of Scotland) (SNP)
Harvie, Patrick (Glasgow) (Green)
Henry, Hugh (Paisley South) (Lab)
Home Robertson, John (East Lothian) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Hyslop, Fiona (Lothians) (SNP)
Ingram, Mr Adam (South of Scotland) (SNP)
Jackson, Dr Sylvia (Stirling) (Lab)
Jackson, Gordon (Glasgow Govan) (Lab)
Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Kerr, Mr Andy (East Kilbride) (Lab)
Lamont, Johann (Glasgow Pollok) (Lab)
Livingstone, Marilyn (Kirkcaldy) (Lab)
Lochhead, Richard (North East Scotland) (SNP)
Lyon, George (Argyll and Bute) (LD)
MacAskill, Mr Kenney (Lothians) (SNP)
Macdonald, Lewis (Aberdeen Central) (Lab)
Macdonald, Margo (Lothians) (Ind)
Macintosh, Mr Kenneth (Eastwood) (Lab)
Maclean, Kate (Dundee West) (Lab)
Macmillan, Maureen (Highlands and Islands) (Lab)
Martin, Paul (Glasgow Springburn) (Lab)
Marwick, Tricia (Mid Scotland and Fife) (SNP)
Mather, Jim (Highlands and Islands) (SNP)
Matheson, Michael (Central Scotland) (SNP)
Maxwell, Mr Stewart (West of Scotland) (SNP)
May, Christine (Central Fife) (Lab)
McAteer, Mr Frank (Glasgow Shettleston) (Lab)
McCabe, Mr Tom (Hamilton South) (Lab)
McFee, Mr Bruce (West of Scotland) (SNP)
McMahon, Michael (Hamilton North and Bellshill) (Lab)
McNeill, Mr Duncan (Greenock and Inverclyde) (Lab)
McNeill, Pauline (Glasgow Kelvin) (Lab)
McNulty, Des (Clydebank and Milngavie) (Lab)
Morgan, Alasdair (South of Scotland) (SNP)
Muldoon, Bristow (Livingston) (Lab)
Mulligan, Mrs Mary (Linlithgow) (Lab)
Murray, Dr Elaine (Dumfries) (Lab)
Neil, Alex (Central Scotland) (SNP)
Oldfather, Irene (Cunninghame South) (Lab)
Peacock, Peter (Highlands and Islands) (Lab)
Peatlie, Cathy (Falkirk East) (Lab)
Pringle, Mike (Edinburgh South) (LD)
Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
Radcliffe, Nora (Gordon) (LD)
Robison, Shona (Dundee East) (SNP)
Robson, Euan (Roxburgh and Berwickshire) (LD)
Ruskell, Mr Mark (Mid Scotland and Fife) (Green)
Scott, Eleanor (Highlands and Islands) (Green)
Scott, Tavish (Shetland) (LD)
Smith, Iain (North East Fife) (LD)
Smith, Margaret (Edinburgh West) (LD)
Stephen, Nicol (Aberdeen South) (LD)
Stevenson, Stewart (Banff and Buchan) (SNP)
Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
Swinney, Mr John (North Tayside) (SNP)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
Wallace, Mr Jim (Orkney) (LD)
Watson, Mike (Glasgow Cathcart) (Lab)
Welsh, Mr Andrew (Angus) (SNP)
White, Ms Sandra (Glasgow) (SNP)
Wilson, Allan (Cunninghame North) (Lab)

The Deputy Presiding Officer: The result of the division is: For 16, Against 87, Abstentions 0.

Amendment 62 disagreed to.

Schedule 2

MINOR AND CONSEQUENTIAL AMENDMENTS

Amendments 30 and 31 moved—[Mr Andy Kerr]—and agreed to.

Long title

Amendment 32 moved—[Mr Andy Kerr]—and agreed to.

Amendments 67 and 68 moved—[Mr Duncan McNeil]—and agreed to.

Amendment 69 not moved.

The Deputy Presiding Officer: That ends consideration of amendments.
Smoking, Health and Social Care (Scotland) Bill

The Deputy Presiding Officer (Murray Tosh): The next item of business is a debate on motion S2M-2985, in the name of Andy Kerr, that the Smoking, Health and Social Care (Scotland) Bill be passed. Minister, you have seven minutes, but I think that you have a degree of latitude if you wish to take longer than that.

16:31

The Minister for Health and Community Care (Mr Andy Kerr): I am not sure whether the rest of the members would encourage me to do that.

The Smoking, Health and Social Care (Scotland) Bill will transform Scotland. It will help to save lives and spare families heartache. The measures proposed will improve our productivity, increase our confidence and send a signal across the country and the world that Scotland has changed.

Since devolution, this Government and Parliament have improved Scotland. Police numbers are higher than ever before, crime clear-up rates are better than they have been for generations, waits for hospital treatment—and now by out-patients as well—are reducing dramatically, children are being lifted from poverty at a faster rate than ever before, our pensioners have been provided with safety, security and dignity in their old age, the number of deaths from cancer, heart disease and strokes is falling and pupils, parents and teachers are benefiting from many organisations and individuals who took time to respond to the various consultations, those who gave evidence to the committees, the members of the Finance Committee, the Subordinate Legislation Committee and, in particular, the Health Committee, which considered the bill diligently, and the clerking teams of those committees, which ensured that events have progressed smoothly. I especially want to thank the pupils of Firhill High School, who eloquently expressed their views on smoking on behalf of the younger generation in Scotland. I also want to record in the Official Report my appreciation of the Scottish Executive bill team, which has worked hard to support ministers and to prepare detailed and timely briefings for MSPs. The team has done a fantastic job.

I advise the Parliament that Her Majesty, having been informed of the purport of the Smoking, Health and Social Care (Scotland) Bill, has consented to place her prerogative and interests, so far as they are affected by the bill, at the disposal of the Parliament for the purposes of the bill.

The bill comprises a wide range of health provisions. Each of those is an important measure in its own right, but there is also a high level of interaction among them. The powers for general dental services and pharmaceutical care services will allow health boards to provide assistance towards the provision of premises, among other things. The powers under the joint ventures provisions will provide a valuable new tool to help to deliver those services. The new pharmaceutical care services contract will allow pharmacists to take a greater role in the monitoring of patients on long-term medication. The pharmaceutical care services contract will enable community pharmacists to play a key role in the provision of smoking cessation services to support people who wish to give up smoking.

It is important that the public should have confidence in the health care professionals who deliver their care. The provisions on listing and disclosure of the Parliament for the purposes of the bill are important steps to increase that confidence in the health care professionals who deliver our care.

However, the keynote provisions in the bill are the provisions that will deliver a smoke-free Scotland. They will protect the people of Scotland from second-hand smoke, improve public health and denormalise smoking in our society. As I have said many times, the bill is the most important piece of public health legislation in a generation. As many members reflected today, it shows how Scotland can lead the way in the United Kingdom and is a tribute to the success of devolution. We have been congratulated on the fact that our proposals go further than the measures that have been proposed in England so that we can address...
the problem of Scotland’s higher incidence of smoking-related disease.

The bill will have an immediate impact by protecting people from second-hand smoke, but that will be far outweighed by the benefit that future generations will enjoy as they turn away from smoking as a socially acceptable activity. The decision to legislate was not easy and hard choices had to be made, but the greatest rewards for our country come from our taking the toughest decisions. We must ensure that our children and their children will be able to live longer, healthier lives free from the scourge of smoking.

Today is a proud day for a great many people in Scotland. I am proud to be a part of this great effort on this historic day in the Scottish Parliament. The bill is the gateway to a better, healthier way of life in Scotland. Today, we lead the way.

I move,

That the Parliament agrees that the Smoking, Health and Social Care (Scotland) Bill be passed.

16:37

Shona Robison (Dundee East) (SNP): It is difficult to address every aspect of the Smoking, Health and Social Care (Scotland) Bill, because the bill is so wide ranging. As I have said before, the Executive should reflect on that, because the wide-ranging and complicated nature of the bill has at times given rise to difficulties.

I certainly agree with the minister that the Smoking, Health and Social Care (Scotland) Bill is probably the most important piece of public health legislation that could be passed in Scotland to address the health concerns that plague our nation. The ban on smoking in enclosed public places will have an immediate health benefit for people who work in pubs, restaurants and other enclosed public places and for people who visit those establishments. Just as important, it will also have long-term benefits, because it will denormalise cigarette smoking. I have said all along that, for me, that is probably the most important element of the bill.

The ban will have a huge impact on future generations. We know that far too many children perceive smoking as a normal activity because everyone around them smokes. It is important for society to put across a different message and tell those children that smoking is not a normal activity and that they should not take it up. The bill provides that important counterbalance in those children’s lives.

The bill also creates an environment that will encourage many people to give up smoking. We know that a huge percentage of smokers want to give up smoking. The evidence from New York shows that, after the smoking ban was introduced in that city, there was an 11 per cent increase in the number of people who gave up smoking; there has been a similar success in Ireland. The ban will give people who want to give up the impetus to do so. It will also make it much easier for them, because when they are out socialising they will not be sitting in an environment in which everybody around them is smoking. The ban will have that benefit for a great number of people.

There has been much discussion about the economic impact of the bill and evidence has been put forward by those on both sides of the debate. What is true is that the bill provides the opportunity for Scotland to promote itself as a smoke-free destination for many who wish to come here. We must harness that to promote Scotland abroad. For example, my local hotel introduced a smoking ban in advance of the bill being implemented and its takings have increased, so there is evidence that, when people are ahead of the game and promote their establishment, particularly to families and so on, that can have an economic benefit. That is not to say that some will not have difficulties—we must be honest about that. However, opportunities are available for those who are able and willing to take them.

Addressing Scotland’s poor health record must be the Parliament’s overriding priority and concern. It is telling that the vast majority of members agree with that. I am afraid that only the Tories are left as an isolated rump on the issue, although, even among them, some are not entirely comfortable with their party’s position. The Tories should reflect on their position.

Mr Brian Monteith (Mid Scotland and Fife) (Con): The member tries to portray the Conservatives as a rump and an isolated minority. Does she accept that, in her party group, in the Labour group and even among ministers, some people have doubts about a total ban? The argument that we articulate represents the majority view of Scottish people, which is that, although a ban should be introduced, it should not be a total ban.

Shona Robison: Frankly, the Tories do not represent a majority view on anything.

I will deal with other important issues in the bill. We have long supported the introduction of free eye and dental checks but, if the checks are to be effective, services must be provided for people to take them up and for follow-up work to be undertaken. We are not convinced that that will be the case, particularly in dentistry, because people in many parts of Scotland do not have access to a dentist. More work has to be done. People will in principle have free oral health examinations, but we will need people on the ground to deliver that...
On behalf of my party, I have great pleasure in supporting the bill, but it is work in progress. We will pass the bill today and it will come into force next year, but we must do far more to address Scotland’s chronic health problems. We can do more on smoking. We must ensure that smoking cessation opportunities are available to far more people. When people want to give up smoking, the services must be available to help them. We require to take many other public health measures to ensure that Scotland no longer has the tag of the sick man of Europe. However, the Parliament can be assured of our support for this important bill.

16:44
Mrs Nanette Milne (North East Scotland) (Con): The Smoking, Health and Social Care (Scotland) Bill is a fairly simple-sounding title for a complex and diverse bill that will affect many people’s lives. We are generally content with parts 3 to 5, which deal with pharmaceutical care services, discipline and miscellaneous provisions, such as those on joint ventures and amendments to the Regulation of Care (Scotland) Act 2001.

However, we share the concerns that have been expressed about future service provision under the new pharmacy contract for patients who require stoma appliances. We hope that the Executive’s reassurance that the new services will be at least as good as, if not better than, the present service will be justified in practice. Patients and stoma nurses are certainly not convinced that that will be the case.

We are very disappointed that the bill has not been amended to extend eligibility for ex gratia payments from the Skipton Fund to families of the victims of blood-product induced hepatitis C who died before 29 August 2003. That measure would have removed an obvious inequity, and the lack of any such amendment is a slap in the faces of the many people who have campaigned so tirelessly on the issue.

We cannot support the part 2 provisions on free dental checks and eye examinations. The most vulnerable people are already eligible for free checks; the problem is that many of them are the very people who are not having them carried out. Instead of wasting valuable and scarce resources on people who are perfectly capable of taking personal responsibility for their own dental and eye health, we need to ensure that vulnerable people access the services that they need. Eyesight problems in children must be diagnosed and dealt with early. In accepting Duncan McNeil’s amendment 64, which places a duty on ministers to provide for such diagnosis and treatment, and given the minister’s reassurances, we are satisfied that the national screening committee’s present and future recommendations will be implemented.

As for free dental checks, there seems to be little point in passing such legislation at a time when the NHS does not have enough dentists to carry out the checks or to provide the necessary treatment thereafter. Given dentists’ lukewarm response to the Executive’s recently proposed changes to the dental service in Scotland, it does not seem that the problem is any closer to being resolved.

On part 1, we are disappointed that the Executive has not taken a more reasoned approach to smoking in enclosed public places. In recent years, there have been great strides towards smoke-free provision. For example, buses, trains, airlines, many public buildings, workplaces and restaurants are now smoke free and pubs are beginning to follow suit. I have no doubt that that trend would, without legislation, have increased anyway in response to public demand.

During the bill’s passage, there has been much discussion about the inability of ventilation systems to remove carcinogens from the air in establishments that allow smoking. However, ventilation can in many workplaces that allow such substances in the atmosphere bring carcinogens down to a level that is acceptable. Surely if air quality can be shown to be acceptable, there is no reason why there should not be more exemptions from the smoking ban.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Is the member unaware of the evidence that was given to the Health Committee that shows that what she has just said is patently untrue? Does she accept that ventilation only exacerbates the problem because people assume that the carcinogens have been removed?

Mrs Milne: There is conflicting evidence on the efficacy of ventilation. Only this week, I read that ventilation can reduce the amount of carcinogens not necessarily to zero, but to a level that would be acceptable in a workplace that has carcinogenic materials in its atmosphere. We breathe in carcinogens when we sit in our cars on congested roads or walk along Princes Street. What I am saying is that we could bring such carcinogens
down to an acceptable level. I see no reason why there should not be more exemptions based on air quality, such as those that Brian Monteith proposed in his amendments today.

We are seriously concerned that, as a result of the legislation, smoking will be displaced to the home. That would increase children’s exposure to smoke-filled atmospheres and might lead to an increase in home consumption of alcohol, which is a growing public health problem.

In much of the debate on the bill, the rhetoric has pointed logically to a total prohibition of tobacco. However, such a step is not practicable, which leaves us with a situation in which smoking is, although harmful to health and undesirable, nonetheless a legitimate pastime. As a result, we feel that there must be some choice for smokers as well as for non-smokers. We do not disagree that smoking is a bad thing; indeed, I and my colleagues without exception want less of it. We would certainly support a sustained and vigorous campaign against taking up smoking and we would support measures to provide practical help, support and encouragement to people who wish to kick the habit, with the ultimate goal of achieving a smoke-free environment for everyone.

However, for the reasons that I have stated, we cannot give our full support to parts 1 and 2 of the bill, and we must therefore oppose it in its entirety.

16:50

Nora Radcliffe (Gordon) (LD): By contrast, I rise to support the bill with enthusiasm and to acknowledge it as a major achievement for the Scottish Parliament. I commend the committee, the Executive, members of staff and all the people outwith Parliament who contributed during the consultation process and who gave evidence to the committee. I am also pleased to welcome the bill as a major delivery of Scottish Liberal Democrat policies.

Members: Ah!

Nora Radcliffe: I said that I was enthusiastic.

Attention has inevitably and quite rightly focused on the smoking aspects of the bill. The banning of smoking in enclosed public places is a crucial step in helping to shed Scotland’s image as the sick man of Europe. The Scottish Liberal Democrats were the first party in Scotland to support a comprehensive ban on smoking in enclosed public places, and we are supporting the ban not because it is popular but because we believe that it is the right thing to do. I note that, at Westminster, the United Kingdom Government now accepts that it will eventually have to go for a comprehensive ban, rather than the messy compromise with which it is currently wrestling and which depends on the type of food that a pub serves. If and when that happens, England will be following the trailblazing work of this Parliament.

I would like to talk about another key Liberal Democrat policy that the bill will deliver: free eye and dental checks. From 1 April 2006, oral health assessments and dental examinations are to be available free of charge. The abolition of those charges clearly underpins our commitment to health promotion and early intervention. We acknowledge the difficulties that are currently being experienced in providing national health service dental services, but those difficulties will be resolved. There exists the commitment and political will to do whatever is necessary to get that sorted.

I would like to mention three pieces of survey evidence from the RNIB that demonstrate the importance of regular eye checks and why the legislation is important. First, a 2001 survey showed that more than 40 per cent of people who are exempt from paying for check-ups are unaware that they are exempt. Secondly, since 1989, when the Tories introduced charges, there has been a progressive increase in the proportion of people who leave up to five years between sight tests. Finally, a survey that was published earlier this month in Wales showed that one person in five has never heard of glaucoma and that just 3 per cent know that a person could suffer from glaucoma without necessarily displaying any symptoms. Up to 40 per cent of useful sight can be lost before a person realises that anything is wrong, but if it is caught early enough glaucoma can, in nearly all cases, be successfully treated and no sight need be lost.

There is proof that charges deter people from having regular check-ups, even when they may be eligible for free tests. Regular check-ups can catch dental problems and eye problems such as glaucoma before they become more serious. When the Health Committee took evidence on the bill, the proposal to provide free eye and dental checks received near universal support. Their provision represents an excellent progressive step for Scotland. The recent Kerr review stated:

“the most appropriate place for the Health Service to begin to narrow the gap between rich and poor is through the systematic adoption of the principles of anticipatory care and preventive medicine.”

I see free eye and dental checks as the embodiment of anticipatory care and preventive medicine.

The banning of smoking in enclosed public places will be the most important piece of public health legislation since devolution. The bill represents a good day for Parliament and for the Liberal Democrats.
16:54

Janis Hughes (Glasgow Rutherglen) (Lab): I join other colleagues in thanking the clerks to the committee, other staff who are associated with the committee and the many witnesses who gave evidence for the huge efforts that they put into helping the bill’s passage through Parliament. The clerks to the committee are becoming old hands at dealing with legislation, so I place on record my gratitude to them.

It is a great honour to stand here today as a member of the Labour party, which has been at the forefront of striving to address health inequalities, and to speak in support of a bill that I consider to be one of the most significant pieces of public health legislation in Scottish history. That point was also made by Nora Radcliffe. One of my constituents recently told me that he believed that the bill is the most important piece of legislation in his lifetime. We should all be proud that the Scottish Parliament is taking such a decisive lead.

In considering legislation such as this, it is always good to examine the experiences of other countries, so the Health Committee did just that during its deliberations. We took video evidence from New York and we visited southern Ireland. We learned a great deal from their practical experience of passing and enforcing legislation such as that which we are about to vote on today. The legislation gives us an opportunity to address our poor health record here in Scotland.

