OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 5 February 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 5 February 2019

CONTENTS

HEALTH AND SPORT COMMITTEE
4th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Miles Briggs (Lothian) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Bob Doris (Glasgow Maryhill and Springburn) (SNP)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Alison Johnstone (Lothian) (Green)
Monica Lennon (Central Scotland) (Lab)
Mike Rumbles (North East Scotland) (LD)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 5 February 2019

[The Convener opened the meeting at 09:31]

Health and Care (Staffing) (Scotland) Bill: Stage 2

The Convener (Lewis Macdonald): Good morning, and welcome to the fourth meeting in 2019 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are off or in silent mode, please. Mobile devices may be used for social media purposes, but they should not be used for photography or for recording the proceedings.

We have received apologies from Alex Cole-Hamilton and David Torrance, and we are joined by Bob Doris, who is a substitute member for David Torrance. Welcome to the meeting.

The first item on the agenda is continued stage 2 consideration of the Health and Care (Staffing) (Scotland) Bill. I once again welcome the Cabinet Secretary for Health and Sport, Jeane Freeman, who is accompanied by Diane Murray, Louise Kay, Julie Davidson and Jonathan Brown. Fiona McQueen, too, is accompanying the cabinet secretary. I welcome the officials to the table.

I also welcome Monica Lennon, who will speak to and move amendments, and Mike Rumbles who will speak to amendments in due course. I am glad to welcome members of the public who have joined us.

Members should have a copy of the bill, the marshalled list of amendments that was published on Thursday, and the groupings of amendments, which sets out the amendments in the order in which they will be debated.

I will briefly explain the procedure again. There will be a debate on each group of amendments. I will call the member who has lodged the lead amendment in the group to speak to and move that amendment, and to speak to all the other amendments in the group. I will then call other members who have lodged amendments in the group. Members who have not lodged amendments in the group may also contribute—they should simply catch my eye in the usual way. If she has not already done so, I will invite the cabinet secretary to contribute to the debate just before we move to the winding-up speech by the member who moved the lead amendment.

Following the debate on each group, the member who moved the lead amendment in the group should indicate whether they wish to press it to a vote or to seek to withdraw it. If they wish to press it, I will put the question on that amendment. If a member wishes to withdraw their amendment after it has been moved, they must seek the agreement of other members to do so. If any member present objects to its being withdrawn, the amendment will immediately be put to a vote.

If any member does not want to move their amendment when called, they should say, "Not moved." It is open to any other member then to move that amendment. If no one moves the amendment, I will move immediately to the next amendment on the marshalled list.

Only committee members and substitute members may vote. Voting in a division is by show of hands. Members should indicate their intention clearly and keep their hands up until their vote has been recorded.

The committee is required to approve formally each section of the bill, so I will put the question on each section at the appropriate point.

The intention is that we will finish stage 2 today, if we can. If we are unable to do so, we will return to it after the February recess. We have approximately three hours set aside in which to complete proceedings today. I hope that we can get through the amendments.

Section 4—NHS duties in relation to staffing

The Convener: The first group of amendments is entitled "Common staffing method: purpose and frequency of use". Amendment 18, in the name of the cabinet secretary, is grouped with amendments 93 and 22.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Amendments 18 and 22 relate to the frequency of use of the common staffing method in proposed new section 12IB of the National Health Service (Scotland) Act 1978. The common staffing method includes use of the staffing level and professional judgment tools and consideration of the results that they produce. Proposed new section 12IB(3)(c) will provide Scottish ministers with the power to prescribe the frequency of use of the staffing level and professional judgment tools as part of the common staffing method. It will not allow ministers to prescribe the frequency of use of the common staffing method as a whole.

The data output that is produced as a result of using the tools should be used only as part of the common staffing method and should not be used in isolation. Similarly, the common staffing method should not be used without using the tools and data output from the tools. Therefore, it is the

Scottish Government's intention that the whole common staffing method, as set out in proposed new section 12IB of the 1978 act, rather than just the tools, be used at a specified frequency.

Having reflected on the matter, the Scottish Government considers that the power in proposed new section 12IB(3)(c) of the 1978 act would be too narrow to achieve that, because it relates only to frequency of use of the tools, rather than of the wider common staffing method. Accordingly, amendment 22 will remove proposed new section 12IB(3)(c).

Amendment 18 sets out a replacement power for Scottish ministers to prescribe in regulations the frequency at which the common staffing method as a whole—rather than just the tools—is to be used. It is worth emphasising that it will be a minimum frequency: health boards will have discretion to use the common staffing method more often, if they wish to do so.

As well as clarifying that Scottish ministers can specify the frequency with which the whole common staffing method, and not just the tools, should be used, amendments 18 and 22 should also remove any suggestion that the output of the tools can be used separately from the common staffing method, or that the common staffing method can be followed without using the data from the output of the tools.

I will now speak to Mr Briggs's amendment 93, which seeks to provide that the purpose of the common staffing method is to set staffing establishments. Although the common staffing method is used to set staffing establishments, that is not its only purpose: it is designed to be used more widely. Indeed, the bill already reflects its wider use as a method to support service redesign. That is set out as a specific step in proposed new section 12IB(2)(d) of the 1978 act.

If we were to say that the common staffing method was purely about setting a staffing establishment annually, the opportunity that is being created by the bill would be missed and we would merely be making voluntary use of the existing tools a statutory requirement. Throughout the consultation on the bill, we were told that it needs to go beyond looking at just how the establishment is set. The common staffing method that is set out in the bill will do just that. To restrict it to setting establishments would undermine the purpose of the legislation.

However, although I do not believe that amendment 93 accurately conveys the range of uses for which the common staffing method can bring benefits, it is worth noting that those other uses do lead to the setting of an establishment figure, and would therefore be captured within the purpose that is set out in amendment 93. Therefore, I will not oppose amendment 93, although I ask Mr Briggs to confirm that his intention is that the amendment cover not only the routine regular staffing establishment setting process, but its use to provide an establishment figure as a result of other triggers, including the need to redesign a service.

I move amendment 18.

Miles Briggs (Lothian) (Con): Amendment 93 seeks to designate the common staffing method as the process by which the staffing establishment figure will be set. In the bill as drafted, the common staffing method is the only process that can be used to set staffing levels. It is required that the staffing tool and the professional judgment be run as the first step in the common staffing method. If current practice is followed, in almost all cases the two tools will be run on an annual or biannual basis. In some specific settings, such as neonatal care, the staffing tool would be run daily, if current practice continues.

Given the steps that the common staffing method requires, it is a way to set a staffing establishment figure. That is what I am looking to incorporate. It is not a real-time process to monitor staffing, safety or quality.

I have heard what the cabinet secretary has said, but I think that amendment 93 could still complement the bill.

Sandra White (Glasgow Kelvin) (SNP): I have a couple of questions for the minister, and, perhaps, a comment to make. I thank the minister for clarifying the situation around amendment 18, particularly with regard to frequency. In my mind, we are moving more towards integration, and this is part of it. I have concerns about some of the amendments, so I appreciate clarity on that one.

I know that the minister has said that she is minded to agree to Miles Briggs's amendment 93, but I would like him to say whether his amendment would prevent the service redesign and flexibility that the bill is all about. That is my concern about it.

The Convener: If Mr Briggs wishes to respond to that question, he will have to make an intervention on Sandra White, or on the minister, in due course.

Miles Briggs: I will intervene just now. The wider context of health and social care integration is the important background to the bill, and I think that committee members are committed to it. Through amendment 93, I am looking to strengthen the bill in respect of the common staffing method. Currently, it is the only process that is used in establishing staffing levels.

Sandra White: Will you take an intervention?

The Convener: You still have the floor, Ms White.

Sandra White: Thank you, convener. I would like Miles Briggs to clarify the point that he just made. He quite rightly spoke about the long term, which is a difficult issue to address. However, I asked about service redesign and flexibility. Would amendment 93 stop service redesign and prevent flexibility in relation to staff?

Miles Briggs: I do not believe that amendment 93 would do that.

The Convener: That concludes Sandra White's contribution. I invite the cabinet secretary to wind up.

Jeane Freeman: I have little to add. I am grateful for Miles Briggs's confirmation that he does not believe that amendment 93 would restrict or prevent service redesign. With that assurance, I press amendment 18 and will not stand in the way of his amendment 93.

Amendment 18 agreed to.

Amendment 93 moved—[Miles Briggs]—and agreed to.

The Convener: The next group of amendments is entitled "Common staffing method: steps and factors in method". Amendment 94, in the name of Miles Briggs, is grouped with amendments 95, 19, 20, 96 to 98, 21, and 99 to 102.

Miles Briggs: The purpose of amendments 94, 95, 97, 99, 100 and 101 is to remove the hierarchy within the common staffing method so that tools, patient acuity and dependency, and the clinical advice of nurses of appropriate seniority are given equal weight.

The current common staffing method is based on average workload for each specialty across Scotland. It is supplemented by considering the specifics of local contexts, including the age profile of staff, local recruitment challenges, quality indicators and professional judgment. As drafted, the use of a staffing level tool and a professional judgment tool is the first step; a consideration of current staffing levels, local context and so on is the next step; and the final step is a consideration of patient need and appropriate clinical advice. That means that, in the common staffing method, the tools hold more weight than patient need and the clinical advice of nurses of appropriate seniority, and the common staffing method is not truly triangulated. The process that is set out by the common staffing method should give equal weight to the use of staffing tools, patient acuity and dependency, and the clinical advice of nurses of appropriate seniority.