I represent a constituency that has very high incidences of death from strokes, cancer and heart disease. I am sure that no one—not even in the Conservative party—would doubt that a hugely significant number of deaths from those diseases throughout Scotland are caused by smoking. For too long we have done little to address that, but now we are getting serious. I am pleased that the bill has, by and large, attracted cross-party support, but I am disappointed—although not particularly surprised—that we have heard during the passage of the bill that the Conservatives are still campaigning against the ban on smoking. They ignore medical evidence and continue to argue that they know best and that passive smoking does not exist. The wrecking amendments—

Mr Monteith: Will the member give way?

Janis Hughes: I am sorry, but we heard Brian Monteith’s arguments in the committee and we have heard exactly the same arguments today. They have been voted down on both occasions. The wrecking amendments that were rejected by Parliament today and, as I said, the similar amendments that were previously rejected by the committee, expose the Tories’ real agenda of putting profit before people. We should not allow people to forget that.

To argue—as the Tories have done—that a ban on smoking in public places is an attack on civil liberties is simply wrong. The ban is clearly an attack on one of the major causes of ill health, but I argue that it will defend the civil liberties of the 70 per cent of Scots who do not smoke. An outright ban on smoking may well be attacked as being an attack on civil liberties, but a ban on smoking in public places, which will benefit the health of smokers and non-smokers, including staff who work in smoky environments, does not constitute anything other than common sense. It is a prime example of what we as policy makers should be doing to promote Scotland’s public health.

I hope that today we will pass the bill, which deals not only with a ban on smoking in enclosed public places. It is unfortunate that some of the other very important measures in the bill have not enjoyed the same profile as the smoking ban. Nonetheless, we have heard about a number of them today, including during the minister’s opening speech.

The bill will not in itself cure Scotland of its appalling health record. However, it represents a hugely significant first step; a first leap towards a better and brighter country. We should all embrace that. Like the minister, I am proud to be part of this historic occasion in Parliament today. I am delighted to support the bill and I hope that Parliament will follow suit.

16:58

Stewart Stevenson (Banff and Buchan) (SNP): This is not the end and it is not the beginning of the end, but it might just be the end of the beginning in eliminating the evil trade of the tobacco barons.

People who are called Stewart obviously have a particular view on the subject of tobacco. My colleague Stewart Maxwell is, in comparison with me, a moderate on the issue. I commend him for bringing the issue into play through his previous member’s bill and I congratulate the Executive on responding to it and bringing forward wider measures. All are to be praised to the skies for that.

As an extremist on the subject, I have of course studied it in some detail. The cigarette came to these islands during the Crimean war, when our soldiers saw the French and the Turks smoking this new device. War has proved to be a remarkably effective platform for the evil people in the tobacco companies to broaden the franchise for this pernicious addiction. During the second world war, the proud boast of the tobacco companies was that they provided two packs of

...
cigarettes for every soldier, as a treat for our brave fighting men. That laid the foundations of the addiction that afflicts our society.

A wide range of health conditions are derived from the use of tobacco in a variety of delivery mechanisms and many famous people have died as a result of their addiction. Jackie Kennedy lost a child two days after that child was born, entirely because she had smoked during her pregnancy. She died of lung cancer, but she is far from alone. I have with me 13 pages of names of well-known people: Gracie Allen, Louis Armstrong, Desi Arnaz, Lucille Ball, Tallulah Bankhead, Leonard Bernstein, Neville Brand, Humphrey Bogart, Paul Brinegar, Yul Brynner, Rory Calhoun, John Candy, Jack Cassidy, Rosemary Clooney, Nat King Cole—have members noticed that many of those people might have been smoking in public for entertainment purposes? I have a dozen more pages of names.

Of course, we are not here to protect the great and the good; we are here to protect the ordinary people of Scotland. By passing the bill we will take a great step forward and we will set an example for others, as our friends across the Irish sea did. Yesterday, Shaun Woodward, the Parliamentary Under-Secretary of State in the Northern Ireland Office with responsibility for health, made an announcement that relates to our debate. People in Northern Ireland have responded in huge numbers—some 70,000—to a consultation on smoking. Of that huge number of respondents, 91 per cent said that Northern Ireland should follow the example that Ireland has set and which Scotland is following. They have said that because they could see what was happening across the border.

I will paraphrase Tom Nairn. Scotland’s people will not be free of the health scourge that we have been debating until the last tobacco share certificate has been wrapped around the last ounce of tobacco and smoked by the last tobacco addict—given his current form, perhaps that will be Brian Monteith.

17:02

Eleanor Scott (Highlands and Islands) (Green): How can I follow Stewart Stevenson?

I warmly welcome the bill on behalf of the Scottish Green Party. I will mention my reservations about the bill first and get them out of the way so that I can finish on an optimistic note. I am concerned about the fact that the bill has been described as “the smoking bill” or “the bill about smoking and other stuff”. The bill deals with a wide range of issues, many of which do not sit well together. I am happy with most of the bill’s content and I will support it, but its provisions are ill sorted.

The range of issues with which the bill deals was reflected in the lobbying that all members received about the bill. Various organisations sent us briefing notes and letters. For example, the RNIB Scotland commented on eye checks for children. Although Kate Maclean’s amendment 63 was not agreed to, I am happy with the Executive’s reaffirmation that eyesight tests for pre-school children—a measure that is dear to my heart—are secure, and with its commitment to consider evidence on eyesight programmes that emerges in the future. Stoma users expressed concern about potential changes to their services. I hope that those concerns will prove to be unfounded and that the minister’s reassurances on the matter will be honoured. I am sure that stoma patients will get in touch with us—and that we will get in touch with the minister—if there are problems.

We heard from publicans and representatives of the licensed trade. I am happy to say that, from my experience in Ireland, I think that their fears are unfounded and that they will not suffer the loss of trade that they expect. Their businesses will do well and will attract people who currently do not often go to pubs. About 70 per cent of people do not smoke; many of them find smoky pubs unpleasant and object to being smelly when they come out of such pubs.

We were lobbied by sufferers of hepatitis C. I will say more about the matter, but I think that we let that group down today.

We were lobbied by Unison, which is concerned about joint ventures. I am concerned about the level of public sector involvement that that might entail. It would have been good to debate those points, so it is a pity that the member who lodged the relevant amendment was not here to speak to it.

I warmly support the provisions on eye and dental checks, but reiterate what other members have said: checks are fine, but we must also be able to offer treatment. As has been said before in the chamber—it will be said again, particularly by members from the Highlands and Islands—we need more dentists. That will not happen overnight and I do not expect the Executive to wave a magic wand, but we must start growing more of our own dentists.

The hepatitis C issue somewhat tarnishes the shining face of the bill, which is really unfortunate; we could have done better today. I am however, warmly supportive of the smoking provisions. The bill will make great legislation. It is innovative and courageous and I hope that it will have a tremendous effect on our public health, particularly the health of young women. Rates of smoking among young women are worryingly high and have not been going down. There is a large social element to that. I am sure that many young...
women who start smoking do so in social situations, or carry on smoking because of social situations in which smoking is the norm. If smoking ceases to be the norm in such situations, young women will find it much easier to stop and others in the future will find it easier not to start. That is crucial for young women who are, after all, the future mothers of the next generation. Rates of smoking in that group must be brought down. I agree with what has been said about the need for back-up smoking cessation services, but the bill is a welcome and courageous first step.

Although I have reservations about parts of the bill—I think that they would have been better in separate legislation—there is so much in the bill that I must support. We will give it our warm-hearted support at 6 o’clock, or whenever we actually vote on it.

17:07

Irene Oldfather (Cunninghame South) (Lab): Today in the Scottish Parliament I believe that we are witnessing a moment in history. Those who vote for the bill today vote to improve the health and lives of future generations.

Sometimes, we in the Parliament are accused of irrelevance or political expediency. From time to time, we are justly criticised. Today, we do the right thing as legislators. Our primary motivations are to increase life expectancy, to reduce ill health and to address health inequalities. In doing so, and in tackling preventable illness and early death, we also increase resources in the health service for research into new drugs and the development of new technology to assist us to treat illnesses that some would say have been underresourced—Huntington’s chorea, multiple sclerosis, motor neurone disease, Parkinson’s disease, and Alzheimer’s disease. Today, therefore, we are in a win-win situation.

There has been a sea change in attitudes towards the banning of smoking in public places. This piece of legislation would not have been possible six years ago. For those of us who have campaigned on the matter over the years, the legislation represents the widest possible ban that could have been obtained at this point in time. Since the stage 1 debate, we have travelled a considerable distance and made great progress. I am especially pleased that the Executive has held its ground on day centres. In the face of arguments from both sides, the Executive has strictly limited exemptions in adult care homes and psychiatric units to designated smoking rooms and extended the definition of enclosed areas to include partly enclosed areas.

I am delighted at the minister’s commitment to work in the future with the cross-party group on tobacco control and to closely monitor issues such as smoke drift and cessation. The policy intention of my amendments seeking to extend the scope of the bill to cover outside areas did not attract as much support today as I would have liked. Members and the minister felt that the evidence was not robust enough. I accept that viewpoint, but I also believe that, just as our opinions have changed in the past six years, it is only a matter of time before we move in that direction, although it was not the Parliament’s will to do so today.

Members might be interested to know that Queensland is considering extending its ban to outside areas. Also, visitors from California who have been staying with me over the past week tell me that California intends to extend its ban to public parks, not because of evidence of ill health, but simply because smoking has become socially unacceptable, especially for young people. It is my hope that the bill, which is comprehensive, will start the ball rolling in Scotland and ensure that it is only a matter of time before smoking is the exception, not the norm, particularly among our young people. Helping people to kick the habit must be an integral part of the policy development.

I said during the stage 1 debate that there was a moral imperative to act because smoking kills 19,000 Scots every year. One death in five in Scotland is smoking related. We know that smoking is responsible for 33,500 hospital admissions every year and that second-hand smoke is a class A carcinogen. That costs the NHS in Scotland an estimated £200 million every year. That is the financial cost, but every member can give an example of the human cost. Today, we take concrete measures to address that problem in Scotland.

It would be remiss of me to conclude without thanking members of the cross-party group on tobacco control, members of the Health Committee clerking team, who assisted me with the drafting of amendments, Action on Smoking and Health, the British Medical Association, the Royal College of Nursing and many others who have worked together to make today possible. However, without the commitment of the Scottish Executive, the health ministers and the First Minister, who took the lead on the matter, we would not have such a comprehensive bill. The Scottish Parliament can stand tall. We can be proud of the legacy that we put in place today for our children and our children’s children.

I support the motion to pass the bill.

17:12

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): To begin with, I will focus on part 2 of the bill, which contains enabling
legislation that is designed to ensure that the Executive's commitment to radically improve the state of the nation's dental service is achieved. That is particularly important to my constituents, who have the lowest number of NHS dentists in the country. Earlier this year, the Executive announced its action plan for improving oral health and modernising NHS dental services in Scotland. The measures in the bill reinforce the Executive's dental action plan by allowing health boards to provide direct assistance and support "to any person providing, or proposing to provide, general dental services."

For the public to benefit fully from the free dental checks that the bill makes available, everyone needs to have access to good NHS dental services. The proof of the pudding is always in the eating and Lewis Macdonald—the new Deputy Minister for Health and Community Care—who has responsibility for NHS dental services, has a huge task to ensure that, when the bill's provisions come into operation next year, everyone who needs it has access to an NHS dentist. If access to NHS dental services for all is not forthcoming, the Executive will have failed in its objective. I do not expect Executive ministers to fail in that task.

It is fortunate that the problems of accessing NHS dental services are not replicated in optometry. Public access to free eye checks should not pose the same problems, but I urge the Executive to ensure that, now that plans for the reform of the dental and ophthalmic services are in place, we put those plans into action as soon as possible. Agreement with both professions on the implementation of the provisions on ophthalmic and dental services must be reached soon. We need to up the pace on those issues.

Part 1 of the bill contains provisions to prohibit smoking in enclosed public places. For far too long, the rights of individuals to enjoy clean air and be free of cancer-causing pollutants have been ignored. Smoking kills, as does so-called second-hand smoke. As recently as last year, Professor David Hole's research concluded that second-hand smoke was associated with up to 2,000 deaths a year in Scotland. I have no truck with those such as the Conservatives who refuse to recognise the medical evidence. They are the same people who for years refused to accept that tobacco kills people.

Even now, the tobacco lobby is active in trying to deny the effects of environmental tobacco smoke. Its latest wheeze—may I call it a wheeze?—is to claim that if only bars and restaurants could install super-duper ventilation systems, all would be well. Unfortunately for the tobacco industry, the evidence that was presented to the Health Committee completely debunks the myth that ventilation systems can remove the harmful effects of tobacco smoke. They cannot and they do not. In fact, ventilation systems make matters worse, as I said to Nanette Milne in an intervention. They remove the smoke and make the air more comfortable for the individual, but they do not remove the 50 or so carcinogens from the atmosphere; the individual feels better and perhaps stays longer, to receive an even larger dose of the pollutant.

There is no doubt in my mind that the bill will make a huge contribution to making Scotland a healthier place to live. The members of the Health Committee made a very useful visit to see for themselves the effects that legislation on smoking have had on Irish communities and people. The Irish ban, which was introduced on 29 March last year, has been a huge success. We were told that the compliance rate with the legislation is a very high 94 per cent. Cigarette sales fell by 10 per cent in 2003 and by a further 17 per cent in 2004. No wonder the death merchants of the tobacco trade are worried.

I have no doubt at all that there may indeed be some fall in trade, as the Scottish Licensed Trade Association has highlighted. However, I cannot for one moment accept that that argument carries any weight at all when put alongside the public health benefits that the measures in the bill will produce. One cannot argue for profit before lives.

This is a landmark bill. It includes major policies such as free eye and dental checks for all and it endorses the right of people to enjoy clean air in enclosed public places. Parliament should support the bill with enthusiasm; it is the right thing to do.

17:17

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I never thought that I would see this day and I never expected that I would be a politician and in Parliament on such a day. Honestly and truly, I thought that it would never happen.

When I qualified in 1965, one of my first jobs was in a thoracic unit. If I was ever in any doubt about what cigarette smoking could do to a person, I learned then. Later, I worked as an anaesthetist for eight years. Let me assure members that somebody who has been a smoker can have difficulties and can make it hard for the anaesthetist. We always dreaded having to put to sleep somebody who said that they smoked 20 cigarettes a day but probably really smoked 40 or 80 a day.

I thank Stewart Maxwell for starting the ball rolling. It was a wonderful start and the Executive has to be congratulated on taking it up. This has been a wonderful attempt to look for the first time at long-term benefits. Governments do not usually do that sort of thing; I would never have thought
that the Government would get involved. However, I am proud to be part of the Parliament that has brought in this bill.

Members will have guessed that I am in favour of the bill. There have been a few glitches along the way and I am a little bit sad about the dates for the Skipton Fund. However, we must think about the reductions in heart and lung disease, strokes, diabetes and kidney disease that will follow from the bill. Kidney disease is on the rise. Much of that is to do with vascular problems and many vascular problems come from cigarette smoking.

We all know that a person who goes back to smoking after a bypass operation is more likely to have to have the operation redone. Of the people I know or have worked with who smoke, most would love to stop. The bill is one way of encouraging them, but we will have to do a lot to help people to stop smoking, which is a serious addiction. Trying to stop smoking is as bad as trying to stop taking heroin. I know that, because my parents were heavy smokers. I have known many other people who would be addicted again tomorrow if they had one cigarette. Addiction to tobacco is serious and people need a great deal of help when trying to stop smoking.

We were worried about what would happen in homes as a result of the bill. I was encouraged by the evidence from Australia that I read, which did not find any resulting increase in the incidence of smoking in homes or of childhood illnesses.

Like all other members, I worry about the workforce for the dental side of things, but I appreciate what the Executive is trying to do. I remind members that doctors examine patients’ digestive tracts. The digestive tract starts in the mouth, so oral examinations can be done by general practitioners. When examining people, GPs may also notice that there are a few things to fix in people’s teeth, which they cannot do—for that, people will have to go to their dentist, if they have one. However, oral checks are part of a medical examination. General practitioners can look in people’s mouths to see whether any cancer is lurking there.

I will limit my comments to a few issues that worry me. Pharmaceutical services are changing greatly. We have been lobbied a great deal by people who enjoy stoma services from companies that supply the appliances. Many years ago, those companies started supplying nurses and contributing to the cost of their services. I have never known a nurse push a particular product. As I said at the Health Committee, stomas are as individual as the people who have them, so they need special attention. I appreciate the fact that the Minister for Health and Community Care and his deputy have tried to allay fears on the issue. I would like to ensure that they make clear, as they have, that no one will have any problems because of the change. Every time that there is a change to a service, someone is liable to fall through the net. Many of the people to whom I refer have enjoyed stoma services for many years. They are terrified that they will become housebound because there will be a glitch in the service and they will not be able to get what used to be delivered to their house. I hope that I will hear at the end of the debate that this issue will be addressed.

Another important provision that I have read in regulations concerns the indemnity for all practitioners other than doctors, nurses and dentists, which is important for patients, in particular. In Scotland and England, indemnity is usually provided by the Medical Defence Union. Usually, insurance policies start on the date on which the policy was issued and end on the stated date. If practitioners fail in any way to keep up the policy and do patients harm, patients may suffer.

This is a huge bill, any part of which could have been a bill in itself. If we had not already worked on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, which was introduced by Stewart Maxwell, we would have had difficulty dealing with it. As all members know, I have great doubts about the provisions relating to joint ventures. I have found that private companies limited by guarantee that are not wholly made up of public bodies do not seem to be subject to the Freedom of Information (Scotland) Act 2002. I am not against private companies being involved, but I would not like them to take over the NHS or the medical needs of people working in the NHS and, subsequently, patients. I would like to be reassured on that issue.

I am delighted with most of the bill. I am ecstatic about the provisions that relate to smoking. It is wonderful for me to be here today to see history created. I appreciate all the work that was put in by the clerks and others, who are great when members try to lodge amendments but do not know what they are doing. I congratulate all those, from top to bottom, who have been involved with the bill, as they have been very hard-working. I wish the bill well and am sure that the health of our nation will improve as a result. In 15 to 20 years, we will be very pleased that we passed it.

17:25

Mr Kenneth Macintosh (Eastwood) (Lab): It is rare for people to admit that they are wrong; it is rarer still for politicians to do so. Given that this is the last day before the recess and judging colleagues to be in forgiving mood, I open my remarks with a confession—maybe it is even an apology. I was wrong about smoking.
I am pleased to make my contribution to today's proceedings as joint convener of the cross-party group on cancer and as a member of the cross-party group on asthma. I speak also as a former smoker. Twenty years ago—indeed, probably a lot more recently—I would have called the bill a step too far. In the 1980s, I distinctly remember watching television programmes and reports from America on the first bans on smoking in public places, including in restaurants—I think the Californians went first. I remember seeing smokers and anti-smokers—I call them that because they were not just non-smokers—having heated altercations, one of which resulted in an interviewee throwing a glass of water over another interviewee. I felt at the time that I was watching one set of extremists imposing their view on another—indeed, I remember describing it as health fascism. I also remember decrying any link between health and passive smoking, a position that I held mostly through ignorance.