When the committee took evidence on this issue, we looked specifically at a piece of work around an ultimate focus on outcomes to be achieved. I believe that the amendments complement the legislation in that regard.

I move amendment 94.

09:45

Jeane Freeman: I will speak to amendment 20 in particular. I addressed that amendment last week, and I do not intend to repeat everything that I said then. However, I would like to point out that, in developing amendment 20, I listened to the Royal College of Nursing view that the leadership role of the senior charge nurse should be recognised. That was covered by the 2008 report "Leading Better Care: Report of the Senior Charge Nurse Review and Clinical Quality Indicators Project", which set out that, in recognition of their leadership role, senior charge nurses should not be completely case load holding. We will continue to work on the leadership role of the senior charge nurse, and the workload planning tools and common staffing method provide an evidence-based way to do so.

It is not appropriate that nurses have been singled out for preferential treatment in a bill that is not only about nursing. I have looked further at amendment 91, in the name of Alison Johnstone, which was passed last week, and I am not convinced that it does what she intended it to do. I have serious concerns about the way in which it is worded and the impact that it could have on patient care, and I will return to that issue later in the process.

Amendment 20 aims to recognise the unique roles and responsibilities that are placed on all clinical team leaders and sets out an additional step in the common staffing method that requires health boards to consider the role and professional duties of lead clinical professionals. It takes account of the multidisciplinary nature of the services that we aim to provide. For example, in a rehabilitation ward where the team leader is a physiotherapist, that person will be allowed appropriate time to fulfil their leadership role. It will also mean that midwives are afforded the same support as nurses for their leadership role. Given the passing of amendment 91, that is all the more important to ensure that all staff groups are supported in their leadership role. The Scottish executive nurse directors group is also supportive of that approach, which it believes clearly articulates the role of the clinical leader in the common staffing method. With that in mind, I ask the committee to support amendment 20.

Amendment 19 sets out that, as part of the common staffing method, health boards and the agency must take into account the different skills and levels of experience of its employees. It aims

to address the concern that has been raised by some of our stakeholders that the workload tools do not result in a definition of the level of skill and experience that are required to deliver the workload. By amending the bill in this way, I intend to ensure that health boards and the agency not only look at how to put in the correct number of staff but ensure that those staff have the skills and experience that are necessary to provide the safe and high-quality service that I am keen to see across our national health service.

Amendment 21 sets out that, as part of the common staffing method, comments by individuals who have a personal interest in the patient's healthcare, such as family members and carers, should be taken into account, as well as those of the patient himself or herself, in so far as those comments relate to the duty to ensure appropriate staffing. That recognises that, for various reasons, patients are not always able to speak for themselves, although that does not mean that their wishes should not be heard and responded to.

I am not clear about the intention of amendment 96, in the name of David Stewart. From my reading of it, it could be about underlining the importance of multidisciplinary services, avoiding the unintended consequences of covering one staff group by a workload planning tool for other staff groups, or recognising that some aspects of care could be carried out by more than one profession. I agree with all of those and they have been considered in the drafting of the bill, so I would welcome Mr Stewart's clarification of the intention of amendment 96.

I see no issues with many of the amendments that have been lodged by Mr Briggs, although some appear to be based on a misunderstanding that there is some kind of hierarchy in the common staffing method which, for clarity, I say is not the case. All steps in the method must be carried out and all are given equal weight. However, it does no harm to change the order in which the steps appear so, if Mr Briggs wishes to do that, I will not stand in his way.

The amendments that give me cause for concern are amendments 94, 95 and 102. In relation to amendments 94 and 95, I am concerned by the lack of clarity on what is meant by "peer-reviewed evidence" and "professional and improvement organisations". What is the definition of "peer-reviewed evidence" and would there necessarily be any certainty that something that is reviewed by a health "peer" should always be taken into account? In the health field, there could be numerous trials or pieces of work that some people might class as evidence but on which clinicians disagree. Is it the case that all such work should be taken into account? Similarly, what is a "professional and improvement organisation"? Those are exactly the questions that will be asked by the working group that is set up to develop a tool and it is the working group that will be best placed to determine what is relevant for that tool.

When Healthcare Improvement Scotland reviews the effectiveness of the tools and the common staffing method, as set out in amendment 17, it will take into account the most up-to-date and relevant evidence and guidance, as is its professional duty. I do not feel that it is appropriate for legislation to require that a senior charge nurse, for example, carry out a review of available evidence every time he or she runs the common staffing method. My preference is to include something in guidance, in order to allow for greater clarity and flexibility. However, I would be happy to work with Mr Briggs to see whether we could develop an amendment for stage 3, if he feels strongly that he wants to include something in primary legislation, although I do not believe that that is necessary. I therefore ask Mr Briggs not to press amendment 94 or move amendment 95.

I believe that amendment 102 is based on a proposal by the RCN, which is keen to see excellence in care referenced in the bill in some way. If my assumption is correct, amendment 102 is completely unnecessary, as proposed new section 12IB(2)(b) of the 1978 act sets out that account must be taken of,

"in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) by the Scottish Ministers".

Excellence in care will be one such measure. Therefore, I cannot see what the amendment adds. If Mr Briggs feels that the current provisions do not achieve what is required then—as is the case with amendments 94 and 95—I will be happy to work with him to develop an amendment for stage 3 that does. As it stands, I am hesitant to support amendment 102 and I ask the member not to move it.

David Stewart (Highlands and Islands) (Lab): Like many other amendments in the group, amendment 96 seeks to add to the list of considerations that must be taken into account when determining staffing levels. In evidence at stage 1, the committee heard concerns from a number of stakeholders that the bill could have the unintended consequence of drawing resources into the supply of professions that are covered by the existing tools at the expense of other healthcare professions that are not yet covered by the tools, which would not benefit the delivery of quality services or improve outcomes for patients and service users. Therefore, amendment 96 would require account to be taken of the potential

impact on other staff and professions when determining appropriate staffing levels.

Amendments in other groups that have been lodged by the cabinet secretary and by Alex Cole-Hamilton seek to embed a multidisciplinary approach through the development and review of tools, which is welcome. However, I submit that amendment 96 is needed in addition to the amendments that reference multidisciplinary working approaches, to ensure that all professions are considered from day 1 of the implementation of the bill and not only when the tools are reviewed. Amendment 96 does not detract from the multidisciplinary amendments; rather it makes explicit their ultimate aim and is complementary to them. I hope that my comments cover the questions that the cabinet secretary raised in her opening remarks.

Emma Harper (South Scotland) (SNP): I want to clarify that, if we are going to pursue common staffing methods, many of the tools have not yet been created. About one third of our care homes have nursing staff, but many care homes do not have nurses working in them. We are talking about social care being provided in people's homes, so there are no nursing assessment requirements, unless people are unwell for whatever reason. The tools for a multidisciplinary team approach have not yet been developed and the amendments might restrict the ability to manage common staffing methods. My concern in that regard is about the care home setting, in which not many nurses work.

The Convener: I call Miles Briggs to wind up, and to press or withdraw his amendment.

Miles Briggs: The common staffing method

"means that a Health Board or the Agency ... takes into account ... measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) by the Scottish Ministers".

The aim of amendments 94 and 95 is to set out that peer-led evidence be part of that. Having listened to the cabinet secretary, I am happy to look at how we can come to a cross-party agreement on this issue at stage 3, so I will withdraw amendment 94 and not move amendments 95 and 102.

Amendment 94, by agreement, withdrawn.

Amendment 95 not moved.

Amendments 19 and 20 moved—[Jeane Freeman]—and agreed to.

Amendment 96 moved—[David Stewart]—and agreed to.

Amendments 97 and 98 moved—[Miles Briggs]—and agreed to.

Amendment 21 moved—[Jeane Freeman]—and agreed to.

Amendments 99 to 101 moved—[Miles Briggs]—and agreed to.

Amendment 22 moved—[Jeane Freeman]—and agreed to.

Amendment 102 not moved.

The Convener: The next group of amendments is entitled "Common staffing method: types of healthcare and employees covered". Amendment 23, in the name of the cabinet secretary, is grouped with amendments 24 to 36, 45 and 46.

Jeane Freeman: These are minor technical amendments to the healthcare settings that are covered by the duty on health boards and the agency to use the common staffing method.

The purpose of amendments 23 and 25 to 29 is to clarify that, where multiple types of employees or locations are covered by a healthcare setting in the table in proposed new section 12IC(1) of the 1978 act, the requirement to follow the common staffing method applies where one or more of the employee types or locations are present and not just where all those listed are present. The amendments will ensure that, for example, for neonatal provision, which can be delivered by registered nurses, registered midwives or a combination of the two, the duty to use the common staffing method comes into effect when some of the employee types are present in a particular ward and not just when all those listed are present.

10:00

Amendments 24 and 31 will bring the definitions of "Adult inpatient" and "Small ward provision" in line with the nursing and midwifery workload and workforce planning programme guidance for the use of those specific staffing-level tools.