I have travelled a long way in 20 years. At that time, someone could smoke in their workplace. It was a rare desk at the BBC, where I worked in those days, that did not have an ashtray piled high with cigarette ends. Even I did not mind the removal of that supposed right. All of us at the BBC immediately noticed the improvement in the environment in which we worked.

It took a few years and a few attempts before I managed to stop smoking. Looking back on it now, I can see that I managed to stop because I did not go to the pub as often as I had done previously. I am not saying that everyone should stop going to the pub in order to stop smoking. However, if pubs had been non-smoking when I was trying to give up smoking, I would have found it easier to quit.

I am also no libertarian: I believe that Governments can make a difference by doing good and helping to improve people's lives. I am supporting the bill not because I want to impose my own preferences or tastes on others or because of my own personal journey but because public attitudes, too, have changed dramatically over the past 20 years. Just as it is no longer acceptable to drive drunk or to tell racist jokes, I believe that Scotland is ready to accept a ban on smoking in public places.

I agree that individual rights have to be balanced with the public good. I also agree that we are redrawing the line on what is acceptable. However, it is precisely because of that public good that the arguments for the bill are overwhelming. How many members have used their position in the Scottish Parliament to argue for a new positron emission tomography scanner for cancer patients, for example? How many of us have argued for extra ring-fenced resources for the Beatson oncology centre or other cancer services? How many of us have pushed and supported the Government to reduce waiting times for cancer patients?

All those measures will make a big difference to patients but none is even remotely on the scale of what we will achieve if we can reduce the number of Scots who smoke. Millions of people worldwide and more than 13,000 people a year in Scotland die prematurely because of smoking. The scale of the problem is immense and so is the importance of supporting the bill that is before us today.

The Scottish Parliament was established not just to manage the government of Scotland better but to build a better future. Although we are all proud to be Scottish, I for one am not proud that Scotland has the worst cancer record, worst heart disease record and worst dental health record of any modern European country. I did not come into the Scottish Parliament to defend the right of young Scots to have a cigarette but to see all our children grow up healthy—taller, fitter, more self-confident and enjoying life.

Although I started off with an apology, I make no apology for the bill. Quite simply, the bill is one of the most important measures that we will take in a generation. Today of all days I am very proud to serve in the Scottish Parliament.
The result of the vote on amendment 24 was 56 to 52 and I was on the losing side. I have been lectured to by the Scottish Socialist Party more times than I care to remember about the Skipton Fund and hepatitis C, but if five members from the SSP had been here, I would not have been on the losing side this afternoon. Our distinguished Presiding Officer said some fine words to us about the importance of democracy and speaking one’s mind, but democracy also means being in the right place at the right time to vote for what one believes in, rather than manning the barricades. The less I say about the matter, the less trouble I will get into, but I repeat that, if those five members had been here, that would have tipped the vote over the edge and we would have had a truly excellent bill. I hope that members learn a lesson from that stupidity.

On the smoking provisions, I support the amendment that surfaced from Duncan McNeil that will allow the age limit for the purchase of cigarettes to be raised. I agree with Stewart Maxwell that we must encourage ministers to do that; because the more disincentives to smoking that we put in place, the better. I hope that the Government looks seriously at that point and formulates further regulations on the matter.

The bill’s provisions on smoking have not come about by accident; several people over several years have contributed to them. My colleague Kenny Gibson, who was a member in the first session of Parliament, raised the issue to much derision and mirth, but that started the debate. Stewart Maxwell has taken up the cudgels effectively. [Interruption.]

The Deputy Presiding Officer (Trish Godman): Mr Swinney, I remind you that mobile phones must be switched off, not just left on silent.

Mr Swinney: I commend the Executive for taking the issue further and creating a bill with which to address the problem. I am not yet familiar with the mechanics of Government—I stress the word “yet”—but, while I commend the First Minister and the Minister for Health and Community Care for bringing the bill to the Parliament, I am pretty certain that it is here because of the stance that Mr McCabe took when he was Deputy Minister for Health and Community Care. It is worth putting that on record.

The bill says to the people of Scotland that we, as a democratic Parliament, are looking at Scotland as we find it today and seeing the depth and seriousness of the problems and challenges that our society faces. It is therefore essential that we respond with well-crafted and bold legislation that has a big effect and that can lead to a culture change in our society. The bill will become the type of legislation that can change a culture in our society and make our country healthier and fitter and a place where people look after their health in the way that people in other countries do. As a consequence, people will find that their self-esteem and self-confidence grow magically. Of course, if there is growth in self-esteem and self-confidence, my politics may prosper even further in the years to come. I leave the issue on that party-political note. The bill is good at addressing a deep problem with our country’s health and I look forward to seeing the fruits of that in the years to come.

Much has been said about the commercial implications of the ban on smoking in public places. I suspect that the proof of the pudding will be in the eating, but I take a lot of comfort from examples around the country of businesses that have taken a lead and have simply got on with things. Such businesses have seen the mood of the nation and the direction of legislation and have decided what they are going to do.

As we embark on the summer recess, I say to the Minister for Health and Community Care that if he has time to spare, perhaps on the day when he visits the excellent Whitehills community hospital in Forfar, he could travel to a fantastic ice cream parlour called Visocchi’s in the town of Kirriemuir, which is perhaps five miles north of Forfar. I have just thought of that. Weeks ago, Michael and Elena Visocchi took the courageous decision to ban smoking in their cafe. They took that decision with some trepidation, but business has been fine and people who would never have gone into the cafe because it was smoky now go into it with their children. If the minister is looking for a good place for an ice cream when he comes to Forfar on 13 August, I shall give him directions to the cafe. I might even pay for him.

17:36

Mr Brian Monteith (Mid Scotland and Fife) (Con): To draw on the earlier reference to the Crimea, I rather sense that I am leading the light cavalry into the Russian guns at Balaclava.

Before I proceed, I thank the Health Committee’s clerks, who have been particularly helpful to me and my colleagues in drafting amendments and giving us timely advice. Not all of them are here, but I pay tribute to their work in particular, which has helped the political process.

It is unfortunate that the Conservatives cannot support the bill. We would have liked to support it, but we believe that the sections on free eye tests and dental checks and the total ban on smoking go further than is necessary. We would support more screening for tests with schoolchildren and more targeting of dental checks, but I remain unconvinced that it is necessary to extend the current free provision to everyone who can afford
to pay. Why people like me who are prepared to pay for designer frames should be given a free eye test by the taxpayer when some opticians already offer free tests has not been convincingly explained. Indeed, Dolland and Aitchison launched its free tests on the day that the bill was debated at stage 1.

The Conservatives do not support the status quo on smoking restrictions. We would support the extension of restrictions and we could have supported more being done, but a total ban goes too far. From April fools’ day next year, there will be no smoking in pubs, restaurants, cafes, bingo halls, airport departure lounges or even in specialist tobacconists. Private members’ clubs—which can hardly be called public places—will also be covered by the ban. In an example of cultural censorship that would have embarrassed the ancient Philistines, even the portrayal of smoking on stage or in a television studio in which “River City”, for example, might be being filmed will be banned.

On the evidence, no one has yet been able to explain how a Labour Minister for Health and Community Care in Edinburgh and a Labour Secretary of State for Health in London can reach entirely opposite views on the threat that is posed by inhaling other people’s tobacco smoke. In Edinburgh, the evidence that tobacco smoke kills people is considered to be conclusive, but in London, it is not. The result is that the smoking ban is England will not be total, but partial, which is a proportionate response that respects the rights of minorities. No such tolerance is to be allowed in Scotland. There is no medical evidence that shows that passive smoking kills. Indeed, as we found last month, in a landmark ruling by the Scottish judge Lord Nimmo Smith, even the medical evidence to show that direct smoking kills is not considered conclusive. That is the crux of the matter. All that we have is statistical evidence about the dangers of smoking, although that evidence is generally accepted, even by me.

Janis Hughes suggested that Conservative members are putting profit before the concerns of people. As someone who lost his father—who was a smoker—to lung cancer, I do not dispute the health concerns, but I will not be lectured to on the basis that I am making a judgment that is somehow influenced by the profit that is made by tobacconists. The statistical evidence is quite different from the medical evidence. We already know that the medical evidence is disputed and that the statistical evidence, although we accept it, is hotly disputed by learned scientists who do not smoke, who detest smoking and who are not necessarily, and not often, in the pay of tobacco barons.

The dispute on the evidence is being ignored because the ministers wish to introduce a total ban. The evidence is being accepted in England because Westminster plans to introduce a partial ban. The real aim of ministers in Scotland—I pay tribute to Andy Kerr for being honest about it—is to denormalise smoking. They want to stigmatise smokers, so that people will give up smoking. So much for the inclusive society that so many MSPs constantly talk about. Someone can be Catholic, Muslim, Protestant, atheist or heathen; they can be straight, lesbian, gay, bisexual or transgender; and they can be of any colour, and there shall be no bigotry, discrimination or exclusion. That is how it should be, and I support that view. I sign up to it. Each to their own within the law, I say. However, if someone is a smoker, they are excluded—the bill will exclude them. They will not be considered normal. Their smoking will not be considered normal and it will not be allowed to be portrayed as normal. That is what denormalisation means.

John Swinburne (Central Scotland) (SSCUP): Will the member give way?

Mr Monteith: No. I must carry on.

The logical extension of that is to ban smoking altogether. I know that one or two members would like to do that, but the Parliament will not do that because it knows that that would not carry the support of the public.

The smoking issue divides our nation, which is why an accommodation—a compromise—should have been found. I believe that ventilation offered that compromise, but it was not considered seriously. Indeed, the Health Committee suspended the laws of physics and would not accept the fact that gases mix. Gas laws tell us that when ventilation extracts particles and gases, it extracts them at the same ratio because they mix. Ventilation fans do not work out first whether the gases are carcinogenic; they extract them at the same ratio.

Stewart Stevenson: Will Brian Monteith take an intervention? He is wrong.

Mr Monteith: No. I will not take an intervention from somebody as rude as Stewart Stevenson.

If we suspend the laws of physics and do not accept the advice of learned scientists who tell us that the evidence is not conclusive, we cannot say that we have considered the issue seriously. If we had reached a compromise and found some places where people could smoke, it would have been possible for the Conservatives to support the bill. People could have chosen to go to bars and restaurants where there was no smoke or they could have chosen to go to places where people could smoke and mixed freely. Sadly, that will not happen. Smoking will be denormalised in this country, along with tolerance. Tolerance is being
denormalised, and that is one reason why I cannot support the bill.

17:44

Mr Stewart Maxwell (West of Scotland) (SNP): I start on a rather disappointing note in relation to the reinsertion of the cut-off date for claims to the Skipton Fund. It is rather unfortunate that that happened. I, for one, was delighted to be here today and to be moving to a conclusion on the bill so that we could have a healthier Scotland in the future through the banning of smoking in public places. I believe that the Executive is simply wrong on the issue, but I lay the blame for allowing the Executive to reinsert the date not on it but squarely at the door of the Scottish Socialist Party members. Their pathetic, childish, amateurish and downright anti-democratic antics at First Minister’s questions meant that they could not be here this afternoon when the vote was taken and narrowly lost. In my opinion, that is unforgivable. John Swinney was right on that point.

The minister was right when he said that this was an historic day. I am delighted to have been involved so closely in the campaign to introduce a ban on smoking in enclosed public places. Many people were involved in that campaign. As John Swinney said, Kenny Gibson in the first session, Brian Adam, Tom McCabe and the current Minister for Health and Community Care have been involved and the First Minister threw his weight behind the campaign. Others throughout the chamber, particularly those who are on the cross-party group on tobacco control, have been involved.

It is funny—we often hear it said that a week is a long time in politics, but two years seems a very short period of time in relation to the legislation on smoking. Two years ago, I launched the proposal, which was that we would ban smoking in public places; that was my intention. With a few honourable exceptions throughout the parties, I was almost a lone voice on the subject at that time. Indeed, 18 months ago, the First Minister said that a smoking ban was both unworkable and impractical. John Swinney was right on that point.

What a tremendous turnaround there has been in the past 18 months. I am delighted that so many members and parties have changed their mind and stance and now support this extremely important and welcome health measure, which is of course SNP policy. The Lib Dems cannot rewrite history, as Nora Radcliffe tried to do and as Mike Rumbles has tried to do before. I have ignored it before, but today I will mention it. The Liberal Democrats were not the first party to support a public smoking ban; that is just not true. They can repeat the claim as often as they like, but it is fundamentally wrong.

Nora Radcliffe: Will the member give way?

Mr Maxwell: No. The member had her chance. The SNP was the first party to support the ban; that is a matter of fact and it is on the record. Let us get that clear.

One thing that was missing from the minister’s opening speech was what will happen in the next 15 months or so. That is important and I hope that the minister, when he sums up, will set out what will happen in the run-up to the ban. It is clear that this is a once-in-a-lifetime opportunity. We have often talked about people taking this opportunity to give up cigarettes in advance of the legislation coming into force. In Norway, there was a 3 per cent drop in smoking rates before the legislation came into force. What education programmes and advertising campaigns will there be? Can the Executive tell us about anything else that will happen in that extremely important period? I said 15 months, but that is incorrect—it is less than a year until the ban comes in. I would like to know exactly what we are going to do in the run-up. Let us ensure that we do not miss the opportunity.

When I was preparing for the debate, I decided to read about the history of smoking—not the current situation in Scotland and the figure of 13,000 deaths a year from smoking-related ill health that we all know about. One of the interesting facts that struck me was that ever since tobacco arrived in Europe, it has generated huge debate and controversy. Stewart Stevenson said that in the Crimean war many of our soldiers were introduced to cigarettes for the first time. Of course, the history of tobacco goes back a lot further than that of cigarettes. It is thought that tobacco plants first began to grow around 6,000 BC in the Americas. By the start of the Christian era, tobacco use was well established all over the Americas, but there is no record of tobacco being grown or used anywhere else in the world. When the American continent was first opened up, tobacco use spread out of it to Europe. However, the far east, for example, did not adopt the habit. China banned the planting and use of tobacco in 1612 and Japan followed suit in 1620—if only they had kept those bans in place.

Things were slightly different in Europe. In 1665, smoking was made compulsory for boys at Eton College—perhaps that explains the Tory view today. Right from its introduction into Europe, there were conflicting theories and views about tobacco. At the end of the 16th century, tobacco was attracting interest from many herbalists and was believed to be good for treating many illnesses from toothache to colic. Yet, as early as 1602, a book was published that claimed that illnesses in chimney sweeps were linked to their exposure to smoke and drew a parallel with tobacco smoking. We all know, of course, that
James VI wrote a marvellous treatise, “A Counter-blaste to Tobacco”, in 1604. However, all those theories lacked proper scientific research to back them up and proper statistics from which conclusions could be drawn. Now, of course, statistics are carefully recorded and, if we turn to America, where smoking started, we can see what has happened in that continent in the 20th century.

In 1914, there were only 371 cases of lung cancer in the whole of the United States of America. In 1919, a young medical student who went on to do important work on the link between smoking and cancer was told to attend an operation on lung cancer because it was so rare that that might be his only chance to see it in his career. However, by 2003, there were 172,000 cases of lung cancer in the USA. The number of cases rose from 371 in 1914, to 2,500 by 1930 and to more than 7,000 by 1940. What had changed? Smoking was being taken up by more and more Americans. Cigarette rations were given to soldiers during the first world war and smoking among men became prevalent. Women did not take up smoking until the end of the second world war and many women are today suffering from the effect of that cultural shift.

The 20th century was the century of the cigarette, but I hope that the 21st century is a century of no cigarettes and that we move away from tobacco, smoking and the disease and ill health that they bring.

Many people have been involved in the bill. I thank the campaigners outwith the Parliament, the staff of the non-Executive bills unit and the clerks of the Health Committee, the Subordinate Legislation Committee and the Finance Committee, who worked extremely hard on the bill. I also thank the staff in my office, who worked extremely hard in the background to ensure the success of the campaign.

It is not often that one gets a chance to force a subject to the top of the political agenda and see it succeed and I feel extremely privileged to have done so. I have been asked many times why I took up this issue. My motivation is simple. I fought this campaign for the young people of Scotland, for the children who are not yet born and, in particular, for the future of Catherine, my daughter. She will grow up and go out to smoke-free restaurants and pubs and go to work in smoke-free places. For her sake and for the sake of all the children of Scotland, I take the greatest pleasure in supporting the bill this evening.

17:52

Mr Kerr: Many emotions are felt on a day such as this. Many members have talked about their feelings of pride, which today are well placed. We can reflect on what we are about to do through the bill and we should feel proud about doing something so significant.

It was my good fortune that I was able to pick up the legislation as minister at the point that I did, as that gave me the opportunity to see it through its final parliamentary stages. As many members have done, I must mention the First Minister, who has led from the front, Tom McCabe, Malcolm Chisholm, Rhona Brankin, Lewis Macdonald, the cross-party group on tobacco control, Scotland CAN—which stands for clear air now—and other organisations outwith the Parliament, Stewart Maxwell, Kenny Gibson and other members from various parties who have done a lot of work on the subject.

However, although I feel a sense of good fortune and pride, I also feel a little bit of anger that, when people turn on their televisions tonight, they will probably see four juvenile, spoiled little brats from the SNP—[Laughter.] Sorry, I should say four juvenile, spoiled little brats from the SSP who put their own narrow political interest before that of the Parliament.

It is about time that the Tories caught up. On the economic arguments, let me quote James McBratney, who owns a bar and a restaurant in New York and was the main campaigner against the smoking ban in the city. However, he has since said:

“I've seen no falloff in business in either establishment”.

He went on to describe what he once considered unimaginable—customers seeming to like the ban. He has said that he likes it, too. In Scotland, Stuart Ross, the chief executive of the Belhaven Group, recently said:

“It's not the end of the world. It's just a big situation for people to manage. But the Irish have adapted to it. Why should Scotland be any different?”

On the health evidence, I must say that Mr Monteith is not the leader of a band of hearty soldiers going into battle; he is like King Canute standing before the waves in rejecting all the evidence from the Scientific Committee on Tobacco and Health, the World Health Organisation, all the research done by universities around the world and the evidence from Ireland and New York about the positive effects that such a ban will have.

What can we expect to happen? It might, as some people claim, take 10 to 15 years for our health figures to turn around but, in the first two years of the ban in New York, 188,000 people stopped smoking—a 15 per cent reduction in the number of smokers—and exposure to second-hand smoke dropped by a third. In Ireland, cigarette sales are down by 15 per cent in just one year. That illustrates the positive effects that the
legislation will have and the benefits that it will bring to our communities.