Amendment 30 removes the "Perioperative provision" entry from proposed new section 12IC of the 1978 act. A review of the perioperative staffing-level tool, which would be used as part of the common staffing method in perioperative healthcare settings, has identified issues, which are currently being investigated. Because of that, the tool is currently unavailable for use by health boards, and as such they would be unable to comply with the duty to use the common staffing method in perioperative settings.

Amendments 34 and 35 clarify that medical students and student nurses and midwives are not included in the staffing establishment for the purposes of the common staffing method. The exclusion can be extended to other types of student in the future if necessary, as more staffing

groups, such as allied health professionals, are brought within the common staffing method.

Last week, I spoke about the importance of taking a multidisciplinary approach and, in doing so, recognising the important role that allied health professionals play in achieving outcomes for service users. Those professionals highlighted that point during the stage 1 evidence sessions and it was noted by the committee. Amendment 36, which arises from productive engagement with the Allied Health Professions Federation, clarifies that allied health professionals are an example of the type of employee that can be covered by the common staffing method. That means that, when new tools are developed that cover allied health professionals, the duty to use the common staffing method can be extended to cover them.

Amendment 46 expands the definition of "employee" in proposed new section 12IG to include those who are employed by a local authority under the lead agency model of integration. That means that those local authority employees will be captured under the common staffing method, which is necessary to ensure its correct operation in lead agency settings.

Amendments 32, 33 and 45 are minor technical corrections to ensure that the legislation operates as intended. Throughout the bill, the term "individual" is used to describe a natural person and the term "person" is used to describe a legal person. However, section 12IC(2), which sets out the types of healthcare to which the duty to use the common staffing method applies, and the definition of "appropriate clinical advice" in 12IG use the term "person" to describe a natural person. Amendments 32, 33, and 45 therefore change those references from "person" to "individual" to provide clarity that they refer to a natural person, and to provide consistency throughout the bill.

I move amendment 23.

Amendment 23 agreed to.

Amendments 24 to 36 moved—[Jeane Freeman]—and agreed to.

The Convener: The next group is entitled "Common staffing method: training and consultation of staff". Amendment 103, in the name of Miles Briggs, is grouped with amendments 6 and 104 to 106.

Miles Briggs: Amendments 103 to 106 seek to put a duty on NHS boards to support, as well as encourage, staff to share their views on the boards' compliance with the legislation. Under the bill as drafted, NHS boards will be required only to encourage employees to give views on their staffing arrangements, and that requirement covers only the areas that use the common staffing method.

Employees of NHS boards will have valuable experience of staffing issues as well as views on whether the care that they are able to provide is safe and of high quality. As a result, the duty on NHS boards should be strengthened to ensure that they must actively seek their employees' views and support them in making their views known. That might mean, for example, NHS boards ensuring that reasonable systems are in place for collecting those views.

A strengthened duty to engage with employees would mean that those working in areas covered by the common staffing method would have a significant opportunity to comment on and, potentially, to shape board processes for discharging the duties that the legislation puts on them. The operation of the legislation could, in practice, be further strengthened if the provisions for staff engagement under proposed new section 12ID(a) and (b) of the 1978 act and the provisions for reporting back to staff in proposed new section 12ID(e) were not solely focused on the use of the common staffing method but took into consideration the guiding principles for staffing and the duty to ensure appropriate staffing. Given that amendments have been agreed to on the need for NHS boards to establish protocols to identify monitoring and assess risk, supporting staff in giving their views on the protocols should be covered in the bill, too.

Amendment 104 seeks to ensure that nurses of appropriate seniority are trained in the common staffing method. The bill contains provision for NHS employees to be trained in the use of the method and for their having adequate time to use it. Given that being educated in the use of the method and having the time to use it are hugely important to the bill's outcomes, it should be made explicit that NHS boards will make training on the common staffing method available to nurses of appropriate seniority across all settings.

I move amendment 103.

The Convener: I welcome Mike Rumbles to the meeting. I invite him to speak to amendment 6, in the name of Alex Cole-Hamilton, and the other amendments in the group.

Mike Rumbles (North East Scotland) (LD): Thank you very much, convener; it is a pleasure to be here. Unfortunately, Alex Cole-Hamilton cannot be here for today's meeting of the Health and Sport Committee—indeed, he is visiting a hospital at the moment—so he has asked me to attend to speak to his amendment on his behalf.

In Alex Cole-Hamilton's view, amendment 6 takes nothing away from the bill; it simply adds to and improves it. It seeks to add the phrase "and

areas for improvement" to proposed new section 12ID(b) of the 1978 act so that it reads "use any such views it receives to identify best practice and areas for improvement in relation to such staffing arrangements". The amendment, which is supported by the Royal College of Nursing, would, I think, add greatly to the intention behind that section of the bill.

Jeane Freeman: I have no concerns about amendment 103 and I am happy to accept amendment 6, which I think is a helpful addition to the duty on boards in proposed new section 12ID of the 1978 act. I maintain, though, that amendment 104 is unnecessary, as proposed new section 12ID(c) as drafted already requires all staff who use the common staffing method to be trained.

I appreciate what amendments 105 and 106 seek to do with regard to the real-time staffing assessment procedures but, technically speaking, they would be placed in the wrong part of the bill. The real-time staffing assessment procedures apply to all employees of a health board, whereas the amendments would apply only to employees covered by the common staffing method, because proposed new section 12ID, into which the amendments would be inserted, applies only to employees engaged in the common staffing method, not to all health board employees. I assume that Mr Briggs's intention is to cover all employees.

In addition, the opening words of proposed new section 12ID of the 1978 act explicitly make compliance with the duty to use the common staffing method in proposed new section 12IB dependent on fulfilling the duties listed in section 12ID. Given the differing coverage of the sections, it makes no sense to make compliance in law by health boards with section 12IB dependent on new procedures relating to the real-time staffing assessment procedures, which are not linked to the common staffing method. The correct link for any requirements relating to those new assessment and escalation procedures is with proposed new sections 12IAA and 12IAB, which the committee agreed to last week, precisely because of their wider application to all of a board's employees.

I therefore ask Mr Briggs not to press amendments 105 and 106 and instead to lodge at stage 3 alternative amendments that amend the technically correct sections of the bill. I am happy to work with him on those amendments.

The Convener: I call Miles Briggs to wind up and to press or withdraw amendment 103.

Miles Briggs: I welcome the cabinet secretary's agreement to support my amendments. As we head towards stage 3, there will be a lot of housekeeping to clean up the bill, so at this stage, I am happy not to press amendments 105 and 106.

Sandra White: On a point of clarification, the cabinet secretary has picked up on what I intended to say, but I will go over it again. When Mr Briggs was talking to his amendments at the beginning, he mentioned nursing staff, and I was concerned about that. The cabinet secretary has clarified her position as regards staffing levels, and I am concerned that he is leaning more towards nursing staff than any other types of staff. Would Mr Briggs consider having a chat with the committee or the cabinet secretary in order before lodging his amendments at stage 3? I have some concerns about how prescriptive they are. I hope that my comments are helpful.

Miles Briggs: We are all agreed on the multidisciplinary nature of the bill. When it comes to health and social care integration, we are trying to make legislation work for two different sectors. My understanding is that the cabinet secretary is content with amendments 103 and 104 in my name, but I am happy not to move amendments 105 and 106, with the understanding that, at stage 3, I will lodge amendments on which we can all agree.

Sandra White: Thank you for that.

Miles Briggs: I press amendment 103.

Amendment 103 agreed to.

Amendment 6 moved—[Mike Rumbles]—and agreed to.

Amendment 104 moved—[Miles Briggs]—and agreed to.

Amendments 105 and 106 not moved.

The Convener: We come to amendment 107, in the name of David Stewart.

David Stewart: I have had a discussion with the cabinet secretary and I am happy that she has taken on board the spirit of the amendment.

Amendments 107 and 123 not moved.

The Convener: In debates on groupings, other than when moving an amendment, if members wish to contribute to the general debate, they should indicate that before I call the cabinet secretary to speak, so that I can take their contribution separately. Of course, members can always intervene on other members and on the cabinet secretary, but if they wish to make comments on a group, I encourage them to do so.

The next group of amendments is entitled "Reporting on staffing by health boards and the Scottish ministers". Amendment 37, in the name of

Jeane Freeman, is grouped with amendments 38, 40, 108 and 109.

10:15

Jeane Freeman: Amendments 37 and 38 will strengthen the duty on health boards to report on how they have carried out their new duties under the bill. That includes reporting on section 2, on which Monica Lennon's amendment 85—which was agreed to last week—also inserted a reporting duty.

Boards will have to provide a report detailing how they have complied with the general duty to ensure appropriate staffing and the duties on: the common staffing method; real-time assessment of staffing; escalation of staffing concerns; and the training and consultation of staff. Boards will have to submit the reports to ministers and publish them within one month of the end of the financial year.

Amendment 40 will create an additional duty on ministers to inform Parliament about how the reports provided by the health boards have been, or will be, taken into account when setting national staffing policy for NHS services.