Of course, many others have been involved in the long campaign for a ban. I had the privilege to meet Sir John and Dr Eileen Crofton, who, 50 years ago, were early campaigners on the issue. They campaigned for the first smoke-free taxi in Edinburgh. They stuck with the campaign for all those years and we should recognise their contribution. One night in Edinburgh, I had the honour to meet Barbara Wood from Aberdeenshire. Her husband, who is now sadly dead, was a lifelong non-smoker. He was a head teacher who spent far too much of his life in smoke-filled staffrooms. Those are the real people whom we are fighting for today. We want to ensure that we deliver for them and their families.

Up in the gallery today are representatives from Firrhill High School. If members look up, they might see some familiar faces—the young pupils who brought to the Parliament their campaign to ban smoking in public places. Their maturity, skill and determination have been shown today—we met them at Bute House earlier and, on Sky TV, they said that what is right for young people is right for Scotland and that they support the measures that the Parliament is about to take in relation to a smoke-free Scotland.

People throughout the world fought year after year for democratic Parliaments and we are no different here in Scotland. Scots campaigning for 300 years for the Scottish Parliament. Why did they do that? They did that to see democratically elected representatives debate and decide on the issues that matter to them and their families under laws established by the Parliament. They did not campaign so hard simply to see a handful of self-publicists treat the country’s Parliament like a school playground. Today must be remembered not for the antics of the infantile few, but for the momentous decision that we are on the verge of making.

Devolution means that we can no longer blame others for our national ills. We have no excuse for abdicating our responsibility for tackling our poor health. Today, our country will lead the way in the UK and we will be at the forefront of change in Europe. I would have preferred it if our Conservative colleagues had embraced the bill fully and put the national interest before private interests, but I fully expect them to respect the Parliament’s decision when it is made. I say to them that the facts are absolutely clear. Smoking is bad for people’s health; second-hand smoke is bad for people’s health; and smoking is bad for the country’s health.

The choice is clear. We can take the responsibility here and now and do something about smoking or we can consign Scotland to another generation of poor health and disease, with more families being shattered by the premature death, to smoking, of a loved one. We can seize the opportunity to make our enclosed public places cleaner, healthier and more attractive. We can pass legislation to make our pubs, clubs and restaurants more marketable to a population that increasingly avoids smoky venues.

This is another defining moment in the Parliament. This time last year, we passed the Antisocial Behaviour etc (Scotland) Bill, which provided powers to improve the lives of families and communities the length and breadth of Scotland. One year later, I urge members to support the Smoking, Health and Social Care (Scotland) Bill, which will improve Scotland as a whole so that families can stay together for longer, enjoy more choice about where they go and what they do and be part of a more confident, ambitious and healthy Scotland.

As the minister who is responsible at this stage of the bill’s progress, I welcome the opportunity to commend the legislation. I thank all those who have played their part over the years—including those who are in the chamber today—and I note their contribution. I was sent many e-mails on the matter and, as I travelled around Scotland, people’s warmth towards, and support for, the bill was all too clear. Mr Keith Hughes of Edinburgh sent me a thought whose sentiment is engraved on the pavement outside the Writers Museum at Lady Stair’s House. He said that the only way we can repay our debt to the past is by making the future indebted to us. I believe that that is what we are about to do.
Decision Time

The Presiding Officer: The second question is, that motion S2M-2985, in the name of Andy Kerr, that the Smoking, Health and Social Care (Scotland) Bill be passed, be agreed to. Are we agreed?

Members: No.

The Presiding Officer: There will be a division.

**FOR**
- Adam, Brian (Aberdeen North) (SNP)
- Alexander, Ms Wendy (Paisley North) (Lab)
- Arbuckle, Mr Andrew (Mid Scotland and Fife) (LD)
- Baillie, Jackie (Dumbarton) (Lab)
- Baird, Mark (Lothians) (Green)
- Ballard, Mark (Lothians) (Green)
- Barrie, Scott (Dunfermline West) (Lab)
- Boyack, Sarah (Edinburgh Central) (Lab)
- Branikin, Rhona (Midlothian) (Lab)
- Butler, Bill (Glasgow Anniesland) (Lab)
- Canavan, Dennis (Falkirk West) (Ind)
- Chisholm, Cathie (Edinburgh North and Leith) (Lab)
- Craigie, Cathie (Cumbernauld and Kilsyth) (Lab)
- Crawford, Bruce (Mid Scotland and Fife) (SNP)
- Cunningham, Roseanna (Perth) (SNP)
- Curran, Ms Margaret (Glasgow Baillieston) (Lab)
- Deacon, Susan (Edinburgh East and Musselburgh) (Lab)
- Ewing, Fergus (Inverness East, Nairn and Lochaber) (SNP)
- Ewing, Mrs Margaret (Moray) (SNP)
- Fabian, Linda (Central Scotland) (SNP)
- Ferguson, Patricia (Glasgow Maryhill) (Lab)
- Fergusson, Alex (Galloway and Upper Nithsdale) (Con)
- Finnie, Ross (West of Scotland) (LD)
- Gibbon, Robin (Highlands and Islands) (SNP)
- Gilson, Karen (Clydesdale) (Lab)
- Godman, Trish (West Renfrewshire) (Lab)
- Gorrie, Donald (Central Scotland) (LD)
- Grahame, Christine (South of Scotland) (SNP)
- Harvie, Patrick (Glasgow) (Green)
- Henry, Hugh (Paisley South) (Lab)
- Home Robertson, John (East Lothian) (Lab)
- Hughes, Janis (Glasgow Rutherglen) (Lab)
- Hyslop, Fiona (Lothians) (SNP)
- Ingram, Mr Adam (South of Scotland) (SNP)
- Jackson, Dr Sylvia (Stirling) (Lab)
- Jackson, Gordon (Glasgow Govan) (Lab)
- Jamieson, Cathy (Carrick, Cumnock and Doon Valley) (Lab)
- Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
- Kerr, Mr Andy (East Kilbride) (Lab)
- Lamont, Johann (Glasgow Pollok) (Lab)
- Livingstone, Marilyn (Kirkcaldy) (Lab)
- Lochhead, Richard (North East Scotland) (SNP)
- Lyon, George (Argyll and Bute) (LD)
- MacAskill, Mr Kenny (Lothians) (SNP)
- Macdonald, Lewis (Aberdeen Central) (Lab)
- MacDonald, Margo (Lothians) (Ind)
- Macintosh, Mr Kenneth (Eastwood) (Lab)
- Maclean, Kate (Dundee West) (Lab)
- Martin, Paul (Glasgow Springburn) (Lab)
- Marwick, Tricia (Mid Scotland and Fife) (SNP)
- Mather, Jim (Highlands and Islands) (SNP)
- Matheson, Michael (Central Scotland) (SNP)
- Maxwell, Mr Stewart (West of Scotland) (SNP)
- May, Christine (Central Fife) (Lab)
- McAveety, Mr Frank (Glasgow Shettleston) (Lab)
- McCabe, Mr Tom (Hamilton South) (Lab)
- McConnell, Mr Jack (Motherwell and Wishaw) (Lab)
- McFee, Mr Bruce (West of Scotland) (SNP)
- McMahon, Michael (Hamilton North and Bellshill) (Lab)
- McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
- McNell, Pauline (Glasgow Kelvin) (Lab)
- McNulty, Des (Clydebank and Milngavie) (Lab)
- Morgan, Alasdair (South of Scotland) (SNP)
- Muldoon, Bristow (Livingston) (Lab)
- Mulligan, Mrs Mary (Linlithgow) (Lab)
- Murray, Dr Elaine (Dumfries) (Lab)
- Neil, Alex (Central Scotland) (SNP)
- Oldfather, Irene (Cunninghame South) (Lab)
- Peacock, Peter (Highlands and Islands) (Lab)
- Peattie, Cathie (Falkirk East) (Lab)
- Pringle, Mike (Edinburgh South) (LD)
- Purvis, Jeremy (Tweeddale, Ettrick and Lauderdale) (LD)
- Radcliffe, Nora (Gordon) (LD)
- Robson, Shona (Dundee East) (SNP)
- Robson, Euan ( Roxburgh and Berwickshire) (LD)
- Rumbles, Mike (West Aperdeenire and Kincardine) (LD)
- Russell, Mr Mark (Mid Scotland and Fife) (Green)
- Scott, Eleanor (Highlands and Islands) (Green)
- Scott, Tavish (Shetland) (LD)
- Smith, Iain (North East Fife) (LD)
- Smith, Margaret (Edinburgh West) (LD)
- Stephen, Nicol (Aberdeen South) (LD)
- Stevenson, Stewart (Banff and Buchan) (SNP)
- Stone, Mr Jamie (Caithness, Sutherland and Easter Ross) (LD)
- Sturgeon, Nicola (Glasgow) (SNP)
- Swinburne, John (Central Scotland) (SSCUP)
- Swinney, Mr John (North Tayside) (SNP)
- Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)
- Wallace, Mr Jim (Orkney) (LD)
- Watson, Mike (Glasgow Cathcart) (Lab)
- Welsh, Mr Andrew (Angus) (SNP)
- White, Ms Sandra (Glasgow) (SNP)
- Whitefield, Karen (Airdrie and Shotts) (Lab)
- Wilson, Allan (Cunninghame North) (Lab)

**AGAINST**
- Aitken, Bill (Glasgow) (Con)
- Brocklebank, Mr Ted (Mid Scotland and Fife) (Con)
- Brownlee, Derek (South of Scotland) (Con)
- Davidson, Mr David (North East Scotland) (Con)
- Douglas-Hamilton, Lord James (Lothians) (Con)
- Fraser, Murdo (Mid Scotland and Fife) (Con)
- Gallie, Phil (South of Scotland) (Con)
- Goldie, Miss Annabel (West of Scotland) (Con)
- Johnstone, Alex (North East Scotland) (Con)
- McEgrigera, Mr Jamie (Highlands and Islands) (Con)
- McLetchie, David (Edinburgh Pentlands) (Con)
Milne, Mrs Nanette (North East Scotland) (Con)
Mitchell, Margaret (Central Scotland) (Con)
Monteith, Mr Brian (Mid Scotland and Fife) (Con)
Munro, John Farquhar (Ross, Skye and Inverness West) (LD)
Scanlon, Mary (Highlands and Islands) (Con)
Scott, John (Ayr) (Con)

**ABSTENTIONS**

Tosh, Murray (West of Scotland) (Con)

**The Presiding Officer**: The result of the division is: For 97, Against 17, Abstentions 1.

*Motion agreed to.*

That the Parliament agrees that the Smoking, Health and Social Care (Scotland) Bill be passed.
Smoking, Health and Social Care (Scotland) Bill
[AS PASSED]

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Smoking, Health and Social Care (Scotland) Bill
[AS PASSED]

An Act of the Scottish Parliament to prohibit smoking in certain wholly or substantially enclosed places; to enable the Scottish Ministers by order to vary the minimum age limit of those to whom tobacco may be sold; to make provision in relation to general dental services, general ophthalmic services, personal dental services, pharmaceutical care services and detection of vision problems in children; to make provision in relation to disqualification by the NHS Tribunal; to enable the Scottish Ministers to establish a scheme for the making of payments to certain persons infected with hepatitis C as a result of NHS treatment and to certain persons infected with the virus by transmission of it from a person infected with it as a result of such treatment; to amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission; to make provision providing further time for applications to be made for registration of child care agencies and housing support services under the Regulation of Care (Scotland) Act 2001 and provide authorisation for the payment of certain grants to such services while not registered under that Act; to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland; to amend the rules as to membership of and other matters relating to the Scottish Hospital Endowments Research Trust; and for connected purposes.

PART 1
SMOKING: PROHIBITION AND CONTROL

1 Offence of permitting others to smoke in no-smoking premises

(1) A person who, having the management or control of no-smoking premises, knowingly permits another to smoke there commits an offence.

(2) A person accused of an offence under this section is to be regarded as having knowingly permitted another to smoke in no-smoking premises if that person ought to have known that the other person was smoking there.
(3) It is a defence for an accused charged with an offence under this section to prove—
(a) that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence; or
(b) that there were no lawful and reasonably practicable means by which the accused could prevent the other person from smoking in the no-smoking premises.

(4) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 4 on the standard scale.

2 Offence of smoking in no-smoking premises

(1) A person who smokes in no-smoking premises commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused did not know, and could not reasonably be expected to have known, that the place in which it is alleged that the accused was smoking was no-smoking premises.

(3) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

3 Display of warning notices in and on no-smoking premises

(1) If notices are not conspicuously displayed—
(a) in, on or near no-smoking premises so as to be visible to and legible by persons in and persons approaching the premises; and
(b) stating—
(i) that the premises are no-smoking premises; and
(ii) that it is an offence to smoke there or knowingly to permit smoking there,
the person having the management or control of the premises commits an offence.

(2) It is a defence for an accused charged with an offence under this section to prove that the accused (or any employee or agent of the accused) took all reasonable precautions and exercised all due diligence not to commit the offence.

(3) The Scottish Ministers may, after consulting such persons as they consider appropriate, by regulations provide further as to the manner of display, form and content of the notices referred to in subsection (1) and that any such provision is to be treated, for the purposes of that subsection, as if incorporated in it.

(4) A person guilty of an offence under this section is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

4 Meaning of “smoke” and “no-smoking premises”

(1) In this Part, “smoke” means smoke tobacco, any substance or mixture which includes it or any other substance or mixture; and a person is to be taken as smoking if the person is holding or otherwise in possession or control of lit tobacco, of any lit substance or mixture which includes tobacco or of any other lit substance or mixture which is in a form or in a receptacle in which it can be smoked.

(2) In this Part, “no-smoking premises” means such premises or such classes of premises, being premises of a kind mentioned in subsection (4), as are prescribed by regulations.
made by the Scottish Ministers after consulting such persons as they consider appropriate on a draft of the regulations.

(3) Regulations under subsection (2) may prescribe premises or parts of premises or classes of premises or parts of premises which are excluded from the definition of “no-smoking premises”.

(4) The kind of premises referred to in subsection (2) is premises which are wholly or substantially enclosed and—

(a) to which the public or a section of the public has access;
(b) which are being used wholly or mainly as a place of work;
(c) which are being used by and for the purposes of a club or other unincorporated association; or
(d) which are being used wholly or mainly for the provision of education or of health or care services.

(4A) In subsection (4)(b), the reference to work includes work undertaken for no financial advantage.

(5) Regulations under subsection (2) may, for the purposes of that subsection, define or elaborate the meaning of any of the expressions—

(a) “premises”;
(b) “wholly or substantially enclosed”;
(c) “the public”; and
(d) “has access”.

(6) Regulations under subsection (2) may define or elaborate the meaning of “premises”—

(a) by reference to the person or class of person who owns or occupies them;
(b) so as to include vehicles, vessels, trains and other means of transport (except aircraft), or such, or such classes, of them as are specified in the regulations.

(7) The Scottish Ministers may, by regulations, after consulting such persons as they consider appropriate on a draft of the regulations, modify subsection (4) so as—

(a) to add a kind of premises to; or
(b) remove a kind of premises (but not the kind referred to in paragraph (a) of that subsection) from,

those in that subsection.

(8) Regulations made by virtue of subsection (6)(b) may provide as to how the statement referred to in section 3(1)(b) is to be expressed in the case of each of the means of transport referred to in the regulations and that any such provision is to be treated, for the purposes of that section, as if incorporated in it.

4A Proceeding for offences under sections 1 to 3

(1) Summary proceedings in pursuance of section 1, 2 or 3 may be commenced at any time within the period of 6 months from the date on which evidence sufficient in the opinion of the Lord Advocate to justify the proceedings comes to the Lord Advocate’s knowledge.
(2) Subsection (3) of section 136 of the Criminal Procedure (Scotland) Act 1995 (c.46) (date of commencement of summary proceedings) has effect for the purposes of subsection (1) as it has effect for the purposes of that section.

(3) For the purposes of subsection (1), a certificate of the Lord Advocate as to the date on which the evidence in question came to the Lord Advocate’s knowledge is conclusive evidence of the date on which it did so.

5 Fixed penalties

(1) Schedule 1 (which provides as to fixed penalties for offences under this Part) has effect.

(2) Schedule 1 does not extend to an offence under section 1 or 3 committed otherwise than by a natural person.

6 Powers to enter and require identification

(1) An authorised officer of the appropriate council may enter and search any no-smoking premises in order to ascertain whether an offence under section 1, 2 or 3 has been or is being committed there.

(2) A power under this section may be exercised, if need be, by force.

(3) A person who—
   (a) an authorised officer of a council reasonably believes—
      (i) is committing or has committed an offence under section 1, 2 or 3; or
      (ii) has information relating to such an offence; and
   (b) fails without reasonable excuse to supply the officer with the person’s name and address on being so required by the officer,
commits an offence.

(4) A person guilty of an offence under subsection (3) is liable, on summary conviction, to a fine not exceeding level 3 on the standard scale.

(5) In this section—
   “authorised” means authorised for the purposes of this section by the appropriate council;
   “the appropriate council” means, in relation to no-smoking premises, the council of the area in which those premises are.

7 Bodies corporate etc.

(1) Where an offence under this Part which has been committed by a body corporate other than a council is proved to have been committed with the consent or connivance of, or to be attributable to, any neglect on the part of—
   (a) a director, manager or secretary, member or other similar officer of the body corporate; or
   (b) any person who was purporting to act in any such capacity,
that person, as well as the body corporate, is guilty of the offence and liable to be proceeded against and punished accordingly.
(2) Where an offence under this Part which has been committed by a council is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) an officer or member of the council; or
   (b) any person who was purporting to act in any such capacity,
that person, as well as the council, is guilty of the offence and liable to be proceeded against and punished accordingly.

(3) Where an offence under this Part which has been committed by a Scottish partnership is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) a partner; or
   (b) any person who was purporting to act in any such capacity,
that person, as well as the partnership, is guilty of the offence and liable to be proceeded against and punished accordingly.

(4) Where an offence under this Part which has been committed by an unincorporated association other than a Scottish partnership is proved to have been committed with the consent or connivance of, or to be attributable to any neglect on the part of—
   (a) a person who is concerned in the management or control of the association; or
   (b) any person who was purporting to act in any such capacity,
that person, as well as the unincorporated association, is guilty of the offence and liable to be proceeded against and punished accordingly.

7A Sale of tobacco to under-age persons: variation of age limit
(1) The Scottish Ministers may, by order, modify section 18 of the Children and Young Persons (Scotland) Act 1937 (c.37) (offence of selling tobacco etc. to under-age persons and other preventative measures) so as to substitute for the age specified in any of its provisions (at the passing of this Act, 16) such other higher age or ages as they consider appropriate.
(2) The Scottish Ministers may make an order under this section only after consulting such persons as they consider appropriate on a draft of the order.