I know that the committee heard evidence from stakeholders who wished to see a firmer link to workforce planning. Our approach recognises that the bill is not about strategic, national level workforce planning, but that the information generated by implementing the duty on health boards to ensure appropriate staffing and by the common staffing method is a factor that will be considered in such national planning.

In setting out a clear reporting process, my intention is to create transparency around the decisions that are taken by boards, allowing scrutiny of how that is reflected in their workforce projections. Similarly, creating transparency around the information that has been provided to ministers will allow scrutiny of how that information is then reflected by the Scottish Government in national workforce planning.

I do not think that there is anything covered by Monica Lennon's amendments 108 and 109 that is not already addressed by my amendments. Amendment 109 sets out a similar reporting duty on Scottish ministers, however it does not cover the new real-time staffing and risk escalation duties that amendment 17 places on health boards and does not contain the link to how the information is used for wider workforce planning. I ask the committee to resist amendment 109.

I see merit in the intention behind amendment 108, which would require health boards and the agency to report on risks and challenges. I had intended that guidance would set out that boards must include that information in their reports, so I would be happy to make it explicit as part of section 12IF at stage 3. Therefore, I ask Monica Lennon not to move amendments 108 or 109.

I move amendment 37.

Monica Lennon (Central Scotland) (Lab): Similarly to amendments to sections 2 and 3 of the bill in an earlier group, amendments 108 and 109 aim to improve the scrutiny of health boards' compliance with the bill.

Amendment 108 would do that by requiring health boards to specify, in the information that they provide to Scottish ministers, any particular risk or challenge that they have faced in complying with their duties, particularly their duty to provide appropriate staff, taking into account the guiding principles, their duty to follow the common staffing method and their duty to provide appropriate and adequate training to staff. The purpose of including reporting on risk is to allow the identification of any systemic issues that might hinder staffing levels, at both a health board level and a national level.

Amendment 109 would require Scottish ministers to gather the information that they receive from health boards and respond to it publicly. It would also require the public report from ministers to address the risks faced by health boards in relation to their staffing duties. The aim of amendment 109 is to encourage scrutiny of the decisions taken by the Scottish Government with regard to national workforce planning and staffing of our health service.

I note that amendments moved by Alison Johnstone last week also sought to establish a link between the bill and national workforce planning. I supported those amendments and I believe that amendments 108 and 109 would strengthen that connection further by ensuring that Scottish ministers are held accountable for mitigating risks faced by health boards in any area of national policy—be it the supply of trained professionals required by Alison Johnstone's amendments, pay levels, terms and conditions or issues such as the accessibility of workplaces in rural areas.

I welcome the cabinet secretary's comments. I recognise that amendment 40, in her name, also seeks to provide a connection to national Government workforce planning, which is welcome. However, the specific reference to risk in amendment 109 is stronger and therefore I commend it to the committee.

The Convener: As no other member wishes to contribute to the debate, I invite the cabinet secretary to wind up.

Jeane Freeman: I repeat that Ms Lennon's amendment 109 does not cover the new real-time staffing and risk escalation duties that amendment

17 places on health boards, and does not contain the link to how the information is used for wider workforce planning. I believe that that makes amendment 109 the weaker one, and I ask the committee to support instead my amendment 40.

Amendment 37 agreed to.

Amendments 38 to 40 moved—[Jeane Freeman]—and agreed to.

Amendment 108 moved—[Monica Lennon].

The Convener: The question is, that amendment 108 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 4, Against 4, Abstentions 0.

I use my casting vote to vote in favour of amendment 108.

Amendment 108 agreed to.

Amendment 109 moved—[Monica Lennon].

The Convener: The question is, that amendment 109 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Harper, Emma (South Scotland) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 4, Against 4, Abstentions 0.

I will use my casting vote to vote in favour of amendment 109.

Amendment 109 agreed to.

Amendment 41 moved—[Jeane Freeman]—and agreed to.

The Convener: The next group is on ministerial guidance on staffing by health boards. Amendment 42, in the name of the cabinet secretary, is grouped with amendments 43, 44 and 47.

Jeane Freeman: Amendments 42 to 44 and 47 relate to the guidance that ministers can produce under proposed new section 12IF of the 1978 act, which covers the new staffing duties on health boards and the Common Services Agency. Section 12IF sets out that health boards and the agency must have regard to any guidance that has been issued by ministers when carrying out their duties under proposed new sections 12IA to 12IE. Section 12IF(3) lists those whom ministers must consult before issuing such guidance. Amendments 42 to 44 make changes to that list, and amendment 47 is consequential on amendment 42.

Amendment 42 clarifies that ministers must consult every relevant special health board, and amendment 47 sets out that that means those to which such duties apply as a result of section 5. That means that ministers will not be required to consult non-clinical special health boards, because they are not covered by the bill.

It is important that trade unions and professional bodies that represent staff who work in all the bodies to which the duties that are set out in the bill apply are able to offer their views on the guidance. Amendment 43 means that, as well as consulting health boards and the Common Services Agency, ministers must consult representatives of employees who work in relevant special health boards, integration authorities to which healthcare functions are delegated through the Public Bodies (Joint Working) (Scotland) Act 2014 and Healthcare Improvement Scotland.

Amendment 44 adds professional regulatory bodies for employees of health boards, the Common Services Agency, relevant special health boards, integration authorities to whom healthcare functions are delegated through the Public Bodies (Joint Working) (Scotland) Act 2014 and HIS to the list of those whom Scottish ministers must consult before issuing this guidance. That will cover the relevant statutory regulators such as the General Medical Council, the Nursing and Midwifery Council and the Health and Care Professions Council and ensure that they are consulted on guidance that may impact on the professional groups that they regulate.

I move amendment 42.

Amendment 42 agreed to.

Amendments 43 to 47 moved—[Jeane Freeman]—and agreed to.

Section 4, as amended, agreed to.

Section 5—Application of duties to certain Special Health Boards

Amendments 48 to 65 moved—[Jeane Freeman]—and agreed to.

Section 5, as amended, agreed to.

After section 5

The Convener: The next group is on the role of Healthcare Improvement Scotland in relation to staffing. Amendment 66, in the name of the cabinet secretary, is grouped with amendment 66A.

Jeane Freeman: In the stage 1 debate, I committed to lodge an amendment to make the role of Healthcare Improvement Scotland clear. Amendment 66 extends HIS's existing quality assurance and improvement role by inserting new sections into the National Health Service (Scotland) Act 1978 setting out that HIS will be responsible for monitoring the discharge by every health board, relevant special health board—meaning a special health board that provides clinical healthcare services to patients—and the Common Services Agency of their duties under all parts of the bill. Amendment 66 has the full support of HIS and has been drafted in consultation with it.

Proposed new section 12IH of the 1978 act places a duty on HIS to monitor the compliance of boards and the Common Services Agency with the staffing duties introduced by the bill, including the new real-time assessment and risk escalation duties under amendment 17.

Proposed section 12IJ places a duty on HIS to monitor

"the effectiveness of the common staffing method"

and the way in which boards and the agency are using it. HIS must additionally, as and when it considers it appropriate, carry out discrete reviews of the common staffing method with a view to publishing and submitting to ministers a report recommending changes to the common staffing method, if required. Ministers may then, by the regulations already provided for under proposed new section 12IB(4), amend the common staffing method.

HIS must have regard to the guiding principles in carrying out a review. In doing so, it must consult a range of stakeholders, as listed in section 12IJ(3). Ministers will also have the power to direct HIS to carry out such a review of the common staffing method.

Further to that, proposed section 12IK sets out that HIS may also develop, and recommend to ministers

"new or revised staffing level tools and professional judgement tools"

for use as part of the common staffing method, in relation to any kind of healthcare provision. Ministers may then, by regulations already provided for under proposed new section 12IB(3), prescribe the use of said tools as part of the common staffing method. In developing any new or revised tools, HIS must collaborate with the bodies mentioned previously and must again have regard to the guiding principles. Similarly, ministers may direct HIS to develop a new or revised staffing level tool or professional judgment tool.

10:30

In recognition of the view of stakeholders—in particular, the Allied Health Professions Federation—that there is a need to look at the development of multidisciplinary tools, proposed new section 12IL places a duty on HIS, when developing a new or revised staffing level or professional judgment tool, to

"consider whether the tool should apply to more than one professional discipline."

It also gives HIS a power to recommend to ministers that an existing tool should be multidisciplinary. HIS will be under a duty to monitor the effectiveness of any staffing level tool or professional judgment tool that has been prescribed by ministers under section 12IB(3). That would include any new or revised tool.

Proposed new sections 12IM and 12IN aim to ensure that HIS is given access to the support and—crucially—to the data that are necessary to carry out its new functions under the bill. Proposed section 12IM requires health boards, relevant special health boards and the agency to give HIS

"such assistance ... as it requires in the performance of its functions under sections 12IH to 12IL."

Proposed section 12IN gives HIS a power

"in pursuance of its functions under sections 12IH to 12IL"

to

"serve a notice on a Health Board, relevant Special Health Board or the Agency requiring the Board or the Agency ... to provide HIS with information about any matter specified in the notice"

by a specified date. Ministers will also have a power under proposed section 12IO to issue statutory guidance to HIS and to boards about those new provisions.

Finally, but importantly, the existing powers of HIS to inspect NHS services are extended to include the enforcement of those new functions by amendment to section 10I of the 1978 act. HIS is

fully aware of that amendment and is happy with the provisions that are set out in it.

Amendment 66A is unnecessary, as ministers can already direct HIS to carry out a review of the common staffing method under proposed new section 12IJ(4) or to develop a new or revised staffing level tool or professional judgment tool under proposed section 12IK(5). That could include a direction that HIS look at particular matters, including staff absences and bed occupancy levels. However, I do not think that the amendment would do any particular harm, so I will not stand in Mr Briggs's way if he wishes to press it.

I move amendment 66.

Miles Briggs: I welcome the fact that the cabinet secretary has lodged amendment 66, and I think that we are both trying to achieve the same thing in our amendments.

I was specifically looking to allow ministers to prescribe what could be included because of our original discussions about the multidisciplinary approach, which is very different from multidisciplinary tools. Given the different workforces, how we take that issue forward is important.

I am happy to move amendment 66A. I hope that we will finally get something workable in the bill at stage 3.

I move amendment 66A.

Amendment 66A agreed to.

Amendment 66, as amended, agreed to.

Before section 6

The Convener: Amendment 110, in the name of David Stewart, has already been debated with amendment 84.

David Stewart: Following a helpful discussion with the cabinet secretary, I will not move amendment 110.

Amendment 110 not moved.

Section 6—Duty on care service providers to ensure appropriate staffing

The Convener: The next group is on the duty on care service providers to ensure appropriate staffing. Amendment 7, in the name of Alex Cole-Hamilton, is grouped with amendments 111, 112 and 67.

Mike Rumbles: As I said, I will speak to Alex Cole-Hamilton's amendments this morning, but I also want to speak to amendment 67, in the name of the cabinet secretary.

All the amendments in the group are intended to improve the bill; indeed, I think that, whichever way we go, it will be an improvement. However, I think that Alex Cole-Hamilton's amendments are—if I can put it this way—more comprehensive and effective than the cabinet secretary's amendment. Section 6(1) says:

"Any person who provides a care service must ensure that at all times suitably qualified and competent individuals are working in the care service in such numbers as are appropriate for ... the health, wellbeing and safety of service users".

Amendment 7, in the name of Alex Cole-Hamilton, seeks to add the phrase "and staff" to that, which I think is really important and is supported by the Royal College of Nursing. Amendment 7, along with amendments 111 and 112, which seek to change the phrase

"the provision of high-quality care"

in section 6(1)(b) to "the provision of safe and high-quality care and services", provides a far more comprehensive approach than the cabinet secretary's choice in amendment 67 to add to section 6(1)

"(c) in so far as it affects either of those matters, the wellbeing of staff."

After all, amendments 7, 111 and 112 cover health, wellbeing and safety.

I do not need to say any more. Alex Cole-Hamilton's far more comprehensive amendments build on the important intention behind section 6, and I hope that there will be unanimous support for them.

I move amendment 7.

Jeane Freeman: I appreciate the valid aim of amendment 7, which seeks to ensure that staff wellbeing is considered in ensuring adequate numbers of staff. However, as I said last week in relation to amendment 3, we must be mindful that employment and health and safety law are reserved matters and are not for this Parliament to deal with. I also stated in respect of amendment 3—I will restate it again for the sake of clarity—that an almost identical provision to this amendment already exists in health and safety legislation, and we would not want to replicate in the bill any duty that already exists in primary legislation.

With this bill, we seek to ensure safe, high-quality services. Success will create a virtuous circle of better outcomes for patients together with improved wellbeing for staff; indeed, evidence demonstrates that one can affect the other. We already have as a guiding principle

"ensuring the wellbeing of staff"

and, again for the sake of clarity, I point out that throughout the bill we express concern about and put in place provisions to ensure the health and safety of staff.

As I have said, I am not averse to the aims of amendment 7, but I will move amendment 67 as a replacement that I believe answers the committee's request in its stage 1 report to include staff wellbeing in the duty on care service providers to ensure appropriate staffing. As with amendment 15, which, unfortunately, was not agreed to but which dealt with the health context, amendment 67 seeks to keep the bill's primary focus on the welfare of service users, while considering staff wellbeing in terms of how it impacts on the service itself.

I turn to amendments 111 and 112. Section 6 provides that:

"Any person who provides a care service must ensure that at all times suitably qualified and competent individuals are working in the ... service in such numbers as are appropriate for ... the health, wellbeing and safety of service users, and ... the provision of high-quality care."

Under amendment 111, any person who provided a care service would have to ensure that such numbers must be working as would be appropriate for the provision of safe and high-quality care. I therefore have no concerns with the amendment, given the bill's clear aims to secure safe and high-quality care.

Under amendment 112, such numbers must be working as would be appropriate for the provision of high-quality care and services. Although that duplicates what is already provided, as the care is the service, I will not stand in members' way if they wish to agree to the amendment.

I therefore ask the committee to support amendment 67 and not to support amendment 7.

Brian Whittle (South Scotland) (Con): I seek clarity from the cabinet secretary. She highlighted that the primary concern is the wellbeing of patients at all times. However, I am concerned that we should also consistently look after the health of our healthcare professionals. I assume that the cabinet secretary would agree with that, but I am not sure that that will be the case under amendment 67. I think that one goes hand in hand with the other—looking after the health of our healthcare professionals is key to looking after the health of patients.

Jeane Freeman: I am not going to disagree with Mr Whittle, and I have already said that I will not stand in the way of amendments 111 and 112. I have also made the point that, elsewhere in the bill, we have clear provisions that show our commitment to the health, wellbeing and safety of staff. My primary point is that the bill's focus is on the quality of the provision for those who receive it. There is multiple evidence of that virtuous circle that I spoke about and that, in order to achieve that, we have to ensure the health, wellbeing and safety of staff.

We might be dancing on the head of a pin here. I do not have a problem with amendments 111 and 112; my concern is with amendment 7, which I believe replicates legislation when it is not necessarily in our power to do so.

George Adam (Paisley) (SNP): I want to talk first about the positives. I can support amendments 111 and 112 and, obviously, amendment 67. However, I have an issue with amendment 7, which is similar to the issue that I raised last week and which the cabinet secretary has raised today. Although we welcome what amendment 7 tries to do, there is a potential problem with competency, as it moves into reserved issues of health and safety. I mentioned the issue last week and I mention it again now, as I have concerns about it. We need to be mindful of that point.

Mike Rumbles: I am surprised that such a red herring has suddenly appeared in the debate. The point about health and safety legislation is a red herring. The cabinet secretary might not be particularly well advised on the issue, because amendment 7 does not trespass on health and safety law; if it did, we could not have what is already in the bill, which refers to the

"wellbeing and safety of service users".

We cannot draw a distinction and say that the safety of service users is not to do with health and safety law but then say that, with the staff, their safety is about health and safety law—it is not.

Sandra White: I think that Mike Rumbles is mixing things up slightly. Obviously, it is about health and wellbeing, but we are talking about legislation that is reserved—that is the point.

Mike Rumbles: I am sorry, but the member misunderstands my point, which is that the cabinet secretary has introduced the bill, which talks about the "safety of service users". If that contravened health and safety legislation, it could not be in the bill.

Sandra White: But I think—

Mike Rumbles: I have given way already on the point. Amendment 7 would include staff—the people who work in the organisation—as well as the people who use the service. Health and safety legislation applies to everybody who uses a facility, whether or not they are members of staff, and the detail of health and safety law is in health and safety legislation. Amendment 7 does not contravene health and safety legislation; if it did, section 6 would be incompetent. I would like to put that red herring to rest.

Sandra White: It is employment law.

George Adam: Exactly.

The Convener: Order, please. Mr Rumbles, are you pressing amendment 7?

Mike Rumbles: I am, indeed, because it will improve the bill dramatically.

The Convener: The question is, that amendment 7 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Briggs, Miles (Lothian) (Con)
Macdonald, Lewis (North East Scotland) (Lab)
Stewart, David (Highlands and Islands) (Lab)
Whittle, Brian (South Scotland) (Con)

Against

Adam, George (Paisley) (SNP)
Doris, Bob (Glasgow Maryhill and Springburn) (SNP)
Harper, Emma (South Scotland) (SNP)
White, Sandra (Glasgow Kelvin) (SNP)

The Convener: The result of the division is: For 4, Against 4, Abstentions 0.

I will use my casting vote in favour of the amendment.

Amendment 7 agreed to.

Amendments 111 and 112 moved—[Mike Rumbles]—and agreed to.

10:45

Amendment 67 moved—[Jeane Freeman]—and agreed to.

Section 6, as amended, agreed to.

After section 6

The Convener: The next group is entitled "Care services: risk management procedure". Amendment 113, in the name of David Stewart, is the only amendment in the group.

David Stewart: Amendment 113 seeks to ensure that care sector providers have in place appropriate processes for the assessment and management of the risk that is associated with staffing levels, as my amendment 107 sought to do for health services in part 2 of the bill.

Having spoken to stakeholders in the sector, including Scottish Care, I have lodged an amendment that is slightly more pared down than amendment 107.