8 Crown application
(1) This Part binds the Crown.
(2) No contravention by the Crown of this Part or any regulations under it makes the Crown criminally liable; but the Court of Session may, on the application of a council in the area of which the contravention is alleged to have taken place, declare unlawful any act or omission of the Crown which would, but for this subsection, have been an offence.
(3) Subsection (2) does not extend to persons in the public service of the Crown.
8A Detection of vision problems in children

After section 38A of the 1978 Act, insert—

“38B Detection of vision problems in children

(1) It is the duty of the Scottish Ministers, to such extent as they consider necessary to meet all reasonable requirements, to provide for the detection of vision problems in children.

(2) In this section, “children” means persons under the age of 16 years.”.

9 Free oral health assessments and dental examinations

(1) Oral health assessments and dental examinations carried out on or after 1st April 2006 in accordance with arrangements made under section 17C of the 1978 Act, arrangements for the provision of general dental services under Part II of that Act or a pilot scheme under Part I of the National Health Service (Primary Care) Act 1997 (c.46) (the “1997 Act”) are to be free of charge; and accordingly those Acts are amended as follows.

(2) In the 1978 Act—

(a) in section 70A(2) (personal dental services as respects which regulations under section 70A(1) may provide for the making and recovery of charges), for the words “other than those” substitute “except—

(a) oral health assessments and dental examinations carried out on or after 1st April 2006; and

(b) those services”;

(b) in section 71 (charges for general dental services under Part II)—

(i) in subsection (1), after the words “not being—” insert—

“(a) oral health assessments and dental examinations carried out on or after 1st April 2006;”;

(ii) in subsection (2), after “services” where it first occurs insert “(but not being oral health assessments or dental examinations carried out on or after 1st April 2006)”.

(3) In the 1997 Act, in section 20 (charges for dental treatment in accordance with pilot schemes)—

(a) in subsection (1), for the words from “dental” to the end substitute “personal dental services provided in accordance with pilot schemes except—

(a) those services to which section 78(1A) of the 1977 Act or (as the case may be) section 70(1A) of the 1978 Act applies; and

(b) oral health assessments and dental examinations carried out on or after 1st April 2006.”;

(b) subsection (2) is repealed.
Free eye examinations and sight tests

(1) Arrangements under section 26(1) of the 1978 Act for the provision of general ophthalmic services are to include eye examinations and the provision of free eye examinations and sight tests in accordance with such arrangements is to be extended on and after 1st April 2006; and accordingly that Act is amended as follows.

(2) In section 26 (arrangements for the provision of general ophthalmic services)—
   (a) in subsection (1), for the words from “the testing” to the end substitute “the carrying out of eye examinations including where clinically necessary testing of sight.”;
   (b) subsections (1A) to (1E) are repealed.

(3) In paragraph 2A of Schedule 11 (additional provision as to regulations under section 70(1) on charges for optical appliances), sub-paragraph (3)(a) is repealed.

Charges for certain dental appliances and general dental services

(1) The 1978 Act is amended as follows.

(2) In section 70 (regulations as to charges for dental or optical appliances)—
   (a) in subsection (1), for the words “optical appliances” substitute “dental or optical appliances”;
   (b) subsection (1A) is repealed;
   (c) in subsection (2), for the words “(1A)” substitute “(1)”.

(3) In section 70A(2) (personal dental services as respects which regulations under section 70A(1) may provide for the making and recovery of charges), for the words “70(1A)” substitute “70(1)”.

(4) In section 71(1) (charges for certain general dental services), for the words “an amount calculated in accordance with section 71A” substitute “the amount authorised by this section”.

(5) Section 71A (regulations as respects amount of any charge authorised by section 70(1A) for supply of dental appliances or by section 71 for certain general dental services) is repealed.

(6) In paragraph 2 of Schedule 11 (additional provision as to regulations under section 70)—
   (a) after sub-paragraph (1), insert—
       “(1A) The dental appliances referred to in that section are dentures, bridges, crowns and orthodontic appliances.”;
   (b) in sub-paragraph (2)(a), for the words “optical appliance” substitute “dental or optical appliance”;
   (c) in sub-paragraph (3), the words “or (1A)” are repealed;
   (d) in sub-paragraph (4), for the words “70(1A)” substitute “70(1)”.

Arrangements for provision of general dental services

In section 25 of the 1978 Act (arrangements for provision of general dental services) in subsection (1)—
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(a) after the words “dental practitioners” insert “or bodies corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(aa) after the words “dental practitioner” insert “or body corporate”.

13 Assistance and support: general dental services

After section 28C of the 1978 Act, insert—

“Assistance and support: general dental services

28D Assistance and support: general dental services

(1) A Health Board may provide assistance and support to any person providing, or proposing to provide, general dental services.

(2) Assistance and support provided by a Health Board under subsection (1) is to be provided on such terms, including terms as to payment, as the Board think fit.

(3) In this section, “assistance” includes financial assistance.”.

15 Lists of persons undertaking to provide or approved to assist in the provision of general dental services

In section 25 of the 1978 Act (arrangements for provision of general dental services), for subsections (2) to (2B), substitute—

“(2) Regulations may make provision as to the arrangements to be made under subsection (1), and shall include provision as to the preparation, maintenance and publication by every Health Board of a list—

(a) the first part of which shall be of dental practitioners who, and bodies corporate referred to in that subsection which, undertake to provide general dental services under arrangements with the Board;

(b) the second part of which shall be of persons who do not undertake to provide such services under such arrangements but who are approved by the Board to assist in the provision of such services provided under such arrangements.

(2A) In making provision as to the preparation, maintenance and publication of a list referred to in subsection (2), the regulations may include in particular provision as to—

(a) the division of either part (or both parts) of a list into further sub-parts;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);
(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.

(2B) Regulations may provide that—

(a) a dental practitioner who, and a body corporate referred to in subsection (1) which, undertakes to provide general dental services under arrangements with a Health Board may not provide such services unless his name or, as the case may be, the body corporate’s name is included in the first part of the Board’s list referred to in subsection (2)(a);

(b) a person who does not undertake to provide general dental services under arrangements with a Health Board may not assist in the provision of such services provided under arrangements with the Board unless his name is included in the second part of the Board’s list referred to in subsection (2)(b).”.

16 Lists of persons performing personal dental services under section 17C arrangements or pilot schemes

After section 17E of the 1978 Act, insert—

“17F Lists of persons performing personal dental services

(1) Regulations may provide that a person may not perform personal dental services under section 17C arrangements or a pilot scheme with a Health Board unless his name is included in a list maintained under the regulations by the Board.

(2) Regulations under subsection (1) may make provision in relation to such lists and in particular as to—

(a) the preparation, maintenance and publication of a list;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and the documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;
(e) requirements with which a person included in a list must comply
   (including requirements as to standards of performance and patient care
   and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and
   consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw
   from it;

(h) payments to be made by a Health Board in respect of a person suspended
   from a list (including provision for the amount of, or the method of
   calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of
   applications, or suspensions, removals or references to the Tribunal,
   including in particular the disclosure of information about any such
   matter by a Health Board to the Scottish Ministers and by the Scottish
   Ministers to a Health Board.”.

17 Lists of persons undertaking to provide or approved to assist in the provision of
general ophthalmic services

In section 26 of the 1978 Act (arrangements for provision of general ophthalmic
services), for subsection (2), substitute—

“(2) Regulations may make provision as to the arrangements to be made under
subsection (1), and shall include provision—

(a) as to the preparation, maintenance and publication by every Health
Board of a list—

(i) the first part of which shall be of medical practitioners and
ophthalmic opticians who undertake to provide general ophthalmic
services under arrangements with the Board;

(ii) the second part of which shall be of persons who do not undertake
to provide such services under such arrangements but who are
approved by the Board to assist in the provision of such services
provided under such arrangements;

(b) conferring on any person a right to choose in accordance with the
prescribed procedure the medical practitioner or ophthalmic optician by
whom his eyes are to be examined, his sight is to be tested or from whom
any prescription for the supply of optical appliances is to be obtained.

(2A) In making provision as to the matters referred to in subsection (2)(a), the
regulations may include in particular provision as to—

(a) the division of either part (or both parts) of a list into further sub-parts;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for
applications to be made and dealt with and the documents to be supplied
on application);
(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from a list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal, including in particular the disclosure of information about any such matter by a Health Board to the Scottish Ministers and by the Scottish Ministers to a Health Board.

(2B) Regulations may provide that—

(a) a medical practitioner or ophthalmic optician who undertakes to provide general ophthalmic services under arrangements with a Health Board may not provide such services unless his name is included in the first part of the Board’s list referred to in subsection (2)(a)(i);

(b) a person who does not undertake to provide general ophthalmic services under arrangements with a Health Board may not assist in the provision of such services provided under arrangements with the Board unless his name is included in the second part of the Board’s list referred to in subsection (2)(a)(ii).”.

18 Health Boards’ functions: provision and planning of pharmaceutical care services

(1) The 1978 Act is amended as follows.

(2) After section 2C (functions of Health Boards: primary medical services), insert—

“2CA Functions of Health Boards: pharmaceutical care services

(1) Every Health Board—

(a) must, to the extent that they consider necessary to meet all reasonable requirements, provide or secure the provision of pharmaceutical care services as respects the Board’s area; and

(b) may, to such extent, provide or secure the provision of pharmaceutical care services as respects the area of another Health Board,
and pharmaceutical care services provided, or the provision of which is secured, by a Health Board under or by virtue of this subsection may be performed outside their area.

(2) For the purpose of securing the provision of pharmaceutical care services under subsection (1), a Health Board may make such arrangements for the provision of the services as they think fit (and may in particular make contractual arrangements with any person).

(3) A Health Board must publish information about such matters as may be prescribed in relation to the pharmaceutical care services provided under this Part.

(4) Without prejudice to section 13, Health Boards must co-operate with one another in discharging their respective functions relating to the provision of pharmaceutical care services under this Part.

(5) Regulations may provide that services of a prescribed description are, or are not, to be regarded as pharmaceutical care services for the purposes of this Act.

(6) Regulations under subsection (5) may in particular—
   (a) classify services as services which are to be regarded as essential services or which are to be regarded as additional services;
   (b) describe services by reference to the manner or circumstances in which they are provided;
   (c) provide that pharmaceutical care services for the purposes of this Act include the provision, in circumstances specified in directions given by the Scottish Ministers, of drugs, medicines and appliances included in a list specified in such directions;
   (d) describe services which involve the ordering of a drug, medicine or appliance included in such a list by reference to the description of person by whom the drug, medicine or appliance is ordered.

(7) The Scottish Ministers must publish directions given by them under regulations under subsection (5) in the Drug Tariff or in such other manner as they consider appropriate.

(8) Arrangements made under this Part by a Health Board for the provision of pharmaceutical care services may provide for such services to be performed outside Scotland.

(9) Anything done by a Health Board in pursuance of subsection (1) or (2) is to be regarded as done in exercise of functions of the Scottish Ministers conferred on the Health Board by an order under section 2(1)(a).

2CB Functions of Health Boards: planning of pharmaceutical care services

(1) Regulations may make provision requiring every Health Board, in accordance with the regulations, to—
   (a) prepare a plan for the discharge of their duty under section 2CA(1);
   (b) keep a plan prepared under paragraph (a) under review;
   (c) prepare a revised plan; and
(d) without prejudice to section 2CA(3), publish a plan so prepared or revised.

(2) Regulations under subsection (1) may in particular make provision as to—

(a) identification by a Health Board in any such plan prepared by them of—

(i) what pharmaceutical care services they consider are necessary in order to discharge their duty under section 2CA(1);

(ii) whether as respects their area there is convenient access (as regards location and opening hours) to pharmaceutical care services; and

(iii) any under-provision of pharmaceutical care services as respects their area;

(b) the period within which a plan is to be prepared and published;

(c) consultation which a Health Board must undertake in relation to the preparation of a plan;

(d) the duration of a plan;

(e) the frequency with which a plan must be reviewed and revised by a Health Board;

(f) the availability and accessibility of a plan to persons who are resident in a Health Board’s area; and

(g) such other matters as the Scottish Ministers consider appropriate.

(3) Regulations making provision as to a matter referred to in subsection (2)(a) may provide that the matter is to be identified in accordance with such criteria as may be specified in directions given by the Scottish Ministers.”.

(3) In section 18 (duty of the Scottish Ministers), the words “, and of pharmaceutical services,” are repealed.

19 Pharmaceutical care services contracts

For section 17Q of the 1978 Act (assistance and support), substitute—

“Pharmaceutical care services contracts

17Q Health Boards’ power to enter into pharmaceutical care services contracts

(1) A Health Board may enter into a contract under which pharmaceutical care services are provided (whether directly or indirectly) by a contractor in accordance with the provisions of this Part.

(2) A contract under this section is referred to in this Act as a “pharmaceutical care services contract”.

(3) Subject to any provision made by or under this Part, a pharmaceutical care services contract may make such provision as may be agreed between the Health Board and the contractor as respects—

(a) the services to be provided under the contract;

(b) the remuneration to be paid under the contract; and

(c) any other matters.
(4) The services to be provided under a pharmaceutical care services contract may include services which are not pharmaceutical care services; and the contract may provide for such other services to be performed in any place where, by virtue of section 2CA(1), pharmaceutical care services may be performed.

(5) In this Part, “contractor”, in relation to a pharmaceutical care services contract with a Health Board, means the other party to the contract.

17R Mandatory contract term: provision of prescribed pharmaceutical care services

(1) A pharmaceutical care services contract must require the contractor to provide as respects the area of the Health Board pharmaceutical care services of such descriptions as may be prescribed.

(2) Regulations under subsection (1) may in particular describe the pharmaceutical care services by reference to the manner or circumstances in which they are provided.

17S Eligibility to be contractor under pharmaceutical care services contract

(1) A Health Board may, subject to such conditions as may be prescribed, enter into a pharmaceutical care services contract with—

(a) a registered pharmacist; or

(b) a person other than a registered pharmacist who, by virtue of section 69 of the Medicines Act 1968 (c.67), is taken to be a person lawfully conducting a retail pharmacy business in accordance with that section, who undertakes that all pharmaceutical care services provided under the contract will be provided by, or under the supervision of, a registered pharmacist.

(2) Regulations may make provision as to the effect on a pharmaceutical care services contract entered into with a partnership of a change in the membership of the partnership.

17T Payments by Health Boards under pharmaceutical care services contracts

(1) The Scottish Ministers may give directions as to payments to be made under pharmaceutical care services contracts.

(2) A pharmaceutical care services contract must require payments to be made under it in accordance with directions for the time being in force under this section.

(3) A direction under subsection (1) may in particular—

(a) provide for payments to be made by reference to compliance with standards or the achievement of levels of performance;

(b) provide for payments to be made by reference to—

(i) any scheme or scale specified in the direction;

(ii) a determination made by any person in accordance with factors specified in the direction;
(c) provide that the whole or any part of a payment is subject to conditions (including a condition that the whole or any part of a payment is liable to be paid by a Health Board only if they are satisfied as to such conditions as may be specified in the direction);

(d) make provision having effect from a date before the date of the direction, provided that, having regard to the direction as a whole, the provision is not detrimental to the persons to whose remuneration it relates.

(4) Before giving a direction under subsection (1), the Scottish Ministers—

(a) must consult any body appearing to them to be representative of persons to whose remuneration the direction would relate; and

(b) may consult such other persons as they think appropriate.

(4A) The Scottish Ministers must publish directions given by them under subsection (1) in the Drug Tariff or in such other manner as they consider appropriate.

(5) References in this section to payments include fees, allowances and reimbursements.

17U Other mandatory contract terms: pharmaceutical care services contracts

(1) A pharmaceutical care services contract must include (in addition to provisions required by or under other provisions of this Part) such provision as may be prescribed.

(2) Regulations under subsection (1) may in particular—

(a) make provision as to the manner in which, and the standards to which, services must be provided;

(aa) provide that the Scottish Ministers may give directions as to the manner in which, and the standards to which, services must be provided;

(ab) make provision as to—

(b) the persons who are to perform services;

c) the area in which services are to be provided;

d) the persons to whom services are to be provided;

e) requirements to be complied with where a contractor provides any pharmaceutical care services indirectly (including requirements as to the pharmaceutical care services which may or may not be so provided);

(f) the variation of terms of the contract (except terms required by or under this Part);

(g) rights of entry and inspection (including inspection of clinical records and other documents);

(h) the circumstances in which, and the manner in which, the contract may be terminated;

(i) enforcement;

(j) the adjudication of disputes.
(3) Regulations making provision in pursuance of subsection (2)(ab)(d) may make provision as to the circumstances in which a contractor—

(a) must, or may, accept a person as a person to whom services are provided under the contract;

(b) may decline to accept a person as such a person; or

(c) may terminate the contractor’s responsibility for a person.

(4) Regulations making provision in pursuance of subsection (2)(ab)(f) may—

(a) make provision as to the circumstances in which a Health Board may unilaterally vary the terms of a contract;

(b) make provision suspending or terminating any duty under the contract to provide services of a prescribed description.

(5) Regulations making provision of the kind described in subsection (4)(b) may prescribe services by reference to the manner or circumstances in which they are provided.

(6) A pharmaceutical care services contract must contain provision requiring the contractor to comply with directions for the time being in force given by the Scottish Ministers under regulations under subsection (1).

17V Resolution of disputes and entry into NHS contracts: pharmaceutical care services contracts

(1) Regulations may make provision for the resolution of disputes as to the terms of a proposed pharmaceutical care services contract, including, without prejudice to that generality, provision for—

(a) the referral of the terms of the proposed contract to the Scottish Ministers; and

(b) the Scottish Ministers, or a person or panel of persons appointed by them, to determine the terms on which the contract may be entered into.

(2) Regulations may make provision for any person entering, or who has entered, into a pharmaceutical care services contract to be regarded as a health service body for any purposes of section 17A, in circumstances where the person so elects.

(3) Where a person is to be regarded as a health service body for any purposes of section 17A by reason only of an election by virtue of subsection (2) of this section, that section has effect in relation to that person with the omission of the words “under any enactment” in subsection (1) and with such other modifications (if any) as may be prescribed.

(4) Regulations under subsection (2) may include provision as to the application of section 17A in cases where—

(a) a partnership is to be regarded as a health service body; and

(b) there is a change in the membership of the partnership.”.
19A Drug Tariff

After section 17V of the 1978 Act (as inserted by section 19 above), insert—

“Drug Tariff

17VA Drug Tariff

(1) The Scottish Ministers must prepare, maintain and publish a document (to be known as the “Drug Tariff”).

(2) The Scottish Ministers—

(a) must include in the Drug Tariff, such information relating to pharmaceutical care services as may be prescribed;

(b) may include in it such other information relating to such services as they consider appropriate.”.

20 Persons performing pharmaceutical care services

After section 17VA of the 1978 Act (as inserted by section 19A above), insert—

“Persons performing pharmaceutical care services

17W Persons performing pharmaceutical care services

(1) Regulations may provide that a registered pharmacist may not perform any pharmaceutical care service which a Health Board is, under section 2CA(1), under a duty to provide or secure the provision of unless that pharmacist is included in a list maintained under the regulations by the Health Board.