Risk management escalation procedures are there partly to protect staff and employees who will have to find solutions to staffing challenges in real time. The procedures will give them clear guidance on steps that they can take.

Sandra White: Will the member take an intervention?

David Stewart: Can I just finish this and then come back to you?

The Convener: There will be an opportunity to make a contribution once Mr Stewart has finished what he wants to say. I will allow him to take an intervention.

David Stewart: It was suggested that prescribing the steps that must be taken by employees, who are already stretched and hard working, could have the unintended consequence of placing significant responsibilities and bureaucratic burdens on them, which is why amendment 113 places the responsibility on providers to set out risk management procedures that allow flexibility for local contexts.

Risk management procedures must be standard policy, and the amendment seeks to standardise them as much as possible with regard to staffing the sector.

I move amendment 113.

Sandra White: I have consulted and received feedback from various organisations, including the Convention of Scottish Local Authorities—I assume that other members also received a copy of COSLA's feedback—and the social work department in Glasgow. COSLA says that the amendment would put an added burden on care services, particularly smaller ones, and that it would create another "layer of bureaucracy". The feedback was that, if the provision came into force at the same time as the consultation on care services was going on, it might jeopardise any agreement that is made with care services. Further, there was feedback that the amendment does not elaborate on what good care services would be if it was agreed to, and that it would be an additional burden with regard to scrutiny.

I ask David Stewart to take on board the points from COSLA, service users in my constituency in Glasgow and the head of the social work department in Glasgow City Council. I thank him for lodging the amendment, because it is good to have a debate on the issue, but perhaps, as I asked him earlier, he could speak to the cabinet secretary and not press the amendment.

David Stewart: I respect COSLA and all the players in the care sector. I had discussions with a number of them. It is an important amendment, but I am happy to listen to the points that the cabinet secretary might make on it.

Jeane Freeman: I am mindful that the risk escalation procedure that I have proposed for

health settings has been developed through detailed work with representatives of nurses, midwives, medics and allied health professionals. Given its importance, I would be reluctant to apply a similar process to care service providers without working closely with them to ensure that it is proportionate and effective.

I have no issues with the intention of Mr Stewart's amendment 113. However, in terms of its scope, the way in which it is drafted means that it would cover the full range of care providers that fall within section 47(1) of the Public Services Reform (Scotland) Act 2010. That includes childminders, of whom there are more than 5,000 registered in Scotland and who mainly work individually. As worded, amendment 113 would require each childminder to have an escalation policy. I am sure that is not Mr Stewart's intention. I am also sure that the committee would agree that that would be disproportionate.

I ask Mr Stewart not to press amendment 113, so that we can work together to lodge a replacement at stage 3 that is drafted in such a way as to meet his intention but not to be so wide in its scope.

The Convener: I call David Stewart to wind up and press or withdraw his amendment.

David Stewart: In light of the contributions from Sandra White and the cabinet secretary, I am happy to go away and think again about amendment 113, particularly with colleagues in COSLA. I am happy to seek to withdraw my amendment.

Amendment 113, by agreement, withdrawn.

Section 7—Training of staff

The Convener: Amendment 114, in the name of David Stewart, is in a group on its own.

David Stewart: Amendment 114 seeks to ensure that, should the Scottish ministers mandate the use of a staffing tool by care services, they take responsibility for adequately resourcing the training required. The margins of social care providers are tight, and full-time staff numbers are limited. It is important that resources are there to reimburse staff for training that they are obliged to undergo. Similarly, care providers should not be forced to pay for additional training time out of squeezed resources.

As we have seen with the implementation of the living wage for social care workers and overnight carers, new policy and standards from the Scottish Government must be backed up by resources if they are going to make a difference at ground level. The financial memorandum makes reference to funding the training associated with implementing the use of the tools. Amendment 114 merely makes explicit in the bill the obligation on the Scottish ministers to fund the training. That would be important if costs end up higher than was estimated in the financial memorandum.

I move amendment 114.

Sandra White: Once again, I thank David Stewart for his amendment 114, which clarifies some points with regard to funding. Again, I have spoken to COSLA and others, and I am sure that all members have had the letter from COSLA.

COSLA and others ask that funding by commissioners is further considered, as, obviously, the commissioning authorities fund the care sector. COSLA would like to go through the process with commissioners fully.

I ask that the issue is taken into consideration. COSLA is, as always, willing to work with others on this, so I ask that David Stewart does not press amendment 114. The cabinet secretary may have something to add.

Emma Harper: I have a question that David Stewart might be able to answer in his summing up. Does his amendment 114 assume that all training is delivered away from the place of service provision? In my experience, a lot of training is delivered at the bedside, the place of care or the place of residence. Amendment 114 would create a narrow approach that does not enable the diversity of training provision to be widely appreciated.

Jeane Freeman: I appreciate what Mr Stewart is intending to achieve with amendment 114. We all agree that it is entirely right that care staff are properly trained, and I believe that that is recognised in section 7.

Amendment 114, however, is fundamentally flawed, in that the Scottish Government does not directly fund or contract with care service providers. They are private providers, who are contracted by local authorities, integration authorities and health boards. When such providers are contracted and the Scottish Government has a policy approach, as it has for the real living wage, funds are provided to those who contract with care service providers. Should the funds not be passed on, that is a matter between the Scottish Government and those to whom we provide the funds, such as local authorities. We do not have a direct contracting arrangement with care service providers.

We have set out in the financial memorandum our expectation to fund the initial training for using a staffing method. However, I cannot see how the Scottish Government could ensure that everyday training costs for private providers—and for every kind of training, not just training in the use of any new staffing methods—were resourced and

allocated on a year-in, year-out basis. That would be entirely contrary to the existing funding framework and the way that funding for care service providers operates.

On that basis, I ask members not to support amendment 114.

The Convener: I call on David Stewart to wind up and press or withdraw amendment 114.

David Stewart: This is a very important issue. To have fully funded training is essential. On the living wage, I point out that we have seen in practice that, although paying the living wage is Scottish Government policy, some carers are not getting it, so there is clearly a problem in the system. However, I think that we generally all agree on the overall principle. I am happy not to press amendment 114 on the basis that I can come back at stage 3 after perhaps having some further contributions from providers and the Scottish Government.

Amendment 114, by agreement, withdrawn.

Section 7 agreed to.

Section 8—Ministerial guidance on staffing

Amendments 68 to 71 moved—[Jeane Freeman]—and agreed to.

Section 8, as amended, agreed to.

Section 9 agreed to.

Section 10—Functions of SCSWIS in relation to staffing methods

The Convener: The next group of amendments is entitled "Staffing methods for care services: development and review". Amendment 115, in the name of Miles Briggs, is grouped with amendments 116, 72 to 74, 76, 79, 79A and 125.

Miles Briggs: Amendment 115 seeks to amend proposed new section 82A of the Public Services Reform (Scotland) Act 2010, on development of staffing methods. It would change the Care Inspectorate's power to develop and recommend staffing methods for care homes and other care services, as specified by Scottish ministers, to an obligation to do so. Any new tools should be developed and tested in collaboration across the sector: that is what I seek to achieve with amendment 115.

With regard to the bill as a whole, we will need to consider at stage 3 how we can ensure that the bill works for people who are involved in social care.

I will be happy to hear any comments on amendment 115.

I move amendment 115.

Jeane Freeman: I assure members that the Government wants development of a staffing method and tool for care homes for older people, as we state in the policy memorandum. The Care Inspectorate is ready to support that development.

However, I ask members not to support amendment 115. As the approach that is outlined in the bill will be successful only with the co-operation and active participation of the care sector, it must be collaborative. There cannot be an imposed solution, which is what the word "must" in amendment 115 suggests. Collaboration will be crucial to the success of part 3 of the bill. On that basis, I ask Miles Briggs not to press amendment 115.

Members might have gained the impression that the Care Inspectorate has abandoned staffing numbers in care homes. It has, in fact, changed its approach. Rather than relying on historical ratios, it is requiring providers to carry out assessments of individual dependency and is aggregating that information and determining on a regular and dynamic basis what implications it has for staffing profile and numbers. That approach anticipates what will be required as the tools develop, and it should be welcomed.

I have nothing to say on amendment 116.

I turn to my amendments in the group. Section 10 will insert in the Public Services Reform (Scotland) Act 2010 proposed new section 82A, which will empower the Care Inspectorate to develop staffing methods for care services, working together with the persons who are listed in subsection (2) of that proposed new section. Following conversations with relevant stakeholders, we have ensured that amendment 72 will add the Scottish Social Services Council to that list, and that amendment 73 will add every health board.

11:00

Amendment 74 fulfils a request of the Delegated Powers and Law Reform Committee that all guidance in connection with the bill that is issued by Scottish ministers be published. As members are aware, at present there are no tools or staffing methods in use for social care. Amendment 79 will give the Care Inspectorate the power to review and redevelop such tools and methods once they have been developed. In doing so, Social Care and Social Work Improvement Scotland must collaborate, have regard to ministerial guidance and develop staffing tools in the same way as it would if it were developing a new staffing method. Ministers will also be able to direct the Care Inspectorate to redevelop a staffing method, if necessary.