(2) Regulations under subsection (1) may make provision in relation to such lists and in particular as to—

(a) the preparation, maintenance and publication of a list;

(b) eligibility for inclusion in a list;

(c) applications for inclusion (including provision for the procedure for applications to be made and dealt with and documents to be supplied on application);

(d) the grounds on which an application for inclusion must be granted or refused;

(e) requirements with which a person included in a list must comply (including requirements as to standards of performance and patient care and as to declarations, consents or undertakings);

(f) suspension or removal from a list (including the grounds for and consequences of suspension or removal);

(g) circumstances in which a person included in a list may not withdraw from it;

(h) payments to be made by a Health Board in respect of a person suspended from the list (including provision for the amount of, or the method of calculating, the payment to be determined by the Scottish Ministers);

(i) criteria to be applied in making decisions under the regulations;

(j) disclosure of information about applicants for inclusion, refusals of applications, or suspensions, removals or references to the Tribunal.
(3) Regulations making provision as to the matters referred to in subsection (2)(j) may in particular authorise the disclosure of information—
   (a) by a Health Board to the Scottish Ministers; and
   (b) by the Scottish Ministers to a Health Board.”.

21 Assistance and support: primary medical services and pharmaceutical care services

After section 17W of the 1978 Act (as inserted by section 20 above), insert—

“Assistance and support: primary medical services and pharmaceutical care services

17X Assistance and support: primary medical services and pharmaceutical care services

(1) A Health Board may provide assistance and support to—
   (a) any person providing, or proposing to provide, primary medical services under a general medical services contract;
   (b) any person providing, or proposing to provide, such services in accordance with section 17C arrangements;
   (c) any person providing, or proposing to provide, pharmaceutical care services under a pharmaceutical care services contract.

(2) Assistance and support provided by a Health Board under subsection (1) is to be provided on such terms, including terms as to payment, as the Board think fit.

(3) In this section, “assistance” includes financial assistance.”.

PART 3A

PROVISION OF SERVICES UNDER NHS CONTRACTS

14 Provision of certain services under NHS contracts

(1) Section 17AA of the 1978 Act (arrangements for provision of certain services to be treated as NHS contract for certain purposes) is amended as follows.

(2) In subsection (1), for the words from “to”, where it first occurs, to the end of paragraph (b) substitute “to—
   (a) any arrangement under which a Health Board or such other health service body as may be prescribed arrange for the provision to them by a person on an ophthalmic list, or
   (b) any arrangement under which a Health Board arrange for the provision to them by a person on a dental list,”.

(3) In subsection (3)—
   (a) after the word “section—” insert—
   “dental list” means, in relation to a list published in accordance with regulations made under subsection (2) of section 25 of this Act, the first part of the list which is referred to in paragraph (a) of that subsection;”;


(b) the definition of “pharmaceutical list”, and the immediately preceding “and”, are repealed.

PART 4

DISCIPLINE

22 Disqualification by the NHS Tribunal

(1) The 1978 Act is amended as follows.

(2) In section 29 (conditions of disqualification and persons subject to jurisdiction of NHS Tribunal)—

(a) for subsection (2) substitute—

“(2) If the Tribunal receive from a Health Board representations that a person—

(a) who has applied to be included; or
(b) who is included,

in any list meets any of the conditions for disqualification, the Tribunal shall inquire into the case.”;

(b) in subsection (4)(b), the words “the representations are that the second condition for disqualification is met and” are repealed;

(c) in subsection (6)—

(i) for the word “continued” substitute “inclusion or continued”;
(ii) for the words from “list”, where it second occurs, to the end substitute “list—

(a) in relation to a list referred to in subsection (8)(a), (cc) or (e), perform;
(b) in relation to a list referred to in subsection (8)(c) or (d), undertake to provide or are approved to assist in providing;”;

(d) after subsection (7), insert—

“(7A) The third condition for disqualification is that the person concerned is unsuitable (by virtue of professional or personal conduct) to be included, or to continue to be included, in the list.”;

(e) in subsection (8)—

(i) paragraph (b) is repealed;
(ii) for paragraphs (c) to (e) substitute—

“(c) a list of dental practitioners and bodies corporate referred to in section 25(1) undertaking to provide, and of persons who are approved to assist in providing, general dental services;

(cc) a list of persons performing personal dental services;

(d) a list of medical practitioners and ophthalmic opticians undertaking to provide, and of persons who are approved to assist in providing, general ophthalmic services; or

(e) a list of registered pharmacists performing pharmaceutical care services,”;
(f) in subsection (11)—
   (i) the word “and” is repealed;
   (ii) at the end insert “; and cases in which representations are made that the third condition for disqualification is met are referred to below as unsuitability cases”.

(3) In section 29A (cases before Tribunal: supplementary provision)—
   (a) in subsection (1), after “the second condition for disqualification” insert “or, as the case may be, the third condition for disqualification”;
   (b) after subsection (1), insert—
      “(1A) A body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry is to be treated for the purposes of this group of sections as meeting the second condition for disqualification or, as the case may be, the third condition for disqualification if any director meets that condition (whether or not he first met that condition when he was a director).”;
   (ba) in subsection (3)—
      (i) in paragraph (a), after the word “providing,” insert “assisting in providing,”;  
      (ii) in paragraph (b), after the word “provision,” insert “assistance in provision,”;  
   (c) in subsection (5), for the words “a fraud case” substitute “an unsuitability case, a fraud case or an efficiency case”;
   (d) in subsection (6), after the word “in” insert “an unsuitability,”.

(4) In section 29B (disqualification by Tribunal)—
   (a) in subsection (1), after paragraph (b) insert “;
   (c) on inquiring into an unsuitability case, that the person meets the third condition for disqualification”;
   (b) for subsection (2), substitute—
      “(2) The Tribunal shall disqualify him for inclusion in—
      (a) the list to which the case relates;
      (b) all lists within the same paragraph of subsection (8) of section 29 as that list; and
      (c) where the list to which the case relates is a list referred to in—
         (i) paragraph (c) of that subsection, all lists within paragraph (cc) of that subsection;
         (ii) that paragraph (cc), all lists within that paragraph (c).”;
   (c) in subsection (4), for the word “any” substitute “a”.

(5) In section 29C (conditional disqualification)—
   (a) in subsection (2)—
      (i) the word “or” following paragraph (a) is repealed;
(ii) after paragraph (b), insert “;
(c) ensuring that the person—
   (i) performs, undertakes to provide or assists in providing only services specified (or of a description specified) in the condition;
   (ii) undertakes an activity (or course of activity) of a personal or professional nature, or refrains from conduct of a personal or professional nature, so specified (or of a description so specified)”;

(b) in subsection (5)(aa), for the words “17P” substitute “17F, 17P or 17W or this Part”.

(6) In section 32(2) (regulations: inquiry into more than one category of case), for the words “both an efficiency case and a fraud case” substitute “an efficiency case and a fraud case or an unsuitability case or any other combination of more than one such category of case”.

(7) In section 32A (interim suspension by the Tribunal)—
(a) in subsection (2), for the words from “services” to the end substitute “—
   (a) services of the kind to which the case in question, or the case to which the review in question, relates; and
   (b) if the services are either general dental services or personal dental services, both general dental services and personal dental services.”;
(b) in subsection (2A)—
   (i) in paragraph (a), after the words “primary medical services” insert “, pharmaceutical care services”;
   (ii) for paragraph (b), substitute “or
   (b) that it is otherwise in the public interest to do so.”;
(c) in subsection (6)(a), for the words from “a list” to “services” substitute—
   “(i) a list of persons performing;
   (ii) a list of persons undertaking to provide and of persons approved to assist in providing,
   services”;;
(d) after subsection (6), insert—
   “(7) Regulations may provide that where a Health Board, in accordance with regulations made under section 17F, 17P, 17W, 25(2) or 26(2), suspend a person from a list prepared under regulations made under the section in question and the Board apply to the Tribunal for a direction to be made under subsection (2) in relation to the person to whom the suspension applies, the suspension may continue until the Tribunal determine the application.”.

23 Corresponding provision in England or Wales or Northern Ireland

For section 32D of the 1978 Act (suspension provisions in England and Wales or Northern Ireland), substitute—
“32D Corresponding provision in England or Wales or Northern Ireland

(1) This section applies where it appears to the Scottish Ministers that there is provision in England or Wales or Northern Ireland under which a person may be dealt with in any way which corresponds (whether or not exactly) with a way in which a person may be dealt with under sections 29 to 32B.

(2) A decision in England or Wales or Northern Ireland to deal with such a person in such a way is referred to in this section as a “corresponding decision”.

(3) If this section applies, the Scottish Ministers may make regulations providing for the effect to be given in Scotland to a corresponding decision; and where the decision corresponds (whether or not exactly) with a decision which may be made under section 29C or (so far as relating to conditional disqualification) the regulations may provide for the effect to be given to be determined in the prescribed manner by the Scottish Ministers.

(4) That effect need not be the same as the effect of the corresponding decision in the place where it was made.”.

PART 5
MISCELLANEOUS

Infection with hepatitis C as a result of NHS treatment etc.

24 Payments to certain persons infected with hepatitis C as a result of NHS treatment etc.

(1) The Scottish Ministers may make a scheme for the making of payments by them, or out of money provided by them, to, or in respect of—

(ya) persons who—

(a) before 1st September 1991, were treated anywhere in the United Kingdom under the National Health Service by way of the receipt of blood, tissue or a blood product;

(b) as a result of that treatment, became infected with the hepatitis C virus; and

(c) did not die before 29th August 2003;

(za) persons who—

(i) became infected with the hepatitis C virus by transmission of the virus by means specified in the scheme from a person who before 1st September 1991 was treated anywhere in the United Kingdom under the National Health Service by way of the receipt of blood, tissue or a blood product and as a result of that treatment became infected with the hepatitis C virus;

(ii) were at the time of transmission in a relationship mentioned in subsection (1A) with the person from whom the virus was transmitted; and

(iii) did not die before 29th August 2003.

(1A) The relationships referred to in subsection (1)(za)(ii) are—

(a) spouse or civil partner;
(b) person who was living with the person from whom the virus was transmitted as husband or wife or in a relationship which had the characteristics of the relationship between civil partners (or if the person from whom the virus was transmitted was in hospital immediately before death, had been so living when that person was admitted to hospital);

c) other cohabitant (whether or not of the same sex as the person from whom the virus was transmitted);

d) where the person from whom the virus was transmitted was a mother, a son or daughter of the mother;

e) such other relationship as the scheme may specify; and the scheme may specify or elaborate the meaning of relationship for this purpose.

(2) A scheme under this section must—

(a) provide that the questions of whether—

(i) a person became infected with the hepatitis C virus as a result of treatment such as is mentioned in subsection (1)(ya)(a) before the date mentioned there; and

(ii) a person became infected with the virus by transmission of it by means specified in the scheme from a person who became infected as mentioned in sub-paragraph (i),

are to be determined on the balance of probabilities;

(b) provide that a person is not eligible for the making of a payment under the scheme unless, when the claim for the payment is made or, in the case of a claim made in respect of a dead person, when the person died either—

(i) the person’s sole or main residence is or was in Scotland; or

(ii) the person’s sole or main residence is or was outside the United Kingdom but, immediately before acquiring such sole or main residence, the person’s sole or main residence is or was in Scotland;

(c) provide for the procedure to be followed in relation to claims under the scheme (including the time within which claims must be made and matters relating to the provision of information) and the determination of such claims;

(za) provide for a right of appeal against a decision refusing a claim under the scheme; and

(d) provide that a claim may be made in respect of a dead person, without such a claim having to have been made prior to that person’s death.

(3) Without prejudice to the generality of subsection (1), a scheme under this section may—

(za) specify conditions for eligibility for the making of a claim by another person under the scheme in respect of a person falling within subsection (1) who has died without having made a claim under the scheme;

(a) specify conditions for eligibility for the making of a payment under the scheme (and may specify different conditions in relation to different payments);

(b) provide that the making of a claim, or the receipt of a payment, under the scheme is not to prejudice the right of any person to institute or carry on proceedings in relation to the matter which is the subject of the claim or payment;
(c) appoint a person (other than a Minister of the Crown) to manage the scheme on behalf of the Scottish Ministers;

(d) confer functions on the Scottish Ministers or any person appointed under paragraph (c);

(e) provide for any function so conferred on the Scottish Ministers to be carried out on their behalf by any person appointed under paragraph (c); and

(f) make transitional, transitory or saving provision.

(4) Provision such as is mentioned in subsection (3)(c) or (e) does not affect the responsibility of the Scottish Ministers for the management of the scheme or the carrying out of the functions.

(5) The Scottish Ministers may revoke or amend a scheme under this section.

(6) The Scottish Ministers must publish a scheme under this section in such manner as they consider appropriate.

Amendment of Regulation of Care (Scotland) Act 2001

25 Independent health care services

In section 2(5) of the 2001 Act (meaning of “independent health care service”), after paragraph (d) insert “,

but a service may be excepted from this definition by regulations”.

26 Implementation of certain decisions under the 2001 Act

(1) The 2001 Act is amended as follows.

(2) In section 16 (right to make representations to Scottish Commission for the Regulation of Care as respects proposals under Part 1), for subsection (2) substitute—

“(2) Where such a notice has been given—

(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the person to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) that person notifies the Commission in writing that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(2A) In section 37 (right to make representations to Commission under Part 2 as respects conditions), for subsection (2) substitute—

“(2) Where a notice to which this section applies has been given—
(a) the Commission may not decide to implement the proposal until (whichever first occurs)—

(i) where the local authority to whom the notice was given make such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) the local authority notify the Commission that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Commission receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Commission shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(3) In section 48 (right to make representations to Scottish Social Services Council as respects proposal in notice under section 46(2) or 47(1)), for subsection (2) substitute—

“(2) Where such a notice has been given—

(a) the Council may not decide to implement the proposal until (whichever first occurs)—

(i) where the person to whom the notice was given makes such representations as are mentioned in subsection (1) above, it has considered those representations;

(ii) that person notifies the Council in writing that such representations will not be made;

(iii) the period of fourteen days mentioned in that subsection elapses without such representations being made and without the Council receiving such notification; and

(b) where the circumstances are as mentioned in paragraph (a)(ii) or (iii) above, the Council shall implement the proposal unless it appears to it that it would be inappropriate to do so.”.

(4) In section 51(1) (appeal against decision of Council), for the words from “section” to “proposal” substitute “subsection (2) of section 50 of this Act of a decision mentioned in that subsection”.

26A Frequency of inspection of care services under the 2001 Act

(1) The 2001 Act is amended as follows.

(2) In section 25 (inspection of registered care services), after subsection (5) insert—

“(5A) The Scottish Ministers may, after consulting the Commission and thereafter such other persons (or groups of persons) as they consider appropriate, by order amend—

(a) subsection (3)(a) above by substituting for “twelve months” in either or both sub-paragraphs (i) and (ii) a different period (being a period which is not less than twelve months);
(b) subsection (5) above by substituting for “twelve months” in either or both paragraphs (a) and (b) a different period (being a period which is not less than twelve months).

(5B) An order under subsection (5A) above may make different provision for different purposes.”.

(3) In section 78 (orders and regulations), in subsection (2)(b), after the word “3” insert “or 25(5A)”.

27 Provision of information to the Scottish Social Services Council

After section 57 of the 2001 Act, insert—

“Notification of dismissal etc. for misconduct and provision of other information to Council

57A Notification of dismissal etc. to Council

The employer of a social service worker shall—

(a) on dismissing the social service worker on grounds of misconduct; or

(b) on the social service worker resigning or abandoning the worker’s position in circumstances where, but for the resignation or abandonment—

(i) the worker would have been dismissed on grounds of misconduct; or

(ii) dismissal on such grounds would have been considered by the employer,

forthwith notify the Council of the dismissal, resignation or abandonment; and the employer shall in doing so provide the Council with an account of the circumstances which led to the dismissal or which were present when the resignation or abandonment took place.

57B Provision of other information to Council by employer

The employer of a social service worker shall, when requested to do so by the Council, provide it with such information as respects the worker as it may reasonably require in connection with the exercise of the functions assigned to it under this Act or any other enactment.”.

Child care agencies and housing support services

28 Registration of child care agencies and housing support services

(1) Subsections (2) to (4) apply where—

(a) on 1st April 2003 a person was providing a care service to which the 2003 Order applies;

(b) the service—

(i) was, by virtue of article 3(1) of the 2003 Order, treated as if it were registered on that date; and
(ii) by virtue of article 3(2) of that Order, ceased on 1st October 2003 or on 1st April 2004 to be treated as if it were registered; and

(c) the person continued (or continues) to provide the service after it ceased to be so treated as if it were registered at any time during which it was not registered.

(2) If any of the circumstances mentioned in subsection (3) apply, the service is, subject to subsection (4), to be treated for all purposes as if it were registered—

(a) on 1st October 2003 or, as the case may be, 1st April 2004; and

(b) for the period during which there was (or is) a continuation of service as mentioned in subsection (1)(c).

(3) The circumstances are—

(a) that an application for registration of the service was made by the person before 30th September 2004;

(b) that—

(i) no application for registration of the service was made by the person before that date; and

(ii) the person ceased to provide the service before that date.

(4) The service ceases to be so treated as registered by virtue of subsection (2) on whichever of the following first occurs—

(a) where the Commission decides to refuse the application and—

(i) no appeal is made under section 20(1) of the 2001 Act against the decision, the fifteenth day after the day on which notice of the decision is given under section 17(3) of that Act;

(ii) such an appeal is made timeously and the sheriff confirms the decision, the day on which the sheriff does so;

(iii) such an appeal is made timeously but is abandoned, the day on which abandonment of the appeal is intimated to the sheriff clerk or if abandonment is not so intimated the day on which the sheriff deems the appeal to have been abandoned;

(b) where the Commission decides (other than in accordance with an application under section 14(1)(b) of the 2001 Act) to cancel the registration of the service effected by virtue of subsection (2) and—

(i) no appeal is made under section 20(1) of the 2001 Act against the decision, the fifteenth day after the day on which notice of the decision is given under section 17(3) of that Act;

(ii) such an appeal is made timeously and the sheriff confirms the decision, the day on which the sheriff does so;

(iii) such an appeal is made timeously but is abandoned, the day on which abandonment of the appeal is intimated to the sheriff clerk or if abandonment is not so intimated the day on which the sheriff deems the appeal to have been abandoned;

(c) where the sheriff grants an application by the Commission under section 18 of that Act for cancellation of the registration of the service, the day on which the sheriff does so;
(d) the day on which the person ceases to provide the service;

(e) 1st April 2006 or such later day as may be substituted for it by order made by the Scottish Ministers.

(5) In this section—

“the 2003 Order” means the Regulation of Care (Scotland) Act 2001 (Commencement No. 3 and Transitional Provisions) Order 2003 (SSI 2003 No. 205 (C.9));

“the Commission” means the Scottish Commission for the Regulation of Care;

“registered” means registered under Part 1 of the 2001 Act; and references to “registration” are to be construed accordingly.