In addition, proposed new section 82BB of the 2010 act in amendment 79 will require the Care Inspectorate, in developing, reviewing and recommending a staffing tool, to consider whether the tool should be multidisciplinary, thereby making provision consistent with regard to the new functions for Healthcare Improvement Scotland.

Amendment 76 is consequential on amendment 79 and will enable ministers to require, through regulations, use of any redeveloped staffing method that is recommended by the Care Inspectorate.

I am happy to support amendment 79A, which has been lodged by Monica Lennon.

Finally, in relation to Alison Johnstone's amendment 125, I ask for clarification on several issues. Is it her intention that this proposed new section 82BC of the 2010 act would be restricted to reporting on supply to care service providers, or is it intended to apply more widely? I do not believe that that is clear from the amendment. If it is intended to apply only to care service providers, who does she have in mind when she refers in the amendment to "medical practitioners"? That would generally be understood to apply only to registered doctors. However, I presume that that is not who Alison Johnstone has in mind in relation to care. I also point out that care homes are private sector services and that Scottish ministers have no locus in employment or recruitment in the private sector. How does Alison Johnstone anticipate her proposal working in practice? I find the lack of clarity on certain points in amendment 125 troubling, and would therefore struggle to accept it, given that, if it were agreed to, it would become part of primary legislation. However, I will be happy to work with Alison Johnstone on an amendment for stage 3, if she is willing. I therefore ask her not to move the amendment.

I ask members to support my amendments in the group.

The Convener: I call Monica Lennon to speak to amendment 79A, and to other amendments in the group.

Monica Lennon: Amendment 79A relates to the powers of the Care Inspectorate. It would ensure that the inspectorate can review not only use of a staffing tool, but whether suppliers are complying with the general duty under section 6 to provide appropriate staffing levels. The purpose of the amendment is to clarify that the remit of the Care Inspectorate to consider staffing levels is not limited by the existence or otherwise of a staffing tool. Current inspections by the Care Inspectorate consider staffing levels already, as policy. Therefore, the amendment should not place any additional burdens or obligations on providers or on the wider social care sector.

I welcome the support of the cabinet secretary for amendment 79A.

The Convener: I welcome Alison Johnstone to the committee and invite her to speak to amendment 125 and other amendments in the group.

Alison Johnstone (Lothian) (Green): Amendment 125 is similar to amendment 90, which concerned health services and was agreed by the committee last week. Amendment 125, too, recognises that workforce and workload are inextricably linked, and aims to ensure that the Government has considered all the relevant information that is available to it when it commissions training places for those for whom it can commission training places and who work in the care sector.

We know that care homes now care for people with far greater and more complex illnesses than they used to, including people with palliative and end-of-life needs. That means that they face increased challenges around caring for people with dementia, frailty, mobility problems and so on, and that there is a need for specialist input on nutrition and hydration.

It is significant that 65 per cent of care home residents are now assessed as requiring nursing care. In 2007, only 10 per cent of care home residents had a physical disability or a chronic illness: the figure is now 38 per cent. In the same period, there has also been a 44 per cent increase in men over the age of 95 living in care homes, and a 15 per cent increase in women over the age of 95 living in care homes.

The care home workforce data tells us that there are staff vacancies in 77 per cent of services. Therefore, my amendment 125 seeks to ensure that we give the same consideration to the care sector—which is clearly facing significant challenges—that we are giving to ensuring that there are appropriate staff in the NHS. If it is helpful, I am open to working with the cabinet secretary to progress a form of words for stage 3 that would meet with everyone's approval.

Emma Harper: I am interested to see how the proposal would develop. In relation to Miles Briggs's amendment 115, I am concerned that the imposition of any tools that are developed and that are nurse focused would not work in a multidisciplinary team approach. Many care homes have nursing staff, but as I mentioned before, residential care homes are people's homes, therefore I am keen to look at collaboration and a multidisciplinary team approach. Currently, NHS nurses go to care homes to provide nursing assessments and care, and they provide services in a nursing capacity, but I am keen not to put anything in the bill that

would in any way restrict the flexibility of the development of team working—multidisciplinary team collaboration—because that will be key when we look at how to develop care in the future.

Sandra White: My concerns are similar to Emma Harper's, and they have already been raised in relation to amendment 115. My big issue is with the change from "may" to "must", which is too prescriptive. I ask Miles Briggs to think about that. I refer again to the feedback from COSLA and others. I put on the record that David Williams, whom I have mentioned, is not only the chief officer of Glasgow city health and social care partnership, but is chair of the health and social care integration chief officers group.

I apologise to Alison Johnstone for raising concerns about her amendment 90, which has been agreed by the committee, but I am pleased that she is looking at the issue in the care sector by way of amendment 125. It needs to be looked at, but I feel that the amendment should not deal only with nursing staff. She mentioned that there are people who need nursing care in care homes: equally, there are people in care homes who do not necessarily need a nurse there all the time. Therefore, we have to consider having flexibility, so I am pleased that Alison Johnstone has said that she will be happy to work with the cabinet secretary, and perhaps the committee, as the bill moves to stage 3, because I think that the matter of amendment 125 needs a wee bit more clarity.

George Adam: I agree with my colleagues, and I will mention additional points that Scottish Care raised, in particular in relation to amendment 115. Scottish Care said that it needs flexibility and an appropriate set of tools, not the imposition of a patient acuity tool. That is interesting because it is Scottish Care that deals with care homes day in and day out. I am summarising points that it made.

Scottish Care also mentioned a failure to understand that care homes are non-clinical environments. That has been misunderstood, even during today's discussions. It is also concerned that amendment 115 would create a tick-box list of clinical issues that pays no regard to new outcomes, which would take away from the belief that we all share, that we need to have person-centric values at the core of everything that we do.

When we look at the issues that have been raised by people in the sector, we can see why amendment 115 presents a difficulty, but it could be worked on between now and stage 3. We have to make sure that there is a joint-working collaborative approach, as Emma Harper said, because the bill is not just about nursing staff—it is about everyone who works in the sector. That is one of the most important parts of the bill.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): Alison Johnstone has made reasonable points. There is something in her amendment 125 and on the need to get the correct staffing mix in care homes. I am inspired to speak about palliative care, which is a particular interest of mine, and the skills mix.

Sometimes, non-nursing staff in care homes are worth their weight in gold. Different care homes have different models for palliative and end-of-life care. I am slightly nervous about being prescriptive about staffing levels in the various disciplines. However, I appreciate the need to capture the skills-mix demands on care homes in order to ensure that suitable professionals are being trained, and for workforce planning purposes.

There is definitely something in Alison Johnston's amendment 125, but maybe not in the form that it is written. The matter is worth exploring further.

The Convener: I invite Miles Briggs to wind up, and to press or seek to withdraw amendment 115.

Miles Briggs: As we head towards stage 3, we must look at what we are trying to achieve. It is important to highlight that COSLA, in its submission, does not support the inclusion of the social care workforce in the bill.

Given what the cabinet secretary has said, I am happy not to press amendment 115 and will lodge something at stage 3.

Amendment 115, by agreement, withdrawn.

Amendment 116 not moved.

The Convener: The next group is entitled "Staffing methods for care services: content and frequency of use". This is the last group of amendments, although we have a number of questions to put thereafter.

Amendment 117, in the name of Miles Briggs, is grouped with amendments 118, 119, 75, 120, 121, 77, 78 and 122.

Miles Briggs: Amendment 117 is about assisting the development of staffing methods for care services and would require the Care Inspectorate to

"develop indicators of clinical quality"

for adult care home services. However, the sector must commit to developing a tool that is not too restrictive and fits with the person-centred outcome-focused approach that the social care sector wants as we move towards integration.

Amendment 122 is about the potential development of a staffing method for nursing homes. As Bob Doris mentioned in relation to workforce planning, further engagement and

collaboration will be needed to build collective support to develop new tools, given that no tools exist. Any new tool that is developed should pay special attention to the environment of various care homes.

I move amendment 117.

Jeane Freeman: I understand the desire that the Care Inspectorate should develop and use indicators of clinical quality for care home services for adults. That would require any tool that is developed in care to be partially or wholly focused on clinical measures. That does not fit with the person-centred, non-medicalised and outcomes-focused approach to social care that is our aspiration through integration. I wonder whether the amendment was intended to refer to "clinical and quality" rather than "clinical quality". If that is Miles Briggs's intention, it might be that we can work further on the amendment to make that clear.

I have committed to the staffing method being developed by the sector. The amendments are too restrictive, as they make assumptions about what the tool would be. I ask the committee not to support amendments 117 and 118.

The existing common staffing method and tools for health were developed with the nursing, midwifery and—in the case of the emergency care tool—medical professions. The people representing those professions were not told that the method or tools that they developed must take particular things into account; it was for them to decide in their professional judgment what was appropriate. If amendment 119 is agreed to, the same opportunities will not have been afforded to the care sector. In those circumstances, it will be difficult for us to argue that the sector is being treated with the equity and respect with which I know we all wish it to be treated to ensure the successful delivery of integrated health and social care.