29 Grants in respect of housing support services

Payments by a local authority—

(a) made out of sums, or descriptions of sum, received by it from the Scottish Ministers under section 91(1) of the Housing (Scotland) Act 2001 (asp 10); and

(b) purportedly made in compliance with the condition specified in paragraph 2 of the Schedule to the Housing (Scotland) Act 2001 (Payments out of Grants for Housing Support Services) Order 2003 (SSI 2003 No. 140),

which were not validly made merely by virtue of the condition not having been complied with are to be treated as having been validly made notwithstanding the non-compliance with the condition.

Authorisation of medical treatment

30 Amendment of Adults with Incapacity (Scotland) Act 2000: authorisation of medical treatment

(1) The Adults with Incapacity (Scotland) Act 2000 (asp 4) is amended as follows.

(2) In section 47 (authorisation of medical treatment)—

(a) in subsection (1)—

(i) for the words “the medical practitioner primarily responsible for the medical treatment of an adult” substitute “any of the persons mentioned in subsection (1A)”;

(ii) in paragraph (a), for the words “the adult” substitute “an adult”;

(b) after that subsection, insert—

“(1A) The persons are—

(a) the medical practitioner primarily responsible for the medical treatment of the adult;

(b) a person who is—

(i) a dental practitioner;

(ii) an ophthalmic optician;

(iii) a registered nurse; or
(iv) an individual who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfies such requirements as may be so prescribed and who is primarily responsible for medical treatment of the kind in question.

(c) in subsection (2)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who by virtue of subsection (1) has issued a certificate for the purposes of that subsection”;

(ii) for the words “medical treatment” where they second occur substitute “the medical treatment in question”;

(d) in subsection (3)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person on whom that authority is conferred”;

(ii) for the words “medical treatment”, where they second occur, substitute “the medical treatment in question”;

(e) in subsection (5)—

(i) in paragraph (a), for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issues the certificate”;

(ii) in paragraph (b), for the words “does not exceed one year from” substitute “does not exceed—

(i) one year; or

(ii) if, in the opinion of the person issuing the certificate any of the conditions or circumstances prescribed by the Scottish Ministers applies as respects the adult, 3 years, from”;

(f) in subsection (6)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued it”;

(ii) in paragraph (b), for the words “not exceeding one year from” substitute “not exceeding—

(i) one year; or

(ii) if, in the opinion of that person any of the conditions or circumstances prescribed by the Scottish Ministers apply as respects the adult, 3 years, from”;

(g) after subsection (10) insert—

“(11) In subsection (1A)—

“dental practitioner” has the same meaning as in section 108(1) of the National Health Service (Scotland) Act 1978 (c.29);
“ophthalmic optician” means a person registered in either of the registers kept under section 7 of the Opticians Act 1989 (c.44) of ophthalmic opticians.”.

(3) In section 49(1) (medical treatment where there is an application for intervention or guardianship order)—

(a) for the words “Section 47(2)” substitute “Subsection (2) of section 47”;

(b) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person on whom authority is conferred by that subsection”.

(4) In section 50 (medical treatment where guardian etc. has been appointed)—

(a) in subsection (2)—

(i) in paragraph (b), for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) in paragraph (c), for the words “medical practitioner” substitute “person”;

(b) in subsection (3)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) for the words “any person having an interest” substitute “the medical practitioner primarily responsible for the medical treatment of the adult (in a case where the person who so issued the certificate was someone other than that practitioner) or any person having an interest”;

(c) in subsection (4)—

(i) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(ii) for the words “medical practitioner”, where they second occur, substitute “person who issued the certificate”;

(iii) for the words “a medical practitioner (the “nominated medical practitioner”)” substitute “a practitioner who the Commission consider has professional knowledge or expertise relevant to medical treatment of the kind in question (the “nominated practitioner”)”;

(d) in subsection (5)—

(i) for the words “nominated medical practitioner” substitute “nominated practitioner”;

(ii) for the words “medical practitioner primarily responsible for the medical treatment of the adult” substitute “person who issued the certificate for the purposes of section 47(1)”;

(e) in subsection (6)—

(i) for the words “nominated medical practitioner” substitute “nominated practitioner”;
(ii) after the words “personal welfare of the adult” insert “(including, where the certificate issued for the purposes of section 47(1) was issued by another person, that person)”;

(f) in subsection (9)—

(i) for the words “medical practitioners” substitute “practitioners”; 

(ii) for the words “medical practitioner” substitute “practitioner”.

Appeals under Public Health (Scotland) Act 1897

30A Amendment of Public Health (Scotland) Act 1897: appeal against certain orders etc.

After section 156 of the Public Health (Scotland) Act 1897 (c.38), insert—

“156A Appeal to sheriff or sheriff principal in certain cases: sections 54, 55 and 96

(1) Any person in respect of whom—

(a) an order under section 54(1) (for removal to a hospital) or under section 54(3) (for transfer to another hospital) (referred to in this section and section 156C as a “section 54 order”); 

(b) a direction under section 55(1) (for detention in a hospital) or under section 55(3) (for removal to another hospital) (referred to in this section and section 156C as a “section 55 direction”); or

(c) a decision under section 96 (for removal to a hospital) (referred to in this section and sections 156B and 156C as a “section 96 decision”),

is made, or any person having an interest in the welfare of the person in respect of whom the order, the direction or, as the case may be, the decision is made, may appeal under this section against the order, the direction or, as the case may be, the decision.

(2) An appeal under this section against—

(a) a section 54 order or a section 55 direction by a sheriff may be made to the sheriff principal;

(b) a section 54 order or a section 55 direction by a justice may be made to the sheriff principal of either of the sheriffdoms mentioned in subsection (3);

(c) a section 96 decision may be made to the sheriff of either of those sheriffdoms.

(3) The sheriffdoms are—

(a) the sheriffdom in which the person (in respect of whom the section 54 order, section 55 direction or section 96 decision in question is made) is resident immediately before it is made;

(b) the sheriffdom in which the hospital (in which that person is detained pursuant to the section 54 order, section 55 direction or section 96 decision in question) is situated.

(4) An appeal under this section may be made on either or both of the following grounds—
(a) that the section 54 order, section 55 direction or section 96 decision in question was based on an error of law;

(b) that the section 54 order, section 55 direction or section 96 decision in question was not supported by the facts found to be established by the sheriff or justice who made the order or direction or, as the case may be, the local authority who made the decision.

(5) An appeal against a section 54 order, section 55 direction or section 96 decision may be made before the expiry of the period of 21 days beginning with the day on which the order, the direction or, as the case may be, the decision is made.

(6) An appeal against a section 54 order or section 55 direction by a justice or a section 96 decision is to be made by way of summary application.

(7) In an appeal under this section against a section 54 order, section 55 direction or section 96 decision, the sheriff principal or, as the case may be, the sheriff may—

(a) confirm the order, the direction or, as the case may be, the decision;

(b) direct that the order, the direction or, as the case may be, the decision ceases to have effect;

(c) make such other order or direction as the sheriff principal or, as the case may be, the sheriff thinks fit.

156B Further appeal to sheriff principal: section 96 decision

(1) Where, in an appeal under section 156A against a section 96 decision, the sheriff confirms the decision, the person in respect of whom the section 96 decision was made, or any person having an interest in the welfare of that person, may appeal to the sheriff principal against the decision of the sheriff in the appeal on either or both of the grounds mentioned in subsection (2).

(2) The grounds are—

(a) that the decision of the sheriff in the appeal under section 156A was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff in the appeal.

(3) An appeal under this section may be made before the expiry of the period of 21 days beginning with the day on which the decision of the sheriff in the appeal under section 156A is made.

(4) In an appeal under this section, the sheriff principal—

(a) may allow the appeal and when doing so must direct that the section 96 decision ceases to have effect;

(b) may refuse the appeal and confirm the decision of the sheriff;

(c) may make such other order or direction as the sheriff principal thinks fit.
Further appeal to Court of Session: sections 54, 55 and 96

(1) Where, in an appeal under section 156A against a section 54 order or section 55 direction, the sheriff principal confirms the order or, as the case may be, the direction, the person in respect of whom the decision in the appeal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

(a) that the decision of the sheriff principal in the appeal under section 156A was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.

(2) Where, in an appeal under section 156B against a decision of the sheriff in an appeal under section 156A, the sheriff principal confirms the decision of the sheriff in the appeal under section 156A, the person in respect of whom the decision of the sheriff principal is made or any person having an interest in the welfare of that person may, with the leave of the sheriff principal, appeal to the Court of Session against the decision of the sheriff principal on either or both of the following grounds—

(a) that the decision of the sheriff principal in the appeal under section 156B was based on an error of law;

(b) that that decision was not supported by the facts found to be established by the sheriff principal in the appeal.

Effect of appeal in relation to section 54 order, section 55 direction or section 96 decision

A section 54 order, a section 55 direction or a section 96 decision may be given effect notwithstanding that an appeal may be or is made against, or in relation to, it under this Act.”.

Joint ventures

(1) After section 84A of the 1978 Act, insert—

“Joint ventures

(1) The Scottish Ministers may do any (or all) of the following—

(a) form or participate in forming companies to provide facilities or services for persons or groups of persons exercising functions, or otherwise providing services, under this Act;

(b) participate in companies providing facilities or services for persons or groups of persons falling within paragraph (a);

(c) with a view to securing or facilitating the provision by companies of facilities or services for persons or groups of persons falling within paragraph (a)—
(i) invest in the companies (whether by acquiring assets, securities or
rights or otherwise);

(ii) provide loans and guarantees and make other kinds of financial
provision to or in respect of them.

(2) For the purpose of subsection (1), it is immaterial that the facilities or services
provided or to be provided by a company are not provided or to be provided—
(a) only to persons or groups of persons exercising functions, or otherwise
providing services, under this Act; or
(b) to such persons or groups of persons only in that capacity.

(3) In this section—
“companies” means companies within the meaning of the Companies
Act 1985 (c.6);
“facilities” includes the provision of (or the use of) premises, goods,
equipment, materials, vehicles, plant or apparatus.”.

(2) After section 7(7B) of the Health and Medicines Act 1988 (c.49) (powers of the
Secretary of State for financing the health service), insert—
“(7C) The power specified in paragraph (g) of subsection (2) above includes power
for the Scottish Ministers—
(a) to form or participate in forming companies,
(b) to—
(i) participate in companies,
(ii) invest in companies (whether by acquiring assets, securities or
rights or otherwise),
(iii) provide loans and guarantees and make other kinds of financial
provision to or in respect of companies,
where it appears to them that to do so is calculated to facilitate, or to be
conducive or incidental to, the exercise of any power conferred by that
subsection.

(7D) In subsection (7C) above “companies” means companies within the meaning of
the Companies Act 1985; and that subsection is without prejudice to the
generality of subsection (2) above.”.

Scottish Hospital Endowments Research Trust

(1) The 1978 Act is amended as follows.

(2) In section 12 (establishment and functions of the Trust)—
(a) subsections (1) and (2) are repealed;
(b) in subsection (3), for the words “the Research Trust” substitute “the Scottish
Hospital Endowments Research Trust (referred to in this Act as “the Research
Trust”);”;
(c) in subsection (4B), the words from “Subject to” to “activity,” are repealed;
(d) subsection (5) is repealed;

(e) in subsection (6), the words from “, and shall send” to the end are repealed;

(f) subsection (6A) is repealed;

(g) for subsection (7), substitute—

“(7) The Research Trust shall prepare an annual report of their proceedings which
shall include an abstract of their accounts.”;

(h) after that subsection, insert—

“(8) Schedule 7 shall have effect in relation to the Research Trust.”.

(3) In Schedule 7 (further provision as respects the Trust)—

(a) paragraph 1 is repealed;

(b) for paragraph 3, substitute—

“Members

Subject to paragraph 3A, the Research Trust shall consist of such number of
members appointed by the Trust as the Trust may determine.

3A(1) The persons who are the members of the Research Trust immediately before
the day on which section 32 of the Smoking, Health and Social Care (Scotland)
Act 2005 (asp 00) comes into force shall, on that day, continue to be members
(the “continuing members”).

(2) The terms and conditions of appointment of the continuing members shall, on
the 90th day after whichever of the following occurs first—

(a) the day on which that section comes into force; or

(b) the day on which the Research Trust first make standing orders under
paragraph 3F,

be the terms and conditions of appointment the Research Trust determine for
the members appointed by them under paragraph 3B(1).

(3) The provisions of paragraphs 3B(2) and (3) to 3D and 3F shall apply to the
continuing members as they apply to members appointed under paragraph 3;
and in the application of paragraph 3C any period of appointment of a
continuing member as a member (before he became a continuing member by
virtue of sub-paragraph (1)) shall count for the purposes of determining
eligibility for re-appointment in accordance with paragraph 3C.

Terms of office etc.

3B(1) Subject to the provisions of this Schedule, the appointment of a member under
paragraph 3 shall be on such terms and conditions as the Research Trust may
determine, but shall not be for a period exceeding 4 years.

(2) A person holds and vacates office as member in accordance with the person’s
terms of appointment.

(3) A person may resign office as member at any time by notice in writing to the
Research Trust.

Eligibility for re-appointment

3C A person who ceases to be a member of the Research Trust shall be eligible for
re-appointment, but only once.
Payments to members

3D The Research Trust may make payments from their funds to their members in respect of any loss of earnings the members would otherwise have made or any additional expenses to which they would not otherwise have been subject, being loss of expenses necessarily suffered or incurred for the purpose of enabling the members to discharge their duties as members of the Trust.

Staff

3E (1) The Research Trust may appoint such staff, on such terms and conditions (including as to remuneration and allowances), as they consider appropriate.

(2) The Research Trust may—

(a) pay, or make arrangements for the payment of;

(b) make payments towards the provision of; and

(c) provide and maintain schemes (whether contributory or not) for the payment of,

such pensions, allowances and gratuities to or in respect of such of their employees, or former employees, as they may determine.

(3) The reference in sub-paragraph (1) to pensions, allowances and gratuities includes a reference to pensions, allowances and gratuities by way of compensation for loss of employment or reduction in remuneration.

Standing orders

3F (1) The Research Trust—

(a) shall make and maintain standing orders regulating—

(i) the appointment by them of members;

(ii) the appointment of a member as convener;

(iii) the terms and conditions of office of members and convener;

(iv) their procedure;

(v) such other matters as the Research Trust consider appropriate;’’

(b) may, subject to sub-sub-paragraph (a), amend such standing orders from time to time.

(2) The first set of standing orders under this paragraph shall be made before the expiry of the period of 90 days beginning with the day on which section 32 of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00) comes into force.

(3) Subject to the provisions of this Schedule, the Research Trust may regulate their own procedure.

(4) The validity of any proceedings of the Research Trust shall not be affected by any vacancy in membership nor by any defect in the appointment of a member.

Powers etc.

3G The Research Trust may do anything which appears to them to be necessary or expedient for the purpose of, or in connection with, the exercise of their functions.”;
(c) in paragraph 6, the words from “, unless” to “case,”, where it first occurs, are repealed;
(d) paragraph 7 is repealed.

PART 6

GENERAL

33 Ancillary provision

(1) The Scottish Ministers may by order make such incidental, supplemental, consequential, transitional, transitory or saving provision as they consider necessary or expedient for the purposes, or in consequence, of this Act.

(2) An order under this section may—
   (a) make different provision for different purposes;
   (b) modify any enactment, instrument or document.

34 Regulations or orders

(1) Any power conferred by this Act on the Scottish Ministers to make orders or regulations—
   (a) must be exercised by statutory instrument;
   (b) may be exercised so as to make different provision for different purposes.

(2) A statutory instrument containing an order or regulations made under this Act (except an order under section 37(3)) is, subject to subsection (3), subject to annulment in pursuance of a resolution of the Parliament.

(3) A statutory instrument containing—
   (a) regulations under section 3(3) or 4(2) or (7) or paragraph 2, 4(1), 5(2), 12 or 13 of schedule 1 or an order under section 7A or 28(4)(e);
   (b) an order under section 33 containing provisions which add to, replace or omit any part of the text of an Act,

is not to be made unless a draft of the instrument has been laid before, and approved by resolution of, the Parliament.

35 Interpretation

In this Act—

“the 1978 Act” means the National Health Service (Scotland) Act 1978 (c.29);
“the 2001 Act” means the Regulation of Care (Scotland) Act 2001 (asp 8);
“council” means a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994 (c.39);
“prescribed” means prescribed by regulations made by the Scottish Ministers.
Minor and consequential amendments and repeals

(1) Schedule 2 contains minor amendments and amendments consequential on the provisions of this Act.

(2) The enactments specified in column 1 of schedule 3 are repealed to the extent specified in column 2.

Short title and commencement

(1) This Act may be cited as the Smoking, Health and Social Care (Scotland) Act 2005.

(2) Sections 28, 29, 35 and (in so far as it relates to paragraph 1(1A) and (1C) of schedule 2) 36 and paragraph 1(1A) and (1C) of schedule 2 come into force on the day after Royal Assent.

(3) The remaining provisions of this Act, except this section and sections 33 and 34, come into force on such day as the Scottish Ministers may by order appoint, and an order under this section appointing a day for sections 1 to 8 or schedule 1 may specify the time in the day for the commencement of those provisions.

(4) Different days may be appointed under subsection (3) for different purposes.
SCHEDULE 1
(introduced by section 5)

FIXED PENALTY FOR OFFENCES UNDER SECTIONS 1, 2, AND 3

Power to give fixed penalty notices

1 (1) An authorised officer of a council may, if having reason to believe that a person is committing or has committed an offence under section 1, 2 or 3 in no-smoking premises within the area of the council, give that person a fixed penalty notice in relation to that offence.

(2) A constable may, if having reason to believe that a person is committing or has committed an offence under section 1, 2 or 3, give that person a fixed penalty notice in relation to that offence.

(3) In this schedule, “fixed penalty notice” means a notice offering a person the opportunity of discharging any liability to conviction for an offence under section 1, 2 or 3 by payment of a fixed penalty.

2 A fixed penalty notice for an offence under section 1, 2 or 3 may not be given after such time relating to the offence as may be prescribed.

Contents of fixed penalty notice

3 (1) A fixed penalty notice must identify the offence to which it relates and give reasonable particulars of the circumstances alleged to constitute that offence.

(2) A fixed penalty notice must also state—

(a) the amount of the penalty and the period within which it may be paid;

(b) the discounted amount and the period within which it may be paid;

(c) the person to whom and the address at which payment may be made;

(d) the method or methods by which payment may be made;

(e) the person to whom and the address at which any representations relating to the notice may be made;

(f) the consequences of not making a payment within the period for payment.

(3) The person specified under sub-paragraph (2)(c) must be the council in the area of which the offence was alleged to have been committed or a person acting on its behalf.

The amount of the penalty and the period for payment

4 (1) The fixed penalty for an offence under section 1, 2 or 3 is (subject to paragraph 5) such amount as may be prescribed.

(2) The period for payment of the fixed penalty is the period of 29 days beginning with the day on which the notice is given.

(3) The council may extend the period for paying the fixed penalty in any particular case if it considers it appropriate to do so.
Smoking, Health and Social Care (Scotland) Bill
Schedule 1—Fixed penalty for offences under sections 1, 2, and 3

The discounted amount

5 (1) A discounted amount is payable instead of the amount prescribed under paragraph 4(1) if payment is made before the end of the period of 15 days beginning with the day on which the notice is given.

5 (2) The discounted amount for a fixed penalty offence is such amount as may be prescribed.

5 (3) If the last day of the period specified in sub-paragraph (1) does not fall on a working day, the period for payment of the discounted amount is extended until the end of the next working day.

Effect of notice and payment of penalty

6 (1) This paragraph applies where a person is served with a fixed penalty notice in respect of a fixed penalty offence.

6 (2) No proceedings for the offence may be commenced before the end of the period for payment of the penalty.

6 (3) No such proceedings may be commenced or continued if payment of the penalty is made before the end of that period or is accepted by the council after that time.

6 (4) Payment of the discounted amount counts for the purposes of sub-paragraph (3) only if it is made before the end of the period for payment of the discounted amount.

6 (5) In proceedings for the offence, a certificate which—

(a) purports to be signed by or on behalf of a person having responsibility for the financial affairs of the council; and

(b) states that payment of an amount specified in the certificate was or was not received by a date so specified,

is sufficient evidence of the facts stated.

Request for hearing

7 (1) A person to whom a fixed penalty notice has been given may, before the expiry of the period for payment of the penalty, give notice requesting a hearing in respect of the offence to which the fixed penalty notice relates.

7 (2) A notice requesting a hearing under sub-paragraph (1) must be in writing and must be sent by post or delivered to the person specified under paragraph 3(2)(c) in the fixed penalty notice at the address so specified.

7 (3) For the purposes of this paragraph and unless the contrary is proved, the sending of a notice by post is deemed to have been effected at the time at which the notice would be delivered in the ordinary course of post.

7 (4) Where a person has requested a hearing in accordance with this section—

(a) the council must hold the hearing;

(b) a person authorised for the purpose by the council of the area in which the offence was committed must notify the procurator fiscal of the request; and

(c) the period for payment of the fixed penalty must be calculated so that the period beginning with the giving of the notice under this paragraph and ending with the
receipt by the person who gave that notice of the decision reached at the hearing is left out of account.

**Power to withdraw notices**

8 (1) If the council considers (whether after holding a hearing under paragraph 7 or not) that a fixed penalty notice which has been given ought not to have been given, it may give to the person to whom it was given a notice withdrawing the fixed penalty notice.

(2) Where a notice under sub-paragraph (1) is given—

(a) the council must repay any amount which has been paid by way of penalty in pursuance of the fixed penalty notice; and

(b) no proceedings are to be commenced or continued against that person for the offence in question.

(3) The council must consider any representations made by or on behalf of the recipient of a fixed penalty notice and decide in all the circumstances whether to withdraw the notice.

**Effect of prosecution on notice**

9 Where proceedings for an offence in respect of which a fixed penalty notice has been given are commenced, the notice is to be treated as withdrawn.

**Recovery of unpaid fixed penalties**

10 Subject to paragraphs 8 and 9, where a fixed penalty remains unpaid after the expiry of the period for payment of the penalty it is enforceable in like manner as an extract registered decree arbitral bearing a warrant for execution issued by the sheriff for any sheriffdom.

**Judicial determination of enforcement of fixed penalty**

11 (1) A person against whom a fixed penalty bears to be enforceable under paragraph 10 may apply to the sheriff by summary application for a declaration that the fixed penalty is not enforceable on the ground that—

(a) the fixed penalty was paid before the expiry of the period for paying; or

(b) the person has made a request for a hearing in accordance with paragraph 7 and no hearing has been held within a reasonable time after the request.

(2) On an application under sub-paragraph (1), the sheriff may declare—

(a) that the person has or, as the case may be, has not paid the fixed penalty within the period for payment of the penalty;

(b) that the person has or, as the case may be, has not requested a hearing in accordance with paragraph 7;

(c) that, where such a request has been made, a hearing has or, as the case may be, has not been held within a reasonable time after the request; and accordingly, that the fixed penalty is or, as the case may be, is not enforceable.
General and supplementary

12 The Scottish Ministers may make regulations about—
   (a) the application by councils of fixed penalties paid under this schedule;
   (b) the keeping of accounts, and the preparation and publication of statements of
       account, relating to fixed penalties under this schedule.

13 (1) Fixed penalty notices may not be given in such circumstances as may be prescribed.
   (2) The method or methods by which fixed penalties may be paid may be prescribed.
   (3) The Scottish Ministers may by regulations modify paragraph 4(2) or 5(1) so as to
       substitute a different period for the period for the time being specified there.

SCHEDULE 2
(introduced by section 36(1))

MINOR AND CONSEQUENTIAL AMENDMENTS

Public Health (Scotland) Act 1897 (c.38)

A1 In section 157 (no appeal otherwise) of the Public Health (Scotland) Act 1897, for the
   words “the preceding section” substitute “section 156 or as provided in sections 156A to
   156C”.

National Health Service (Scotland) Act 1978 (c.29)

1 (1) The 1978 Act is amended as follows.
   (1A) In section 2(1) (Health Boards and Special Health Boards), in each of paragraphs (a) and
        (b), for the words “under this Act” substitute “relating to the health service”.
   (1B) In section 4 (Scottish Dental Practice Board)—
        (a) in subsection (1A)—
            (i) in paragraph (a), for the words from the second “to” to “he” substitute “or
                body corporate entitled, by virtue of section 43 of the Dentists Act 1984
                (c.24), to carry on the business of dentistry to submit to the Board, in
                relation to treatment which he, or as the case may be, it”;
            (ii) in paragraph (b), after the words “a dental practitioner” insert “or such a
                body corporate”;
        (b) in subsection (1B), after the words “dental practitioner” insert “or body
            corporate”.
   (1C) In section 10(3) (Common Services Agency), for the words “under this Act” substitute
        “relating to the health service”.
   (2) In section 17AA(3) (meaning of “ophthalmic list” for purpose of section), in the
        definition of “ophthalmic list”—
        (a) for the words from “a list” to the end of paragraph (a) substitute “—
            (a) in relation to a list published in accordance with regulations made under
                paragraph (a) of section 26(2) of this Act, the first part of the list which
                is referred to in sub-paragraph (i) of that paragraph;”;


(b) at the beginning of each of paragraphs (b) and (c) insert “a list published in accordance with regulations made under”.

(2A) In section 17C(2A)(b)(ii) (other Part 1 services which may be included in arrangements for the provision of personal dental services), after the word “Part” insert “(but not pharmaceutical care services)”. 3

(2B) In section 17D (persons with whom agreements may be made)—
   (a) in subsection (1)(b)(vi), for the words “an individual” substitute “a person”;
   (b) in subsection (2)—
      (i) in paragraph (b)(v) of the definition of “NHS employee”, for the words “an individual” substitute “a person”;
      (ii) in paragraph (c)(i) of that definition, for the words from the beginning to “or” substitute “a dental practitioner or body corporate whose name is included in the first part of a list prepared under section 25(2) of this Act or in a list prepared under”;
      (iii) in paragraph (c)(ii) of that definition, after the word “who” insert “, or body corporate which,”;
      (iv) in paragraph (b) of the definition of “qualifying body”, for the words “which, in accordance with the provisions of Part IV of the Dentists Act 1984, is entitled to carry on the business of dentistry” substitute “entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;
      (v) in the definition of “section 17C employee”, for the words from “by” to the end substitute “by a person providing services in accordance with the arrangements”.

(3) In section 28A(1) (remuneration for provision of Part II services), for the words “, general ophthalmic services or pharmaceutical services” substitute “or general ophthalmic services”.

(4) In section 28C(3) (indemnity cover)—
   (a) in the definition of “list”, for the words from “has” to the end substitute “means”—
      (a) the first part of a list prepared under section 25(2);
      (b) the first part of a list prepared under section 26(2);”;
   (b) in the definition of “Part II services”, for the words “general dental services, general ophthalmic services or pharmaceutical services” substitute “general dental services or general ophthalmic services”.

(5) In section 29(8A) (meaning of health care professional in section 29(8)(a)), for the words “17D” substitute “17P”.

(6) In section 30(1) (review etc. of disqualification), for the words “any disqualification, conditional disqualification or declaration of unfitness” substitute “a disqualification or conditional disqualification”.

(7) In section 32(1)(a) (regulations as to sections 29 and 31), for the words “31” substitute “30”.

(8) In section 32A(3) (interim suspension), after paragraph (a) insert “and”. 40
(9) In section 32E(1) (payments in consequence of suspension), for the words “32D(2)” substitute “32D(3)”. 

(10) In section 33 (powers of Scottish Ministers where services are inadequate), for the words from “any list” to the end of paragraph (d) substitute “—

(a) the first part of any list prepared under section 25(2), being the part which is of dental practitioners and bodies corporate referred to in section 25(1) who undertake to provide general dental services;

(b) the first part of any list prepared under section 26(2), being the part which is of medical practitioners and ophthalmic opticians who undertake to provide general ophthalmic services.”.

(10A) In section 64(5) (permission for use of facilities in private practice), in paragraph (b), after the word “provide” insert “dental,”.

(11) In section 85AA (means of meeting expenditure of Health Boards out of public funds)—

(a) in subsection (2)(b), for the words “paragraphs (b) to (e)” substitute “paragraph (b)”;

(b) in subsection (4)—

(i) in paragraph (a)(ii), for the words “paragraphs (b) or (c)” substitute “paragraph (b)”; 

(ii) paragraphs (c) and (e) are repealed;

(c) in subsection (5), for the words “paragraphs (b) to (e)” substitute “paragraph (b)”.

(12) In section 85AB (further provision as to expenditure on drugs)—

(a) in subsection (6), for the words “pharmaceutical services” substitute “pharmaceutical care services”;

(b) after that subsection insert—

“(7) In this section, “drugs” includes—

(a) medicines; and

(b) appliances included in a list specified in directions given under regulations made under section 2CA(5).”.

(13) In section 108 (interpretation)—

(a) in subsection (1)—

(i) after the definition of “dispensing optician”, insert—

““Drug Tariff” means the Drug Tariff required to be prepared, maintained and published by the Scottish Ministers under section 17VA of this Act;”;

(ii) after the definition of “general medical services contract”, insert—

““general ophthalmic services” is to be construed in accordance with section 26(1F);”;

(iii) after the definition of “personal dental services”, insert—

““pharmaceutical care services” is to be construed in accordance with section 2CA(5);”.
“pharmaceutical care services contract” has the meaning given by section 17Q(2);”;

(iv) for the definition of “the Research Trust”, substitute—

“the Research Trust” means the Scottish Hospital Endowments Research Trust constituted under subsection (1) of section 12 of this Act (before the repeal of that subsection by section 32(2)(a) of the Smoking, Health and Social Care (Scotland) Act 2005 (asp 00);”;

(b) after that subsection, insert—

“(1A) References in this Act to “carrying on the business of dentistry” are to be construed in accordance with section 40 of the Dentists Act 1984 (c.24.”.

(14) In Schedule 8, in paragraph 8(2)(b), for the words “disqualification, conditional disqualification or declaration of unfitness” substitute “disqualification or conditional disqualification”.

Health and Medicines Act 1988 (c.49)

2 In section 17 of the Health and Medicines Act 1988—

(a) in subsection (1)—

(i) for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”;

(ii) after the words “1978” insert “(referred to in this section as “the 1978 Act”);

(iii) in paragraph (a), for the words from “or” to the end, substitute “or—

(i) in relation to section 17F of the 1978 Act, personal dental services;

(ii) in relation to section 17P of that Act, primary medical services;

(iii) in relation to section 17W of that Act, pharmaceutical care services”;

(b) in subsection (2)(a)(ii), for the words from “or,” to the end substitute “or, with any requirements placed on him by regulations made under section 17F, 17P, 17W, 25(2) or, as the case may be, 26(2) of the 1978 Act”;

(c) in subsection (2)(b)—

(i) after the words “dental practitioner” insert “or body corporate entitled, by virtue of section 43 of the Dentists Act 1984 (c.24), to carry on the business of dentistry”;

(ii) after the word “his” insert “or its”.

National Health Service (Primary Care) Act 1997 (c.46)

2A(1) The National Health Service (Primary Care) Act 1997 is amended as follows.

(2) In section 1 (pilot schemes)—

(a) in subsection (3)(b), after the word “services” insert “nor pharmaceutical care services”;

(b) in subsection (8), at end insert “;
“pharmaceutical care services” has the same meaning as for the purposes of Part 1 of the 1978 Act.”

(3) In section 3(3) (persons with whom pilot schemes for personal dental services may be made)—

(a) in paragraph (b) of the definition of “dental list”—

(i) after the word “Scotland,” insert “the first part of”;

(ii) for the words “section 25(2)(a)” insert “section 25(2)”;

(b) in the definition of “NHS employee”—

(i) in paragraph (b), after the words “dental practitioner” insert “or body corporate”;

(ii) in paragraph (c), after the word “who” insert “, or body corporate which,”.

(4) In section 17(5) (the Dental Practice Boards)—

(a) after the words “dental practitioner” insert “or body corporate”;

(b) after the word “he” insert “or it”.

Police Act 1997 (c.50)

3 In section 115 of the Police Act 1997 (enhanced criminal record certificates)—

(a) in subsection (6C) (as inserted by section 70(3)(c) of the Criminal Justice (Scotland) Act 2003 (asp 7))—

(i) for paragraph (b) substitute—

“(b) dental practitioners or bodies corporate undertaking to provide, and persons approved to assist in providing, general dental services;”;

(ii) in paragraph (c), after the word “provide” insert “, and persons approved to assist in providing.”;

(iii) paragraph (d) is repealed;

(b) in subsection (6D)(a) (as inserted by the said section 70(3)(c)), for the words “(c) or (d)” substitute “(b) or (c)”;

(c) in subsection (6E) (as inserted by the said section 70(3)(c)), for the words “section 17F of the National Health Service (Scotland) Act 1978 (persons performing primary medical services)” substitute “section 17F (persons performing personal dental services), 17P (persons performing primary medical services) or 17W (persons performing pharmaceutical care services) of the National Health Service (Scotland) Act 1978”.

The Scottish Public Services Ombudsman Act 2002 (asp 11)

4 In paragraph 14 of schedule 4 to the Scottish Public Services Ombudsman Act 2002, for the words “17P, 25(2), 26(2) or 27(2)” substitute “17F, 17P, 17W, 25(2) or 26(2)”.

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### SCHEDULE 3
*(introduced by section 36(2))*

**REPEALS**

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<td>Section 25(3) to (5).</td>
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<td>In section 30(2), in paragraph (a) the words from “or” to the end of the paragraph, and the words from “, and, on a review” to the end of the subsection.</td>
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<td>In section 32A, in subsection (3) paragraph (c) and the word “and” immediately preceding that paragraph and in subsection (6) paragraph (b) and the word “, and” immediately preceding that paragraph.</td>
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<td>Section 85AA(11).</td>
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<td>In Schedule 3, the entry concerning section 70(1) of the 1978 Act; and in the entry concerning Schedule 11, the words “the words “dental or” and”.</td>
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<td>National Health Service (Primary Care) Act 1997 (c.46)</td>
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<td>Section 27(2).</td>
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<td>Section 28(2).</td>
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<td>Section 29(2).</td>
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<td>In Schedule 2, paragraphs 43, 44 and 45.</td>
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<td>In Schedule 3, the entry concerning section 25(2)(c) of the 1978 Act.</td>
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<tr>
<td>Health Act 1999 (c.8)</td>
<td>Section 56(3) and (4).</td>
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<td>In Schedule 4, paragraphs 49, 51(d) and (g), 52(c) and 53.</td>
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<td>In Schedule 5, in the entry concerning section 32A of the 1978 Act, the words “and, in subsection (6)(a), “prepared under this Part of this Act””.</td>
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<tr>
<td>Public Finance and Accountability (Scotland) Act 2000 (asp 1)</td>
<td>In schedule 4, paragraph 4(2).</td>
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<tr>
<td>Ethical Standards in Public Life etc. (Scotland) Act 2000 (asp 7)</td>
<td>In schedule 3, the entry relating to the Scottish Hospital Endowments Research Trust.</td>
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<tr>
<td>Community Care and Health (Scotland) Act 2002 (asp 5)</td>
<td>In schedule 2, paragraphs 2(6)(c), (7), (8), (9)(b), (10)(b) and (11).</td>
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<tr>
<td>Freedom of Information (Scotland) Act 2002 (asp 13)</td>
<td>In schedule 1, paragraph 43.</td>
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<tr>
<td>Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)</td>
<td>In schedule 2, paragraph 4(3)(b) and (6)(b).</td>
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<td>Primary Medical Services (Scotland) Act 2004 (asp 1)</td>
<td>Section 5(3)(a).</td>
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<td>In the schedule, paragraph 1(8), (10), (11)(a), (13) and (16)(a).</td>
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</table>
Smoking, Health and Social Care (Scotland) Bill

[AS PASSED]

An Act of the Scottish Parliament to prohibit smoking in certain wholly or substantially enclosed places; to enable the Scottish Ministers by order to vary the minimum age limit of those to whom tobacco may be sold; to make provision in relation to general dental services, general ophthalmic services, personal dental services, pharmaceutical care services and detection of vision problems in children; to make provision in relation to disqualification by the NHS Tribunal; to enable the Scottish Ministers to establish a scheme for the making of payments to certain persons infected with hepatitis C as a result of NHS treatment and to certain persons infected with the virus by transmission of it from a person infected with it as a result of such treatment; to amend the Regulation of Care (Scotland) Act 2001 as respects what constitutes an independent health care service, the implementation of certain decisions by the Scottish Commission for the Regulation of Care or the Scottish Social Services Council, the provision of information to the Council and the minimum frequency of inspection of care services by the Commission; to make provision providing further time for applications to be made for registration of child care agencies and housing support services under the Regulation of Care (Scotland) Act 2001 and provide authorisation for the payment of certain grants to such services while not registered under that Act; to amend the Adults with Incapacity (Scotland) Act 2000 as respects authorisation of medical treatment; to amend the Public Health (Scotland) Act 1897 to introduce a right of appeal in certain cases under that Act; to enable the Scottish Ministers to form, participate in and provide assistance to companies for the purpose of providing facilities or services for persons exercising functions under the National Health Service (Scotland) Act 1978 or of making money available to the health service in Scotland; to amend the rules as to membership of and other matters relating to the Scottish Hospital Endowments Research Trust; and for connected purposes.

Introduced by: Mr Andy Kerr
On: 16 December 2004
Supported by: Rhona Brankin
Bill type: Executive Bill