11:15

In seeking to change the wording in proposed new section 82A(5) of the 2010 act from "may" to "must", amendment 119 would prejudice what would have to be in any staffing method that might be developed. As a result, it would contradict the reassurances that I have given the sector that any staffing methods that are developed for care settings would be developed by the sector, for the sector. Although I take the point that, in the early stages, COSLA did not wish social care to be covered in the bill, we have had significant discussions, important assurances have been given and COSLA has been willing to reconsider its view. Given its experience of and its role in delivering social care, we respect its judgment as well as that of the care sector, and it is now supportive of our approach and is working with us on developing this tool with the Care Inspectorate. Should amendment 119 be moved and agreed to, I will lodge an amendment at stage 3 to ensure flexibility in these provisions with regard to the staffing method.

As I mentioned previously in relation to amendments 94 and 95, I am concerned by the lack of clarity on what is meant by "professional and improvement organisations" in amendment 120. As with amendments 94 and 95, I would prefer to include something in guidance that allowed for greater clarity and flexibility.

Written evidence to the committee from MND Scotland and others highlighted the position of carers and their families and emphasised the importance of their voice. Amendment 75 seeks to clarify that taking their comments into account on the general appropriate staffing duty is one of the elements that may be included in any staffing method that is developed by the Care Inspectorate under proposed new section 82A of the 2010 act.

Amendment 121, in the name of David Stewart, seeks to require that ministers ensure that adequate resources are allocated to the Care Inspectorate to enable it to develop staffing methods for care services. The financial memorandum to the bill already clearly sets out the financial support for the Care Inspectorate. I am of the view that this is a matter not for primary legislation but for the normal executive duties of Government, and that it is for scrutiny by members from across the Parliament as part of the budget process, not for scrutiny by the courts, which is what a statutory duty could lead us to. On that basis, I ask David Stewart not to move amendment 121.

Amendments 77 and 78, which relate to the frequency of use of any staffing methods for care services that are prescribed through regulations that are made under proposed new section 82B of the 2010 act, cover similar ground to previous amendments 18 and 22 on the frequency of use of the common staffing method in the NHS. Proposed new section 82B provides the Scottish ministers with a power to prescribe the use of a staffing method that has been developed by the Care Inspectorate, with section 82B(2)(c) setting out that the regulations may specify the frequency of use of staffing level tools. It does not allow ministers to prescribe the frequency of use of a staffing method as a whole.

Although a staffing method and tool for care settings has yet to be developed, the expectation is that a method and tool would not be run separately. That is reflected in the requirement in proposed new section 82A(4) for any staffing method that is developed by the Care Inspectorate to include the use of staffing level tools. It is

therefore the Scottish Government's intention that the staffing method and not just the tools be used at a specified frequency. Accordingly, amendment 78 seeks to remove proposed new section 82B(2)(c), while amendment 77 sets out a replacement power for the Scottish ministers to prescribe in regulations the frequency at which the staffing method as a whole, not just the tools, is to be used. As with the health provisions, as well as providing clarity that Scottish ministers can specify the frequency with which a staffing method for care services, and not just the tools, should be used, these amendments also remove any possible suggestion that a tool can be used separately from a staffing method or that a staffing method can be followed without using a tool.

Amendment 122 is, I believe, based on a proposal from the RCN, which is keen for the views of a senior nurse to be sought if a staffing method and tool is developed for care homes for adults. As I have already said, a tool or method has yet to be developed for that sector, and the amendment makes assumptions about the aspects of care that will be covered by a staffing method. It is unlikely to be supported by the sector, as it is too restrictive. I ask the committee to reject amendment 122.

I ask the members of the committee to support the amendments in my name.

David Stewart: Amendment 121, in my name, is similar to amendment 114, which we discussed earlier, and concerns the resourcing of training in the use of new staffing tools. Amendment 121 places an obligation on the Scottish Government to fully resource and fund the development of tools for the social care sector, should it be considered that they are required. In the financial memorandum, there is reference to the cost of developing the tools being £200,000 per annum over three years, including contributions to the development from the sector. It is acknowledged that development of tools for the sector could be complicated and that it is possible that the time and cost required could be more than is estimated. Should that be the case, organisations in the sector should be appropriately reimbursed, and amendment 121 merely makes the obligation on the Scottish ministers explicit in the bill.

Sandra White: I will speak to some of the amendments in the group. I have looked at this and spoken about it before, and the evidence that I have been given is that amendment 117, in the name of Miles Briggs, would be restrictive, because it says that the Care Inspectorate

"must develop indicators of clinical quality"

for adults. I believe that focusing on clinical measures does not fit in with the person-centred approach to delivering health and social care that, as the debates and contributions have indicated, underpins integration. Amendment 118 also looks at that possibility. People should be spoken to and worked with collaboratively. I therefore cannot support amendments 117 and 118.

David Stewart has explained that amendment 121 is similar to amendment 114, to which I also spoke, and the cabinet secretary also mentioned that the Scottish Government does not give money to care homes. Some of them are private and support has to go through commissioning by local authorities. I therefore have reservations about amendment 121 that are similar to those that I had about amendment 114, which David Stewart withdrew.

Amendment 122 is the most substantive of the amendments. It requires nursing homes to have a staffing pool and to seek the views of a registered nurse. I share the cabinet secretary's views on that. Multidisciplinary staffing teams are used in care homes. We heard evidence that there are various levels of ability. We also have older nurses who have more experience in multidisciplinary nursing. Health and Social Care Scotland rejects

"singling out one element of the multi-disciplinary staffing team for professional treatment. In the spirit of integration, we would hope that tools would be developed in a collaborative way."

We need a multidisciplinary and integrated perspective and a collective approach to tools that would work in that context. The restrictiveness of amendment 122 does not lend itself to that approach. I would like to discuss the issue further with Miles Briggs and others.

Bob Doris: I second David Stewart on the subject of making sure that there are adequate resources and funds available for training across the sector, which is a very important aim. As someone who is not a permanent member of the committee, I am wondering whether the wider issue that we are trying to get at is ensuring consistency in the quality of the training opportunities that are delivered across the sector, irrespective of whether a service is provided by a local authority or is procured through the third sector. If that is the desired aim, perhaps amendment 121 is not the way to achieve it, although it raises an important issue. I will listen to the rest of the debate carefully.

Emma Harper: I will respond on amendment 122. I find it interesting that we might require registered nurses who have no affiliation with a care home to come in and decide how a staffing method would be used or implemented. As Bob Doris said in making the point on palliative care, there are many experienced people across a wide range of care home settings who are able to provide that support and care.

Some of the care homes in my area have only eight beds, while others have 50-odd beds. There is a wide variety of care delivery and we should not be prescriptive or inflexible given that we are trying to collaborate in health and social care integration, taking a multidisciplinary team approach. In my area, great work is being done by paramedics, too.

The Convener: I call Miles Harper to wind up. [*Laughter.*]

Miles Briggs: That is a first.

Emma Harper: What a combo!

The Convener: I am sorry—I meant Miles Briggs. It has been a long morning.

Miles Briggs: Thank you, convener—for trying to put me off.

I have heard the points that have been made on the amendments in my name. Amendment 118 was looking to where there is a lack of consistent data on the quality of care. We should be collaborating with the sector so that we can move that forward at stage 3. The polling of professionals is important and I have had conversations with the cabinet secretary on that point. It is another area where we can make progress at stage 3.

Amendment 121, in the name of David Stewart, is important, as are the points that it raises. When the bill is passed, there will be costs that the sector will have to meet. It is not clear how that will be done in relation to either private or publicly funded care home places.

There is an opportunity at stage 3 to bring all those aspects together and I hope that we can achieve that on a cross-party basis.

Amendment 117, by agreement, withdrawn.

Amendment 118 not moved.

Amendments 72 to 74 moved—[Jeane Freeman]—and agreed to.

Amendment 119 not moved.

Amendment 75 moved—[Jeane Freeman]—and agreed to.

Miles Briggs: I will not move amendment 120 on the understanding that we will return to the issue at stage 3.

Amendment 120 not moved.

The Convener: Amendment 121 has already been debated with amendment 117.

David Stewart: I agree with the points that were made by Miles Briggs and, in order to have an improved amendment at stage 3, I will not move amendment 121 now.

Amendment 121 not moved.

11:30

Amendments 76 to 78 moved—[Jeane Freeman]—and agreed to.

Miles Briggs: On the understanding that we will have another opportunity to improve matters at stage 3, I will not move amendment 122.

Amendment 122 not moved.

Amendment 79 moved—[Jeane Freeman].

Amendment 79A moved—[Monica Lennon]—and agreed to.

Amendment 79, as amended, agreed to.

Alison Johnstone: I believe that, in a truly integrated health and care sector, we should not commission places solely for one part of that sector. I believe that clinical care is often essential to the person-centred care that we all seek, so I do not think that it is an either/or situation. Given what colleagues and the cabinet secretary have said, I will not move amendment 125, but I look forward to working with colleagues on an amendment that can be lodged at stage 3.

Amendment 125 not moved.

Section 10, as amended, agreed to.

Sections 11 to 14 agreed to.

Long title agreed to.

The Convener: Thank you very much, colleagues. That ends stage 2 consideration of the bill. I thank the cabinet secretary and her officials, as well as the members who joined us for that item.

We will consider the rest of our business in private.

11:32

Meeting continued in private until 11:40.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba