HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 10 May 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
12th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING MEMBER ALSO ATTENDED:

Trish Godman (West Renfrewshire) (Lab)

WITNESSES

John Aldridge (Scottish Executive Health Department)
Patrick Browne (Scottish Retail Consortium)
Susan Deacon (Minister for Health and Community Care)
Roger Hammons (Scottish Retail Consortium)
Jennifer Howie (Food Standards Agency in Scotland)
Bob Jamie (Scottish Retail Consortium)
Steve Lindsay (Food Standards Agency in Scotland)
Lydia Wilkie (Food Standards Agency in Scotland)

CLERK TEAM LEADER

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 10 May 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:40*]

Budget Process

The Convener (Mrs Margaret Smith): Good morning everybody. Welcome to this meeting of the Health and Community Care Committee, at which we will continue to examine the budget. We welcome today the Minister for Health and Community Care, Susan Deacon. With the minister is John Aldridge—a glutton for punishment if ever I saw one. If there are any questions that the minister feels technically challenged by, John will be able to sweep in with the answers.

If I may, I will set out the purpose of inviting the minister today. Our role with regard to the finance bill is to examine the health and community care budget for 2001-02. The Finance Committee has set all the committees the fairly onerous task of answering certain questions. As we see it, we have three purposes. First, in his foreword to "Investing in You", the First Minister said that the budget process was not just about committees of the Parliament looking at the budget, but about the wider community and the man and woman in the street looking at it.

First, we see ourselves as the representatives of the man and woman in the street. We are looking at the document and asking, "Does this make any sense? What questions does it leave unanswered? How transparent would the health section be if you did not know anything about the health service? Could you read it and say that all was clear?" Obviously, there is a long way to go on all sides. We regard this as year one of an evolutionary process, in which we are examining the budget in detail. I hope that some of our comments on how we should go about the budget in future years will be taken on board by the Finance Committee and the health department.

Secondly, we have specific questions that the Finance Committee is interested in and which we must get through. From time to time, I may sweep up questions to ensure that we have an answer to give to the Finance Committee, rather than having to say, "Oh, we forgot to ask."

Thirdly, we aim to get a sense of how we can move from a single-year budget snapshot to the wider picture of what the Executive sees as the way forward for health, and what we can contribute to that. That is important to the committee. Two weeks ago, we discussed the long-term picture for health in Scotland and tried to see ways in which we could be radical about it. We touched on the Finnish model, although we know that nothing in life is ever perfect, and we are waiting for a report to see exactly what Finland did. However, this process is not just about looking at one year's budget: it is about seeing it in context. I am afraid that that will take us off into the realms of more general discussion on the back of people's questions.

All members want to ask questions. I am sure that there will be lots of supplementaries as we go along. My understanding is that we will go straight into questions. Thank you once again for coming along, minister. One point that I did not mention was to wish you a happy anniversary, as you are coming up to one year in the job. We are all heading for one year in the job as well, and I hope that you will get a sense from our questions of the committee's thinking on the long-term future of health services and health care. Malcolm Chisholm will ask the first question.

09:45

Malcolm Chisholm (Edinburgh North and Leith) (Lab): Thank you for letting me in first. I have to leave at 10 o'clock for an interview; I am not walking out in protest, or anything like that.

One of the issues that we keep coming back to is the enormous size—which we are all pleased about—of the hospital and community health services block, which will have risen to about £4 billion by the time the new money is added in. One of the fundamental problems that we have is that that funding is not broken up into bits, although we understand that the main reason for that is health board decisions.

One figure that is shown in "Investing in You" is the one for capital expenditure in table 4.4, so I will kick off with a couple of questions on that. We are told under that table that trusts' capital expenditure is not part of the figure. Would it be possible in future years to have a separate line that tells us how much is being spent overall on capital expenditure? Last week, we heard that the figure is increasing quite a lot this year, so it would be in your interests to write that down so that everybody knew about it.

My second question refers to the objectives that are listed on page 53, such as the hospital building programme, walk-in-walk-out hospitals and one-stop clinics, all of which will have capital

expenditure attached to them. We would be interested to know whether you have any estimates of the amount of money that will be needed for those.

The Minister for Health and Community Care (Susan Deacon): Thank you for a wide-ranging and challenging question. I am glad you told me that your early departure is not something that I should take personally.

Malcolm Chisholm raised a number of important points, and I will try to work through them. First, there is no question in anyone's mind but that we need to work continually to develop and improve the presentation of data. Of course, "Investing in You" is not by any means the only document in which financial and other health service data are published, but during consideration of the budget process it has been recognised by a number of committees that we can improve and develop the presentation. I am more than happy to look at some of the points that have been raised by the Health and Community Care Committee.

Malcolm touched on another important point, which is the breakdown between local and national, in terms of figures but also of decision-making processes. I am sure that that will come up in other parts of the discussion today. As has been said, rightly, one of the reasons for presenting much of the HCHS expenditure in block is because it is allocated to health boards for decisions to be taken at a local level. There is a balance to be struck between both the reporting of decisions that are taken at a local level, and the taking of decisions, in terms of how much is decided nationally and how much is decided locally. That issue is being considered at the moment.

That leads me to capital, which has been a matter for some discussion over recent weeks and is a good example of where we are trying to get the balance right. On the one hand, we are trying to ensure that trusts have discretion to reach decisions about local needs, because neither I, nor you, nor Parliament could sit here in Edinburgh and decide where every X-ray machine and scanner is required across Scotland. Trusts have to be able to take such decisions. At the same time, we recognise that various forms of capital investment have to be planned nationally. Cancer equipment and the current investment programme in linear accelerators form one example of where we are trying to plan nationally, while working in co-operation with local boards and trusts.

Walk-in-walk-out hospitals—otherwise known as ambulatory care units—can take different forms, and I anticipate that they will take different forms in different parts of the country as they evolve. It is difficult to indicate the cost implications of developing that form of care, because health providers in many parts of the country are reviewing their acute services provision and—through public and wide-ranging consultation processes—discussing with local communities how best service needs can be met in future. Glasgow is the biggest and most visible example of such an exercise, but it is by no means the only one. Ambulatory care is one of the options under consideration.

It will be possible for us to give a specific answer to Malcolm Chisholm's question only when the local review process has progressed further and the boards have produced more refined and developed proposals on the scale and nature of the new facilities that they want to provide. I hope that I have covered the issues that Malcolm Chisholm raised.

Malcolm Chisholm: That was useful. You are saying that it is impossible to cost some of the objectives at the moment. Is that also true of the one-stop clinics? Presumably we have a more accurate idea of what the hospital-building programme will cost.

Susan Deacon: One-stop clinics can take a number of different forms, some of which will require more investment than others. The point of one-stop clinics is to avoid a patient having to make numerous out-patient visits to different parts of the system to get diagnostic tests and treatment; that happens all too often. Frequently, patients have to wait many months before treatment is administered. One-stop clinics are designed to bring diagnosis and treatment together around particular conditions—an example that is often cited is breast clinics.

The amount of investment in bricks and mortar that is required will vary, depending on what facilities a hospital has available and what equipment it has in place. Many of the changes that are required to deliver one-stop care relate to staff organisation and working practices. There is no obvious figure that can be assigned to that.

We are committed to developing this form of delivering treatment and care, because we think that it is right and that it is better for the patient. We have linked the £60 million allocation that we made to the service last week, as part of the additional allocation from the chancellor's budget in March, to four priority areas that we want boards and trusts to focus on. Those include reducing waiting times and, as part of that, examining different ways of delivering services. As part of our modernisation and development plans for the national health service in Scotland, we have put in place a series of measures to enable us to work with local boards and trusts on examining how, for example, one-stop clinics can be developed more effectively at a local level, and

how that can be matched in our national investment strategies. That takes me back to my earlier point about getting the correct balance between national and local priorities.

The costs of the hospital-building programme are easier to identify, because they relate to specific building projects. John Aldridge will correct me if I am wrong, but I believe that the overall cost of the programme is £480 million.

John Aldridge (Scottish Executive Health Department): That is the total cost of the programme.

The Convener: Dorothy-Grace Elder would like to pick up on some of the points that you made about consultation. Margaret Jamieson will then ask about the central-local relationship that you touched on. However, Mary Scanlon has a supplementary to Malcolm Chisholm's question.

Mary Scanlon (Highlands and Islands) (Con): Last week I asked Mr Aldridge about the issue that Malcolm raised—the cost of the new generation of walk-in-walk-out hospitals. He said that

"the capital cost has tended to be around the £20 million mark"

and that

"The capital expenditure would come from the capital programme".—[*Official Report*, *Health and Community Care Committee*, 3 May 2000; c 840.]

Are we saying that there is no new money to meet the targets that are set out in the document for the one-stop clinics and the walk-in-walk-out hospitals, and that this represents a shift of resources within the existing budget?

At our previous meeting we asked whether some of the projects might come under the private finance initiative. Are we talking about new hospitals, or are we simply talking about re-jigging services within hospitals? If people are to receive diagnosis and treatment on the same day, will not that mean an enormous increase in the equipment budget?

The Convener: Mary, if that was a small supplementary, will you tell me when you are going to ask a big question?

Mary Scanlon: It is all related.

Susan Deacon: Eight new hospitals are being developed. Significant new money is going into the health budget—a total of almost £0.5 billion extra in the current year. The new forms of treatment and care that we have discussed—walk-in-walk-out hospitals and ambulatory care facilities—will in some cases require elements of new build and significant adaptation of existing facilities. The detail of that will be worked out in the discussion processes that are currently under way in different parts of the country, which are seeking to establish how provision can best be made.

Additional investment is one important element in delivering new forms of treatment and care, but changes to ways of working are every bit as crucial. Convener, I was pleased that you were able to represent the committee on our visit earlier this week to the ambulatory care and diagnostic centre in Middlesex. That is one example of how that form of care has been developed and has delivered significant benefits to patients, with reductions in waiting times and hospital stays. In Middlesex, the establishment of the centre combined a major new building project with significant changes to working practices. Those are the two elements that will be required in future, if we are to develop those new forms of care. I am determined that we should do that.

Mary Scanlon: What about the cost of new equipment for the one-stop clinics?

Susan Deacon: As I indicated, equipment is one of the areas that we have identified as important. In the past, it was for trusts to determine how their capital allocations were used. That has meant that non-recurrent funds have sometimes been used for recurrent spending, and that money that we might have presumed would be used for equipment has been used for other capital spending. I do not want us to become wholly directive from the centre or to be overly prescriptive with local trusts. However, I believe that we must work more closely with boards and trusts to ensure that the under-capitalisation of equipment that has taken place over two decades is reversed. We are starting to do that.

When I spoke to the NHS conference last week, I indicated that we would be looking to use some of the additional resources that are going into the health budget in the current year on equipment. Investment in equipment is an important way of taking forward the kind of improvements that we seek.

The Convener: I ask Dorothy-Grace Elder and Margaret Jamieson to pick up on some of the issues relating to the decision-making process.

10:00

Dorothy-Grace Elder (Glasgow) (SNP): Minister, you know better than I that we do not have an ACAD in Scotland—it is a new beast to us. There is only one in England. Do you agree that we need more information on ACADs? As you indicated earlier, there can be different types of ACAD, depending on the geography of their situation.

My next point is about consultation, which is relevant to ACADs and to many other things. Will you give us rough guidelines on how long

consultation should last? As you said, decisions must be made at a local level. All over Scotland, major decisions are pending—for example, in Glasgow, there is only a three-month public consultation on the future of almost every major hospital, involving decisions such as whether the Queen Mother's maternity hospital and the sick children's hospital should move to the Southern general hospital. We are asking only for a six-month consultation period on such a massive issue to keep the public fully informed.

The Convener: Minister, the question is about guidelines on public consultations and where they fit in to the decision-making process. Although Dorothy-Grace Elder used Glasgow as an example, the committee does not wish to focus on any particular locality at the moment.

Susan Deacon: Consultation and public information are crucial. Although none of us has absolutely correct answers on how to proceed on the matter, the Executive, the committee and particularly the health service have all been working hard to develop new forms of communicating with and engaging the public.

It was always going to be the case—rightly, in my view—that, post-devolution, the NHS would be expected to engage more fully with the public on service provision and changes to the configuration of services. Furthermore, it was always going to be the case that, with the abolition of the internal market and a change to a partner-based NHS, there would be more of an opportunity for—and higher expectation of—improved communication and consultation. As a result, I agree with the committee that we must work on this area.

I agree with the three elements of public involvement—informing, engaging and consulting—that Richard Simpson identified in his report on Stobhill hospital. The existing guidelines are unsatisfactory and are a product of a bygone era; furthermore, the existing statutory guidance for statutory consultation within the NHS is both prescriptive and limited, and lays down the three-month statutory consultation period for major service reconfigurations. Such statutory provision might be necessary but is not sufficient. As the committee report has identified, the process of public involvement does not just have a beginning, a middle and an end over that three-month period; it must be an on-going process of engagement with the public.

As for progressing the issue, we should again remember that this project is an on-going process, and does not have a clear beginning, middle and end. I have indicated that I want to review the existing statutory guidance, which will obviously take some time, and I fully expect the committee to contribute to that process. However, as I said, although statutory provision is necessary, it is not sufficient. We must develop more comprehensive guidance for the service—with accompanying training and support—to allow health service managers and clinicians to embark more effectively on the process of public involvement and discussion. Last week, I announced the establishment of a new modernisation board, which will be a joint health department and NHS body, to develop a whole range of reforms, changes and improvements that are currently happening in the NHS. The board will consider consultation, communication and accountability as well as broader questions of governance, and I will welcome the committee's input to that.

Dorothy-Grace Elder: Will you consider Unison's idea of a six-month consultation period for major projects?

Susan Deacon: We will consider that matter when we review the statutory guidance. I do not want to put a figure on the consultation period because that would imply that the NHS consults only during a statutory consultation procedure, whereas we are all striving for a health service that engages with the public 52 weeks a year. Such guidance will take time to develop, and NHS managers, chairs and non-executives are facing great demands as we move in that direction. However, we are all committed to going in that direction.

The Convener: We welcome the minister's comment that, although there is much to do, we are all starting from the premise that we have to shake up existing types of public consultation and take into account the points about staff training that Richard Simpson mentioned in his report on Stobhill hospital. It is not easy to consult the public, so the department has a part to play in developing guidance—statutory and otherwise—and training.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I want to follow on from Dorothy-Grace Elder's comments. There is a difficulty with the public's perception of consultation. I hope that Dorothy-Grace made a mistake when she talked about health service buildings rather than types of care. As the minister pointed out when she talked about ambulatory care units, building types are changing significantly.

The problem that some communities have with the consultation process is that the process begins halfway down the road instead of with the health service asking the public for their thoughts on how an idea can be developed to meet prospective patients' aspirations and how that, for example, ties in with new technology. How do you monitor that through the budgetary process, minister?

Redesigned health care initiatives might have reduced costs in some areas, but they might have

increased them in others. How do you balance that with the available episode of care and translate that as best practice into other areas of the service that are totally resistant to change?

Susan Deacon: I will divide those questions into two parts—and if there is a third or fourth part, I am sure Margaret Jamieson will tell me. She raises two issues: first, how to monitor performance measurement and performance-managing what goes on in the service and, secondly, how to spread best practice.

On the question of monitoring and performance-managing, we will continue to go through a period of changing relationships between the Government—and the health department—and the service. It is worth remembering that the new structure was established only a year ago and that under internal market arrangements individual local trusts were measured particularly on financial outcomes and were expected to determine for themselves at a local level how to develop much wider areas of practice.

Although we still have to performance-manage financial outcomes, Margaret Jamieson's point about the need to monitor wider aspects of practice is important. That is already happening under the new accountability review arrangements that were introduced last year with the new structure.

We are making further changes to the forthcoming accountability reviews so that boards and trusts, representing the health system of an area rather than as individual entities, will increasingly come together with the department to discuss how the system is operating—precisely the sort of issues Margaret Jamieson raises about how patients are being involved and how consultation processes are being taken forward and so on. As well as the traditional quantitative measures, we want to build such qualitative measures into the performance management system. We hope to continue to improve and develop that in the months ahead.

The second point is about spreading best practice—important whether it is in relation to consultation and involvement, to clinical practice or to new forms of design and delivery of services. There are excellent examples of innovation in all those areas in Scotland, but practice is by no means universally high. We are putting in place a range of measures, from websites and newsletters to seminars and network groups—a series of mechanisms that we hope will greatly facilitate the sharing and dissemination of best practice.

We are working towards defining more clearly what we regard to be best practice in a number of areas so that when, for example—as we have done in the past week—we put additional investment into the system, there will be times when we ask for that to be linked to improvements in particular areas. Under the new arrangements for senior managers' pay, for example, we will measure managers against the improvements they have made in patient care. I stress that it is a continuum; it is an evolutionary process, but those are examples of what is being put in place.

In the NHS conference that I mentioned earlier, I was struck that the sharing of best practice came up time and time again. The chief medical officer gave a particularly interesting presentation on the subject of the sharing of good clinical practice. It is easier to say than to do, but it is one of the main keys to improvement in the period ahead.

Irene Oldfather (Cunninghame South) (Lab): I appreciate what the minister says about best practice, but she will be aware that there are already two issues on which the committee feels there has been inadequate consultation. Does she feel that appropriate mechanisms are in place to allow redress for citizens and for sanctions against health boards that have not consulted properly?

The Convener: We have covered consultation quite well. We can ask the minister to take on board your point about what sanctions and redress are available when she considers the review.

Mr Duncan Hamilton (Highlands and Islands) (SNP): You were saying—and I think we all agree—that engaging and consulting is ultimately predicated on people having the correct information. I am sure that Mr Aldridge will have told you about our interesting exchange on the private finance initiative last week. On page 53, there is an objective that has been trumpeted many times and that you have mentioned again this morning:

"We will deliver the biggest hospital building programme in Scotland".

I do not think we received an answer to our question on that last week. Information should be central to the consultation, so can you suggest why a citizen reading the document would think, "That's a tremendous idea" but would not know how much it would cost or whether it was good value for money?

Susan Deacon: I have to challenge the premise upon which the question is based. It is correct that the level of detailed financial information to which Duncan Hamilton refers is not published in the document. That takes us back to how much detail ought to be published in the document. However, financial information regarding the costs of PFI or public-private partnership projects is increasingly available in the public domain. Indeed, one of the changes that was made to the arrangements governing PFI and PPP over the past couple of years was precisely to ensure that business plans

were published, so that that information could be seen by the public.

There is always more that can be done, not least to convert often very detailed financial information into a form that is more accessible and meaningful to the public. There are questions about how much goes into the document, but in no sense is there outright resistance to the publication of financial information on these areas; in fact, it is quite the opposite.

Mr Hamilton: Are you saying that the breakdown of PFI projects by total cost and by component cost is held centrally?

10:15

Susan Deacon: Local PFI projects are required to produce detailed business plans, which are made publicly available. I am not entirely clear what you mean by available centrally.

Mr Hamilton: I think I am right in saying that the Scottish Executive has access to every aspect of a PFI project through information that is held centrally by the management executive or by the Executive. Any PFI project would broadly show what PFI means for the health service in Scotland. Is it correct that PFI could be considered in terms of the cost of each component?

Susan Deacon: The Parliament certainly has access to detailed information about individual PFI projects—as, indeed, increasingly, does the public, under changes that have been made.

Mr Hamilton: So which aspects of projects are not available at this point? If I was—well, I am—a normal citizen. [MEMBERS: "Normal?"] I will leave aside the false modesty. If that information is available, how do people access it?

Susan Deacon: I missed the last part of what you said.

Mr Hamilton: Where can a member of the public access that information?

Susan Deacon: Forgive me for coming back for further clarification, but I am interested to know what level of information we are talking about here.

Mr Hamilton: Perhaps I can help the minister. Last week, I asked Mr Aldridge about the continuing analysis of PFI projects in Scotland. He said that he knows what the total contract cost is. I asked for the various components and he replied that that depended on the contract, so in fact there is no overall assessment of the various components of every PFI project in Scotland, including your eight new hospitals. Is that correct?

My point is, how do people get involved in the consultation process if they have access to only part of the information? I hear what you are saying about the moves in that direction, but what more is planned and how can we make this more accessible?

Susan Deacon: What was both unhelpful and unacceptable in the development of PFI schemes was that, up until a couple of years ago, little information was available in the public domain. I hope Duncan Hamilton and I can agree that the fact that there are now far higher standards of requirement for publication is important. Much of that information is available at a local level, where trusts are taking forward PFI projects. As was discussed with the director of finance, Mr Aldridge, at the meeting last week, business plans are submitted to the department—information that the department has access to and which is in the public domain.

We are talking about detailed and technical financial information. Our concern is to enable the public to have access to greater and better information about how health services are being funded and about how decisions are being taken, but the financial information to which I have just referred is not the same as that which is required to be put into the public domain.

If I may give a practical example of that—

Mr Hamilton: I will come back on that, because it is central. The information exists, but some of it might be held locally and some of it might be held by central Government. Some information is available to you and some is deemed to be acceptable for release to the public. If the document is to mean anything, surely all the information should be available to everyone.

Susan Deacon: What you have just said is not the same as what I said: it is not a question of different levels of information being available to the public. What I said was about the form in which information is made available. A member of the public can access the details of a public-private partnership project, but that is not the same as proactively converting that information into a form that can be embraced by, for example, the Glasgow acute services review.

This is a much wider question than the private finance initiative. It is a question of how financial data are made open and available—we have made a lot of progress in that area—so that the public do not have to search them out and spend a lot of time trying to interpret them. We are converting those data into a form that makes them accessible and genuinely informative.

Mr Hamilton: Will all the details about those eight new hospitals be available in the public domain? If they will, why is there nothing in the document that would tell a member of the public how to find out that information?

The Convener: I would like to add something to that, Duncan. I understand that the department approves all PFI projects, so it should be possible to have some summary information in the document to indicate what the hospital costs, the public capital involvement and the PFI element will be. If there is a hospital capital spend of £480 million, surely it should be possible to say what proportion of that might be PFI.

One could go on and on and make that section of the document enormous, or one could asterisk next to it a bibliography of other areas to which people could go to get information. That way, there could be an element of information about PFI rather than it being buried completely in the other figures. At the same time, people could be made aware that, if they want further information about those projects, there are other places where they can get it. Is there anything to stop the department doing that in a document such as this?

Susan Deacon: That is an excellent summary of some of the issues that have been touched on in our discussion. I have no difficulty whatever with the general principles that have been outlined. We must examine how different levels of information can be reported in appropriate ways to the people to whom we make data available. There is no point in simply giving screeds of financial information, on PPP or on anything else, if—

Dorothy-Grace Elder: Maybe there is, minister.

Susan Deacon: As the convener said, a document the size of "Investing in You" could easily be filled with health data alone. If we are serious about engaging the public, we need a level of information that can be put into this document and other levels of information that can be circulated at local level. There should also be indications as to where the core, detailed information is available if people want to access it. I have no difficulty with that principle. If the committee has specific suggestions as to how that could be translated into practice, I would be delighted to consider them.

Dr Richard Simpson (Ochil) (Lab): I welcome what you say—that there should be a trail, of which this document is the header. That is absolutely right.

It is important that, in future years, the committee understands the relationship between the long-term costs of PFI and revenue. The public need to see that we are deciding to commit funds for the future on an annual basis. That is linked with the vexed question of capital charges, which is something the committee has found hard to follow. There must be some way of dividing the information into what is purely publicly funded, with the costs being part of the public sector borrowing requirement and taken on the nail, and what is funded by PFI and will be taken on revenue future funding. That division would be helpful.

Susan Deacon: I am happy to take those points on board.

Dorothy-Grace Elder: We just want to see in straightforward terms where the dangers and possible benefits lie in those deals. We want to ascertain whether it is true that hospitals are being influenced through PFI deals to cut staff. We just want the books properly opened in an understandable way. You say that those eight hospitals are costing £X million; we cannot see why we cannot be told the basics of those deals and whether the public are getting a good deal in the long run. Twenty years ahead, the public will not own those hospitals, so we naturally need to know much more about those private deals than we might have done about a straightforward, public NHS deal.

Susan Deacon: Those data are in the published business cases.

Mr Hamilton: You seem to be suggesting that all the information that people could ever want access to is currently available, but that cannot be true. Are you giving the commitment today that, for the eight hospitals in question, the books will be thrown open and we will be able to access whatever information we want?

What happened in the intervening week? Last week, when I asked a similar question, I was told that there was not a breakdown of the costs. Mr Aldridge said:

"We will have the costs that the health service will have to meet in payments per year to service the PFI agreement and the total cost, but those will not be differentiated."—[*Official Report, Health and Community Care Committee*, 3 May 2000; c 827.]

In other words, the costs will not be broken down further. You now seem to be suggesting that that information is available to people. Which is the case?

Susan Deacon: I am happy to give a more detailed submission to the committee, stating exactly what information is available and where. Perhaps you can use that as the basis for further comments on the sort of information you think should be available at other levels. I sense that we are covering ground that we may already have touched on.

The Convener: Duncan Hamilton is articulating a genuinely held concern of the committee, not only about PFI projects but about the structure of the document. It is quite difficult, if not impossible, for elements of health funding, to start at the beginning and work one's way through to see where the money goes. Bearing in mind the fact

that we want to cover a number of other areas, we will ask you to put in writing the answer to Duncan's question. If he or other members have supplementary questions on the issue, they should e-mail them to the clerk today.

Mr Hamilton: Can we include my question about the eight hospitals? I would like the minister to outline exactly what information about those contracts is available and what is not, and to justify why some of the information is not available.

The Convener: Ultimately, we want a statement from the department about future public involvement in the decision-making process and about how the public will get information. Lessons must be learnt from what has happened in the past, but we should now focus on going forward.

Going back to a wider area of questioning, the Finance Committee has asked us to establish, by studying "Investing in You", that the department's aims, objectives and key priorities will be achieved. That includes the department's five strategic aims: improving health, developing primary care, developing community care, reshaping hospital services and tackling inequalities. The three clinical priority areas and children are also crucial. Do you think that the document as it stands is clear and that members of this committee can see from it that the department and Executive will achieve their aims and objectives on, for example, mental health?

10:30

Susan Deacon: The document is a step in the right direction, in so far as it aims to link budget information to the stated programme for government commitments—commitments that reflect the actions required to make progress on the five key areas that you mentioned, convener. The document could be greatly refined and improved to make the connections for which we all strive.

I would enter one caveat: a budget process, by its nature, focuses on financial inputs. I am concerned that we should get better at measuring the outputs of health services and, ultimately, the outcomes in health gains. Although I share the view of some committee members that we need to improve the reporting procedure and the data on the budget and financial inputs that are put into the public domain, I hope that we will not pay undue attention to financial inputs when the concern that we all have is to ensure that those inputs deliver the best results.

The Convener: Earlier, you spoke about the ways in which we can go about getting some sort of qualitative assessment of health gain, instead of just considering the amount of money spent, the number of people in beds, and so on.

Kay Ullrich (West of Scotland) (SNP): I want to concentrate mainly on community care. Given that mental health is one of the Executive's stated priorities, why, in table 4.10, is the mental illness specific grant at a standstill? The figures do not move from £12.6 million.

Problems are being experienced in care in the community and local authorities in many areas rely heavily on voluntary organisations. I visited one such voluntary organisation last night. Because of cuts in its grants, it is suffering greatly and cannot provide the type of service it has provided in the past. I am very concerned that table 4.10 shows a reduction in grant to voluntary organisations.

Susan Deacon: Kay Ullrich is correct to say that mental illness specific grant has remained static. A range of individuals and organisations have expressed to me their concern about that. I certainly want us to consider carefully how we can not only increase investment in mental health services but ensure that that investment is in the right areas. Mental illness specific grant is just one area of investment—albeit a very important area—in mental health services.

As has rightly been identified, resources are also channelled through voluntary organisations. Across the Executive—and not only on health issues—we are looking at how we can give better and more sustainable support to the voluntary sector. We are actively considering how the balance of £173 million that has been allocated to the health budget this year will be used. I do not want to prejudge the outcome of that decision-making process, but as part of it I certainly want to consider the funding of mental health and voluntary organisations. For relatively small investment in the work of the voluntary sector—relative, that is, to NHS spending as a whole—we can deliver tremendous results for people. I note your points, which are well made. They are under consideration.

Kay Ullrich: Voluntary organisations are being squeezed from all directions. They are being squeezed by local authorities that are suffering cuts to their funding and they are being squeezed by the health department.

To put it in simple terms, minister, the organisation that I visited last night used to be able to provide a respite service of a full morning or a full afternoon every week to its clients, but it has had to cut that down to one or two hours every week. That is not progress. You have announced your strategy on carers, but on the ground organisations are being squeezed and are suffering from a lack of funding.

The Convener: The concern expressed by Kay Ullrich about the figures for the voluntary sector and about mental health and community care

would be echoed around this table. If the minister is minded to consider mental health spending and voluntary sector spending as options for that extra cash, she would certainly get support from this committee.

Part of the problem is that this is a departmental budget but a lot of the issues cut across departments. How can we get a true picture of whether the Government machine as a whole is investing properly in the voluntary sector? All we see in these figures is a snapshot.

I would like the minister to pick up on Kay's specific points and then to indicate ways in which the budgetary process can take cross-cutting issues into account.

Kay Ullrich: I would also make the point that the growth in funding for mental health is running about 3 per cent behind that for the rest of the health service. Voluntary organisations and mental health appear still to be suffering from a lack of resources—a situation that will continue through to 2002.

Susan Deacon: It is important not to generalise. Significant additional resources are going into a number of the areas Kay Ullrich mentioned. Respite care is an obvious example: funding there has been doubled to support the carer strategy. That said, there are always enormous and growing demands for funding in the voluntary sector. We want to provide greater and more sustainable support for the voluntary sector. As I think we all know from experience, voluntary sector organisations are often destabilised—or even have to fold—not just as a consequence of a lack of resources, but because of a discontinuity of financial support and because of uncertainty over future funding.

I want to ensure that we do not just consider increasing our investment but that we give voluntary organisations the stability they need. Stability, rather than a continual question mark over future funding from one financial year to the next, gives continuity to users who depend on services.

Mental health is an excellent example of the point that I made earlier about not focusing simply on financial inputs—although those are important. The Accounts Commission report on mental health that was published, I think, last year identified the absence of effective joint working arrangements in many parts of the country as a major barrier to the delivery of effective mental health services. People who depend on mental health services are often let down because agencies—statutory and voluntary; health and local authority—do not work effectively together.

In January, I think, we held a summit at which we brought together a wide range of mental health interests and providers to address the complex combination of where, when and how to fund; how agencies work together; and how services are organised around individuals' needs. To take that work forward, we have established a national mental health and well-being group.

In the three clinical priority areas that I have mentioned, cancer and coronary heart disease have for some time had a national group established to take work forward and to inform investment decisions. We did not have that in mental health before, but we have now put such a group in place. Within the next two weeks, the group will begin its first series of visits around the country. Its work will inform our investment decisions. I, as much as anyone, want to ensure that when we say that mental health is one of our three clinical priorities, we mean that and reflect it in our policy and investment decisions.

Kay Ullrich: That brings me to table 4.11 on the grant-aided expenditure to social work, which cross-references to the section on local government. I notice that the figures given are for the GAE for all social work services. Why is it not possible—in order that we might monitor community care in a meaningful manner—to break down the figures to show the indicative figure for social work and community care? Why can that figure not be further broken down by local authority area? This controversy is going on and on. How are the local authorities actually spending their indicative amount on care in the community? Because of cutbacks to local authorities, is that money being siphoned off to other areas such as child protection and families?

The committee was concerned to hear from Sir Stewart Sutherland that, during his investigations, he had found that some £700 million, UK-wide, had not been allocated specifically from indicative amounts by social services departments. It would appear, from application of the 10 per cent rule, that £70 million has been spent in areas other than community care in Scotland. The Association of Directors of Social Work has indicated that social work departments do not spend their indicative amount on community care because of cuts and financial pressures in other statutory areas.

The question really is—

The Convener: I think that that was the question.

Kay Ullrich: All right.

Susan Deacon: On several occasions, we have touched on the question of what information is reported and on the scope for the refinement and development of that information. Additional levels of information are reported on GAE and non-GAE community care spend through other channels—for example, in responses to parliamentary

questions and in other documents. The key question concerns what we do with the data. If the evidence shows that a local authority is spending more or less than its indicative allocation on any one service area, are we saying—as ministers or as the Scottish Parliament—that we want to be prescriptive as to how they should spend that money? That is an important point.

We have to measure and to be aware of what is happening, some of which can be done at Executive level, and some of which will be done by local authorities in their own reporting procedures. However, there is a fine balance to be struck: we must ensure that local authorities, as democratically elected bodies, have the scope to determine local priorities and, at the same time, we must ensure that we work effectively across Scotland to meet certain national priorities.

Kay Ullrich: Surely we have a duty to ensure that people are getting the community care services that they are supposed to be entitled to. There have been cuts in home helps. An average local authority will have 150 people on a waiting list for long-term care, and will be moving only two to four people a month. It does not take a genius to work out that that is a never-ending waiting list. There is clear evidence throughout the country, especially in terms of the new budget that local authorities have produced, that services to the elderly and disabled are being cut.

The Convener: Is it not the case that we have a situation in which the NHS is responsible and accountable for community care spending? It may be spent by local government, but there is a question of accountability and monitoring.

10:45

Susan Deacon: No. Local authorities are directly accountable and answerable to their own electorates for how they decide to spend their GAE resources, based on their own determination of local priorities. In community care, we are attempting to bring the NHS and local authorities much more closely together to agree national priorities and actions in this area, which both the NHS and local government can sign up to and both sides can be required to follow. The work of the joint futures group, which is chaired by Iain Gray, is very much about that.

I share the frustration about the need to ensure that improvements are made in those areas. I would be extremely cautious—I say this within earshot of the convener of the Local Government Committee—about any rash actions or decisions, which may unduly encroach upon the democratic accountabilities and responsibilities of local authorities.

Trish Godman (West Renfrewshire) (Lab): I have a couple of comments. Thank you for allowing me to speak. I will have to be rude and leave in a few minutes.

Susan Deacon is right in her comments about the accountability of local authorities. However, Glasgow is a very good example of the local authority working with the health boards so that the community care money is going exactly where it should go. Over the past two years, bedblocking has been reduced from more than 1,000 to 100. I think that that needs to be said more often.

On voluntary organisations, surely Jack McConnell's proposal for three-year funding will help them. One of the points that they are always complaining about—I am sure that Kay Ullrich will agree with me—is having to fill in forms over and over again.

Mental health has always been the poor relative of the NHS. Will Susan Deacon clarify this? My understanding is that some money was included in the GAE for community care, but nothing for drugs. That is where drugs sits; it sits with mental health. Do you know what I mean? Was extra money found in the GAE for community care early last year? Was it ring-fenced?

Susan Deacon: I am wary about giving a detailed answer to your question, in the absence of detailed information.

Trish Godman: I know that drugs were not featured and, as mental health is always the poor relation, people forget that drugs were included in that, because it is where they sit. Psychiatrists do not like that, because they say that it is not a psychiatric problem. Do you have any thoughts on how you are going to add money there? The specific mental health grant is totally different.

Susan Deacon: On drugs expenditure, one of the exercises that has been going on within the Executive over recent months is an audit exercise to establish precisely what money is spent and where. From that, we will examine how it can be spent most effectively.

A recurrent theme in this discussion has been that, at Executive and at parliamentary level, we are all striving for the data that we need to take informed policy decisions and informed investment decisions—that is an important issue. On delivering effective community care services, Trish Godman's first point is crucial. Where different agencies have come together effectively—working broadly within the policy framework laid down in the community care action plan that was published in 1998—to agree action to deal with or improve community care services at a local level or to deal with specific issues or problems such as delayed discharge, there have often been exceptional results.

I am always aware that when we talk about joint working, partnership working and the new partnership arrangements in the NHS, it can, at one level, sound intangible or like warm words. It is much more than that. Only by breaking down some of the traditional divides that have existed between agencies and professional groups will we deliver the improvements in services that people need.

Dr Simpson: I will shift the discussion to another topic, which is not dissimilar to the mental illness question. It has been a priority for about nine years. Evidence of a shift of budget to mental illness has not been significant. I think that the health framework is helping. Primary care has also been centred and focused—I do not know what this year's verb is, but it is about development of primary care.

Nothing in "Investing in You" indicates that there is a specific target on shift of resources, which has been extraordinarily difficult. We have heard a lot of evidence about the joint investment fund not working. Are you considering setting targets for this? How will you hold the health boards accountable? The centre has been saying this for nine years, but the periphery has not moved anything much to primary care. What targets, if any, will you set for local boards? What monitoring arrangements do you have on data that indicate shifts?

Are we developing any primary medical service pilots? Will there be a Scottish equivalent of the personal medical services pilots in England that resulted from the National Health Service (Primary Care) Act 1997? There are no targets for new ones here. In England, they are up to 269 of those pilots, which are very much part of the modernising agenda. Will you comment on that too?

Susan Deacon: We are taking forward the primary care act personal services projects in Scotland, to examine different methods of delivering primary care, different ways of supporting joint integrated service provision at a local level and different remuneration arrangements, including salaried service for GPs. That has always been part of those pilots. The second round of those was completed a few months ago. So the answer to that question is yes.

On Richard Simpson's question about targets for resource transfer, we do not have targets in the sense that he means, but I recognise the need for us to ensure that we put in place the right levers and incentives to get the transfer of resource and the transfer of emphasis on primary care that was committed to in "Designed to Care". We still need to translate a lot of that into practical reality. The local health care co-operatives are one of the key building blocks of the primary care structure.

We thought that it was important to learn from the experience of the first year of operation of the LHCCs. We have had three regional seminars covering the whole of Scotland over recent weeks. I attended part of each of those. There has been very positive feedback from those seminars, which involved a range of general practitioners and primary care practitioners. Those discussions covered what is working in primary care and at a LHCC level, including the whole question of the effective use of resources and the resource trail and also areas where they think that further improvement is necessary.

The output of those seminars will be produced shortly. We have, as of last week, established an LHCC national network group, which is one of a series of new national network groups, to take forward improvements in a range of areas. Martin Hill, the chief executive of the Lanarkshire Primary Care NHS Trust, is leading the group, which will act on the findings of that work and will conduct further discussion with the primary care sector. I think that it will provide us with a sound basis to inform our national policy-making decisions and will identify and disseminate best practice.

There is no question of our commitment to deliver on the promise in "Designed to Care" and to have an NHS that is truly primary care led. Taking forward work in that area is complex, but we have a range of mechanisms that will help to move us in the right direction.

Dr Simpson: I am not sure how we will be able to develop intermediate care, which involves the transfer of appropriate services from the current acute sector into community hospitals and resource centres, without having specific training and development. It will be difficult to do, but if we do not do it, we will be unable to get cost-effective care close to the patient, which is the counterbalance to the acute services review.

I understand that we have not been able to move forward rapidly because the local health care co-operatives are just getting started. Do you think that the new group that you mentioned will be able to develop a clear strategy with clear costings for the training development that will be needed to allow primary care staff to take on the intermediate care role?

One of my concerns is that some of the new money may be used to pay off the debts of the acute service, which, perversely, would reward inefficiency. Would the money be tied to a requirement for acute services to shift services across? Would health boards be held responsible for ensuring the transfer as part of improved efficiency? If that does not happen, I think that the money will simply be absorbed.

The Convener: That brings in our concerns

about the joint investment fund, which we mentioned before.

Susan Deacon: The nature of Richard Simpson's question demonstrates the complexity of a lot of the issues that need to be addressed if the system is to be made to work effectively. It is tempting for me to issue diktats on how those shifts should take place, but I do not think that that would be right. An element of central direction is required and that has been reflected in some of the recent resource allocation decisions. However, we want to come up with solutions that the service finds realistic, deliverable and manageable. That takes longer to do and requires data such as those from the first year of operation of the LHCCs.

Training is an issue that has been raised through the LHCC seminars, and I expect that the national network group will consider it. I will not prejudge the conclusions of that group. We want to tackle problems that have been for too long regarded as intractable or have been ignored. We have put in place structural changes in the health service that support a new form of working and enable the service to work together on an integrated basis. We want to encourage partnership working with other agencies. We have started to put in place levers and incentives to deliver improvements in the areas such as primary care that have been highlighted. We have further to go, but I said to the service last week that we want one NHS for Scotland.

We seek a true partnership approach across the country. In taking decisions about resource allocation locally, I expect the service to take a whole system approach. In dealing with delayed discharge, for example, the impact on the acute sector cannot be examined in isolation. We have to consider the impact on primary care and community care. In dealing with reductions in waiting time—both the examples I give are real examples from the priority areas linked to the £60 million allocation—I expect the service to consider the matter from the perspective of patients, from the point at which the patient enters the system right through. That requires a whole system approach.

On the point about money being used only for the acute sector or to deal with overspends, we have said that we are looking for financial balance in the system, which we are matching with additional investment. Trusts that have indicated that they will have a year-end overspend are still required to produce recovery plans. I agree entirely that it would be quite wrong to reward poor performance, which would be, as Richard Simpson said, a disincentive to other parts of the system.

11:00

Mary Scanlon: All of us round this table want transparency. We want to understand the figures so that we can make a contribution towards reprioritising in the NHS. There is concern that reprioritising, or reallocating, resources will hit clinical targets.

This week, in reply to a written question, I was told that the minister has announced 12 more oncologists. That is a serious, though welcome, reconfiguration within acute trusts, which requires tremendous back-up and support. What is the difference between your guidance, minister, and what health boards and health trusts are doing? How prescriptive are you? How can you be sure that health boards and trusts will carry out and achieve the priorities that you set?

All that comes against the background of a report that adopts a horizon of 2001-02. Yesterday, I sat in on Highland Health Board as it produced its health improvement programme for the next five years. In October, the board will produce its HIP for the period until 2007. How can we ask health boards and health trusts to move forward and prioritise services when you are making announcements every other week or month based on a two-year plan, and they are expected to plan for seven years? At the same time, they are waiting for the outcome of the Arbuthnott report to see how moneys will be allocated. How can we get some certainty in planning, when there is so much uncertainty around?

Susan Deacon: The simple answer to that is that anyone who looks for certainty will always be disappointed. We will not get certainty. There is much uncertainty around and that will inevitably continue. Many of us know from our past political and professional lives that that is the case. The issue is how we manage uncertainty—how we plan within uncertain conditions and what we do to reduce uncertainty as far as possible.

Mary Scanlon raised a number of specific points, which I will answer. First, on strategy and planning, "Designed to Care", "Towards a Healthier Scotland", "Modernising Community Care: An Action Plan", the mental health services framework and the national acute services review are all examples of major national policy documents that have been developed over the past couple of years, which provide the policy foundations for the operation of the service. They were an important starting point in the process.

First, over the past year, my energies and efforts have probably been focused mostly on ensuring that these policies are translated into practical reality on the ground and ensuring that we have the planning and decision-making processes to

support that. One of the outcomes of the discussions that I had with all NHS chairs in Scotland at the beginning of February was the agreement that some explicit form of national strategy document was needed, a document that could provide the framework for local boards and trusts to produce their local health improvement programmes and trust implementation plans. We are committed to developing a health improvement plan for Scotland with the involvement of the service. The main driver for progressing that and other pieces of work will be the newly established modernisation board. Practical and real steps have been taken to put that framework in place, to aid the service.

Secondly, Mary Scanlon raised the issue of the national-local balance. We have touched on that already. It is important to try to get the balance right, although it will never be perfect. The more transparently and openly that we can discuss these issues, the better. A piece of work is being undertaken in the department, which I expect to be discussed with the service—through the modernisation board, in due course—towards ensuring that existing decision-making and governance arrangements support the new partnership form of working that is in place and bring more closely together local and national decision making. We will continue to move in that direction.

Thirdly, there is the issue of getting that national and local balance right in the context of the clinical priorities that were mentioned. We are putting in place the right way of taking that forward. The Scottish Cancer Group, led by Dr Harry Burns of Greater Glasgow Health Board, is working with a wide range of cancer specialists and various practitioners who are involved in cancer care throughout Scotland, to determine how to plan most effectively for the needs of cancer sufferers now and in the future. It is also considering the issues of early diagnosis and prevention.

I apologise for repeating this point, but it is a relevant one. The investment plans that are now emerging for cancer equipment are a practical outcome of work such as that. Similar work is being undertaken by the coronary heart disease task force, under the direction of Ross Lorimer, and the mental health and well-being support group, under the direction of Dr Ian Pullen. Finally, we have three national groups to lead and to drive our work against those three clinical priorities, and to inform policy-making and investment decisions nationally and locally. That combination of measures will help us to continue to reduce uncertainty, although we will never remove it completely.

Mary Scanlon: You have not mentioned the Arbuthnott report. Health boards are expected to plan for seven years, but your plan is for two years. Given that we hear announcements every other week, and given that managers' pay is now linked to improvements in patient care, how can health boards see those clinical outcomes through? On the priorities and planning guidance that was set out in 1998, three priorities were related to cancer. Two years later, we are only now addressing the issue of the resources that are needed to treat cancer—such as the 12 new oncologists. I welcome the new organisations and the 12 oncologists, but it has taken two years to put them in place.

Managers' pay is linked to improvement in patient care. With all the uncertainty that you have just outlined, minister—plus a possible major shift in resources because of the Arbuthnott report—how will the committee cope with sitting round a table, trying to look at a transparent budget and prioritising resources? How can we say, "I'll take money from there and put it into preventive care"? We do not have the right information. This is about taking notice of the Arbuthnott report and long-term planning.

The Convener: It is also about the impact on health boards and trusts.

Mary Scanlon: Yes, but the boards and trusts implement the measures that you have been talking about, minister. The committee is attempting to say that the problem is the delivery mechanism.

Susan Deacon: Effective planning is complex, and takes time. I make no apology for some measures taking a year or two to put in place. That is how we ensure that we put sustainable systems in place.

It is often tempting for politicians—and certainly for ministers and Government—to put quick fixes in place. The health service has had enough quick fixes; it wants some clarity about the direction of travel. It wants to be assured that investments that are made and policies that are put in place this year will not be unravelled next year. Far too much time, energy and resources have been expended on the health service during a number of years, even decades, through such short-termism. I am working hard to ensure that we do not go down that road.

Some of the changes will take time to implement. I can appreciate why it feels often as if Government announcements come from out of the blue, but they do not. We are working increasingly hard to ensure that, when matters are finalised and are announced in public, they flow from an on-going process of dialogue and discussion with the health service. For example, changes to senior managers' pay date back to changes that were made by the Health Act 1999. That act put in place

the statutory change that provides for ministerial direction over senior managers' pay, and it signalled a marked shift from the previous internal market arrangements.

The proposals that were announced last week were the product of on-going discussions with a range of people. If we can get better at communicating some of the eight ninths of the iceberg that is under the water, I will be more than happy.

The same applies to the Arbuthnott report. As members know, that report was 18 months in production. We then spent several months in detailed consultation, to which the committee contributed fully.

A group is in place, comprising the original group but with input from others. It will take forward the work that is emerging from the consultation exercise. I hope that that work will be completed in the next couple of months and I will be making further statements to Parliament on that because the way in which we distribute health service resources is so important. That is a good example of what members have referred to.

I have received an approach from the convener of the group, apologising for the fact that it will be unable to complete the further work on the consultation exercise by the end of March—or, at least, unable to complete it as thoroughly as the group would wish. I was asked to agree to an extension of the process. I did that because I would rather that we took longer to do something, but got it right, than that we rushed towards policy solutions and investment decisions and got them wrong.

That is the position regarding the Arbuthnott report, and I hope that that provides clarification.

Mary Scanlon: Just a final point, convener—

The Convener: I am sorry—we are into the last quarter of an hour. Four other members have relevant questions. No doubt other members will realise that we are running out of time and will want to ask questions. I ask all members who have questions to make them crisp and I ask the minister to make her answers crisp so that we can get through as many as possible.

On the matter of the health service having had enough of quick fixes, I will move on to Irene Oldfather.

Irene Oldfather: The minister spoke about outcomes and health gains—I will turn to health promotion.

The minister is probably aware that the committee has been impressed by evidence that was given about the Finnish experience of improving health. Dr Dunbar advised us that health had been much improved in Finland, where heart attack rates are down by 73 per cent and lung cancer rates are down by 71 per cent. Against that backdrop, does the minister believe that the health promotion budget adequately reflects the scale of the problem in Scotland? Does she believe that that problem links in with national priorities? On page 57 of "Investing in You", a target for cutting cancer death rates by 20 per cent by 2010 is referred to. Is that ambitious enough?

11:15

Susan Deacon: I will endeavour to be crisp in response to that question on an important and complex area.

The health improvement targets that have been set are ambitious, but—with the right national effort—they are attainable. They were set after considerable discussion of the health white paper, "Towards a Healthier Scotland".

Health promotion spend is just one element of the contributions that will be made towards bringing about those improvements in health. Health promotion is important—it is one of the areas that I have indicated will benefit from the additional £26 million that the Executive has ring-fenced for public health and health improvement. However, delivering on health improvement targets requires a much wider national effort, not only in health policy and health spending, but across the work of the Scottish Executive. That delivery will also involve a range of other agencies.

That brings me to Finland, which I visited with officials from the department in January. The Finns have demonstrated that significant improvements in health can be achieved. It has taken them about a decade, but they have done it. The reasons for that are complex and we cannot do justice to the issue today. I know that the committee is considering the Finnish experience in more detail, as am I.

When I examined the Finnish achievements, I was struck by how much people had united in a common desire for a drive to improve the health of the Finnish people. It is an interesting subject, into which politics come into play. Finland, which has a tradition of coalition Government, has a rainbow coalition Government that involves, I think, five parties—

The Convener: It reflects this committee, minister.

Susan Deacon: Indeed.

The coalition played a part in helping to establish national consensus. The media contributed to the process by raising awareness

about health improvement messages. Schools and employers have become actively involved in promoting occupational health. Cultural and attitudinal changes have taken place, as has a change in practice.

I am about to write to a wide range of organisations about a public health convention that will be held next month. That convention will consider how to take forward the next stages of our public health drive: further implementation of the white paper; how we will build on and progress the national health demonstration projects that are about to be launched; and so on. I hope that we can draw on some of the Finnish lessons in developing such an approach. I welcome the fact that, across the party political divides in the Scottish Parliament, we have agreed to take that approach, on which I hope we can make progress.

Irene Oldfather: I thank the minister for her answer.

I think that the minister will agree that a culture is developing in the Parliament and in the committee of doing something about health improvement and effecting change. Does she, however, accept that it is difficult to measure how much money is going into health promotion? We all welcome the £26 million from the tobacco tax, but it is difficult for us to say, "This is the budget for health promotion. It links into the national priorities in this way and this is how we're going to achieve the targets over the next 10 years." It is difficult to see such connections in "Investing in You".

Susan Deacon: There could be significant improvements in how expenditure that is related to public health and health promotion is shown in the document. For example, the spending of the Health Education Board for Scotland is shown, but it is not broken down. A great deal of health promotion work is, however, done at health board level, which takes us back to the first question on how much detail we gather from information about health promotion. Of course, an increasing amount of health promotion activity is being undertaken through other agencies, such as the work that is being done on developing health-promoting schools. I agree that we could get much better at reporting data, but—for the reasons that I gave—the data will never be comprehensive.

Irene Oldfather: One of the changes that were made in Finland was to make salad available free of charge in schools. Are we tackling the problem in a sufficiently radical way, or are we just saying that there should be information and media campaigns conducted through HEBS? Are there enough new ideas on how to make the radical and cross-cutting changes to departments that will be necessary to achieve the outcomes that have been achieved in Finland?

Susan Deacon: We are starting to make significant changes to how we work—especially across Government departments. On diet, we have been in discussion with a range of different interests from outside the Scottish Executive. A wide range of experts in nutrition and diet are coming together in a few weeks to consider how to give fresh impetus to the drive for dietary change. There is a Scottish diet action plan and we know what must be done—the challenge is to make that happen. However, we must build a much greater sense of national confidence and belief—which we, as politicians, must drive—that we can make improvements in that area.

I should mention another relevant piece of work, which is the establishment of the public health institute for Scotland. We are progressing detailed plans for the institute, which derives from the public health function review that was published in December by the chief medical officer. We all have ideas about what we would like to do to bring about dietary change. For example, I would like to take my two-year-old to a multiplex, to a bowling alley or elsewhere and be able to buy her a yoghurt.

Finland has achieved that change—one can see that in shops, restaurants and workplaces. However, we should be under no illusions about the number of people and the range of efforts that are required to bring about such a change. Policy making must be informed effectively through the public health institute and inclusive discussions.

The Convener: I will bring Ben Wallace into the discussion, if we are talking about changing attitudes and the way in which people make personal decisions. One such personal decision is the decision to smoke, and Ben wishes to address the tobacco tax.

Ben Wallace (North-East Scotland) (Con): My question is actually about the package of new money that was announced recently.

I asked you about the tobacco tax in the chamber, minister, but I would like to try to get a more precise answer. The £26 million is a hypothecation from the UK budget. Both last year's and this year's red books show a decrease in tobacco revenue. Last year, in fact, through no fault of the chancellor, the budget lost £3 billion in revenue. That was not because people had given up smoking, but because of an increase in smuggling. Tobacco revenue is forecast to decrease during the next few years. That would mean that the £26 million would be hypothecated down to £18 million by the end of this year. In other words, we will not get what was promised. That is the danger of hypothecation. Will the minister assure the committee that that shortfall will be matched—if the figure decreases year on year—in order to keep the revenue at the current

level?

Susan Deacon: I cannot give that assurance—those decisions have still to be taken. The decisions for future years are part of the budget process that we are discussing today. We said that we will ring-fence the tobacco tax money—we have taken that policy decision.

As I said when we discussed the matter in the chamber, none of us—not even the Treasury—can make definitive predictions about how much will come in from the tobacco tax. The total amount that we are earmarking for public health expenditure probably exceeds the total amount that will come from the tobacco tax, but we have made a very specific and precise commitment to earmarking that tobacco tax money in future years. Any decisions to add to that through other means will be considered in the various spending review processes.

Ben Wallace: The £26 million, on which you are relying this year, can be used only in the first year, not as part of a three-year plan, because it will change year on year. The health promotion targets that have been set will have to be less ambitious if that income source cannot be relied on.

Susan Deacon: I disagree with that logic. We have made a commitment to hypothecating and ring-fencing tobacco tax money. That was a decision that was taken here in Scotland—it mirrored a decision that was made in England, but it was up to the Executive whether we made such a decision. First, we chose to hypothecate the tobacco tax money to the health budget. Secondly—which is different from elsewhere—we have said that we will earmark the money for public health and health improvement expenditure. I repeat: none of us can predict how much income will be derived from the tobacco tax during the coming period. We have, however, made an explicit commitment for that revenue stream. Other spending decisions will be part of our budget processes.

Ben Wallace: The targets that you set will, therefore, have to take that into account—they will have to be more flexible.

Susan Deacon: Let us remember that the £26 million and the tobacco tax money are net additional moneys. We spend £5 billion on health in Scotland. A great deal of health improvement work is done through other parts of the Executive from its £15 billion budget—for example, through improvements in housing and through social inclusion policy and other measures.

Ben Wallace: You have cut money to health education boards.

Susan Deacon: We have not cut money to the Health Education Board for Scotland.

Ben Wallace: According to an answer that you gave to me, you have cut money to health education boards since 1997 consistently and those cuts are forecast to continue until 2002.

Susan Deacon: We have not cut support to the Health Education Board for Scotland. Perhaps we are back in the realm of how figures are reported.

Ben Wallace: You gave me the figures.

Susan Deacon: I stress that much of the discussion in the committee today and elsewhere in the budget process illustrates the range of efforts that need to be made to improve health. The decision to badge the tobacco tax money specifically for health improvement is radical and important, but we must not imply that that is the only spend or effort that is going into health improvement. I fear that some of what you suggest would indicate that that is the case.

Ben Wallace: You have announced £60 million for health boards. Guidelines have been mentioned—would such guidelines ensure that health boards do not use that money to pay off some of their inefficiencies? How detailed is the guidance? Your press statement said that you would direct money towards unblocking beds and reducing winter pressures. I am aware that you do not want to dictate too much to health boards, but some boards might have slightly different ideas. Will there be a set of guidelines and will the committee be allowed to see them?

Susan Deacon: I want to stress that there is a continuing dialogue with the health service. Four main problems were identified and linked to the £60 million allocation that was made last week, which is only part of the additional moneys that are going into the health budget. There will be improvements in the way in which peaks and troughs are dealt with, especially during the winter. The first meeting of the new group—which will consider preparations for next winter—takes place today. The group will help to inform decisions on that.

Secondly, we want to make improvements regarding delayed discharge and we have put in place a national network group to support that work.

Thirdly, we want improvements in waiting times and waiting lists. There is a group working with the health service on that. The fourth problem is the creation of financial stability. Those four fundamental building blocks need to be right if we are to make radical improvements in service delivery.

We recognise that the scale of the problems and the solutions to them will be different in different parts of the country. We want to give local boards and trusts the scope to come up with proposals

that fit their needs, while making it clear that improvement in those areas is non-negotiable. We are investing additional money to ensure that such improvements are possible. Local boards and trusts are being asked to develop straightforward plans that set out how the boards will make the necessary improvements. Those must be submitted to the department in the next few weeks.

The modernisation board and a number of people who are working on winter planning arrangements will help local health bodies to make those improvements. I do not believe that there is great resistance to making improvements, but—for many reasons—people sometimes find it difficult to make them. Our team will help local health bodies as much as it will monitor them.

11:30

Ben Wallace: I welcome that.

Mr Hamilton: The committee set itself the task of gaining a better understanding of health inflation to help the debate that surrounds real-terms increases. Minister, why do you think that use of the gross domestic product deflator in the health budget is appropriate?

Susan Deacon: If the public or parliamentarians are to monitor and understand the Executive's spending, certain conventions must be established for how that is reported, and the GDP deflator has been established as one such convention. In health, as in other areas, we could present the data differently, but the Scottish Executive has established a reasonable and appropriate way to present data that allow comparisons to be made across departments.

Mr Hamilton: I can see the point of allowing comparisons to be made across departments, but the important issue is output. Would you accept that wage inflation, for example, is well above the GDP inflator?

Susan Deacon: Wage inflation varies from the other measures of inflation.

Mr Hamilton: I am aware that it varies.

Susan Deacon: That seems self-evident.

Mr Hamilton: This year, wage awards are well above the figure of 2.5 per cent that is used in the budget. Many people welcomed that, but it has implications for health boards, which must meet that target. Last week, we were told that 70 per cent of health boards' budgets are spent on wage costs. If the breakdown of health board allocations is on that basis, and if the rate of inflation for wage rises is above what you have assumed it will be—

I see that the minister is shaking her head, but I have not asked my question yet.

The Convener: Hurry up, then.

Mr Hamilton: If what we were told last week is true, and if the rate of inflation for wage rises is above what you have assumed it will be, would it be fair to say that the real-terms figures that we are using are not accurate?

Susan Deacon: I was shaking my head because of what you said about inflation in wages. We exercise choices about how much we pay NHS staff. The question was formulated so as to imply that wage inflation is somehow a matter that is determined purely by the macro-economy. Although the two are connected, we have taken conscious decisions in recent years to make fair and reasonable pay increases for NHS staff groups.

Mr Hamilton: That is not my point. Although everyone supports wage increases, we do not want to put the additional burden on health boards without them having additional resources. If drug inflation, wage inflation and equipment costs are all borne by health boards, and if they are above the 2.5 per cent that you assume, is not it true that the real-terms increase is nothing like what we are talking about?

Susan Deacon: I disagree. It is a question of priorities, and one of our main priorities is to invest effectively in our staff. Around 70 per cent of the NHS budget is spent on staff. Health service staff are the health service in that respect. It is a false dichotomy to say that those costs will be borne by health boards. Health boards are the NHS. More than £5 billion is going into the health service this year and, in each of the next four years, there will be further record additions. In the current year, £500 million will more than cover the wage increases that have been agreed, and will also be directed towards other areas of improvement. It is a question of prioritisation.

Dr Simpson: We welcome the fact that table 4.15 has a real-terms allocation, because that has not been shown at level II for UK figures before. However, for the public to understand health service development and for the figures to be transparent, we must try to define what is new money. The increase in wages, which were underpaid for many years, is welcome. Your department must do calculations that take into account what is used to pay for existing services and the expected increases in drug and wage costs.

Table 4.3 shows the additional expenditure required to meet demographic pressures, and that is also welcome, as it allows us to draw some conclusions. However, it would be helpful to have a table showing how much new money there will be for new services next year—it can be calculated only year on year—once all those

factors have been taken into account. The committee does not fully understand that and the public certainly do not understand it, so they begin to mistrust the figures that we produce.

Susan Deacon: The search for transparency and improved reporting is one to which we have returned time and again this morning. We are all embarked on that process and I am sure that we can improve matters.

On Richard Simpson's point about new money, I make no secret of the fact that the document was about to go to print at the time of the Chancellor of the Exchequer's budget announcement—or rather at the time of the decisions about how we would allocate spending in the health budget. Efforts were made to include as much up-to-date information as possible, and there is a paragraph on page 48 about the additional announcements in the chancellor's budget.

The £173 million extra is shown on a separate line on page 48, but the £300 million extra that had already come through the comprehensive spending review is absorbed in the global totals. As currently presented, the information is not transparent, and that could definitely be improved.

We are happy to build on that. Given the significant additional investment in the health service that is being made, it would be helpful to explain that clearly to people.

The Convener: I will address some points about which the Finance Committee has asked us. You might wish to answer quickly, or you might feel better equipped to provide a written answer in the near future, which will allow us to discharge our duties to the Finance Committee.

One question in the Finance Committee's questionnaire is:

"Are the objectives and specific targets designed in a way which makes it easy to audit whether or not they have been achieved? How will this audit be undertaken within the Executive and by whom?"

Who monitors that to ensure that it takes place?

Other matters relate to hypothecation, inflation and so on—the building blocks of the process. We have discussed inflationary pressures. Another factor is

"any levels of assumed efficiency, or re-engineering savings".

We talked about the drugs budget last week, but there must be savings elsewhere. On Monday, at the ACAD, I was talking to the clinical director about the impact of nurses having many more functions than they had previously—for example, nurse practitioners prescribing. He told me that he foresaw that the cost to the nursing budget would be cut because of the changes that the minister was talking to Mary Scanlon about earlier. Is re-engineering bringing efficiencies anywhere?

Another factor is

"invest-to-save programmes, especially where the savings do not register until beyond the current horizon."

It would be helpful if there were a way of noting how such programmes and investments are being considered in the budget.

Could we have further evidence on the research and development approach of the health department? Organisations from the voluntary sector will tell us that they do not feel that the department is putting as much into research and development as they would like it to. I know that that is an anecdotal, generalised comment, but it would be beneficial if we could have a sense of what is happening in research and development. Although I do not just mean the high-profile pilot schemes, it would be helpful to know your thinking on them. Members have anecdotal and general evidence of excellent pilots—whether they are introduced by health boards or by local authorities, or are funded by European money—which work well in our communities but then, suddenly, the funding is lost. We would like to know what the department is doing to ensure that there are better transitions.

Those are some areas on which we have been asked to comment but which we have not covered today. We should be grateful for a brief comment on any that you regard as being particularly important. Otherwise, it would be helpful to receive a written response—we can supply you with the questions.

Susan Deacon: I am happy to answer briefly now and to give you a written response later, and John Aldridge can answer usefully a few of the detailed points that you raised.

I stress that some of the questions that you ask relate to data that are available and published elsewhere. I accept that, if that is the case, the document ought to refer to those published sources.

You talked about pilots, re-engineering and so on. It is right that we should report on the financial aspects and on efficiency savings. One caveat is that, in many of the re-engineering projects that we are talking about, the real drivers for change must be quality improvements. Although improved efficiency often flows from such projects, I would be concerned if such things started to be cost driven rather than quality driven. However, I am sure that we can find a balance.

11:45

The Convener: That question came to the committee from the Finance Committee; it was not

from the Health and Community Care Committee. Therein lies a difference of emphasis.

Susan Deacon: John Aldridge might be able to respond to the detailed points that you raised.

John Aldridge: I shall try to be brief. To some extent, you will want to judge for yourselves whether the targets are clear and auditable. Because they follow quite closely the commitments in the programme for government, which are pretty specific and tend to have clear end dates or objectives, they are clearly auditable, and the procedures exist—depending on the individual target—to ensure that they are achieved.

You asked whether there are any levels of assumed efficiency in the plans. In Scotland, for several years, no specific efficiency savings target has been set for the NHS. That has been done in England, and was done in Scotland some time ago, but the decision was made not to do it again in Scotland for the reason that the minister outlined: any changes should be driven not by financial concerns, but by the improvements that can be made for patients. When efficiency savings emerge, as they do on occasion, that is a bonus. Historically, the NHS in Scotland has improved its efficiency by between 1 per cent and 2 per cent a year. It is probably reasonable to expect similar improvements to be made in future, through re-engineering decisions. Initiatives such as ambulatory care will help to produce efficiency savings as well as improve services for patients.

Invest to save is something that we are keen to promote. The public health initiatives, and the new focus on public health, are one aspect of that. As committee members have pointed out, the achievement of those objectives is long term in many cases, and requires investment now. More specifically, we are trying to ensure that capital investment is focused on areas in which it can produce longer-term savings in the future.

As the minister says, much more information is available from other sources, but I shall briefly address the issue of research and development. The chief scientist's office sponsors some research directly, but, more importantly, it ensures that the activity that it sponsors directly is fully co-ordinated with the work that is carried out by the Medical Research Council and other bodies, so that the whole range of research is covered, one way or another, throughout Britain.

The Convener: Malcolm Chisholm will finish off our questioning this morning.

Malcolm Chisholm: One of the things that the Parliament is trying to do is mainstream equal opportunities. The Equal Opportunities Committee wrote to the other committees, following evidence that we heard from Engender. There has been quite a bit of discussion in the Parliament about "engendering" budgets—there are positive signs—and we know of your personal commitment to certain issues. I was pleased to see that, in the priorities and planning guidance, specific reference was made to post-natal depression and domestic violence. To what extent did the health department have its eye on gender and race issues when it considered policy and budgets?

Susan Deacon: Better progress has been made towards recognising gender issues and what are often very specific health needs, such as those to which Malcolm Chisholm referred. We could go further in mainstreaming that approach. The work that has been undertaken by the equality unit in the Executive and by the Equal Opportunities Committee will help to inform all of us about the ways in which we can build mainstreaming into the policy-making process.

Further work needs to be done on ethnic minority health issues. I have met several interests in that area, and focused work is being undertaken in the department, which is examining ways in which the needs of ethnic minorities can be met more effectively through the health service and the policies that we formulate. However, we still have some way to go.

One of the more general ways in which we can root those perspectives more effectively into the decision-making processes of the NHS is by ensuring that the decision-making bodies of the NHS are more representative. Work is under way, specifically in the NHS and more widely across the Executive, to reconsider the public appointments procedure and the possibility of attracting a wider range of people into NHS board rooms, to provide a better gender balance and better representation of ethnic minority groups.

The Convener: I thank the minister and John Aldridge for their contributions this morning, and for the contribution of officials from the department last week. We still have some specific questions for you, which we have not been able to ask today—and I thank committee members for their forbearance, as I know that many of them had further questions for the minister—as we have just not had the time. Dorothy-Grace Elder wants to ask a specific question about dental services, and Richard Simpson has further questions. If other colleagues have questions to ask in response to today's discussion—there are probably some that the Finance Committee will want to ask—we will put them together and send them to you in writing. If colleagues forward any questions to the committee clerk today, we will get moving on that as quickly as possible.

I thank the minister for coming along and for answering our questions so fully and frankly.

We will take a five-minute break, after which we will address one item in public before going into private discussion about our initial thoughts on the budget process.

11:51

Meeting adjourned.

11:59

On resuming—

Subordinate Legislation

The Convener: Agenda item 2 is subordinate legislation. We have been approached by the Scottish Retail Consortium. It has some concerns about the Food Safety (General Food Hygiene) (Butchers' Shops) Amendment (Scotland) Regulations 2000 (SSI 2000/93), which have come about because of the findings of the Pennington inquiry in the aftermath of the E coli outbreak in Wishaw some years ago.

Committee members will feel that paramount in our minds is public health and food safety. Within that umbrella, and considering the need for consumer confidence about the food we eat, some areas give the Scottish Retail Consortium cause for concern. I thought that it would be a good idea to hear its concerns.

We will also hear from the Scottish Executive on this issue. This should, I hope, be a fairly brief part of the agenda this morning. We will not take a decision on it, but it will allow members to formulate an opinion and we will come back to it at a later meeting.

Good morning, gentlemen. You can give us an indication of your concerns about the regulations.

Patrick Browne (Scottish Retail Consortium): Thank you, convener. I will start by introducing my colleagues, Roger Hammons, who is the company standards executive with Somerfield Stores Ltd and Bob Jamie, who is consultant to the Scottish Grocers Federation. Both organisations are members of our trade association. I am the director of the Scottish Retail Consortium.

I thank you for giving us the opportunity to come along today to voice our concerns about the butcher licensing regulations. I know that your time is precious. The fact that you have agreed to see us is much appreciated.

In relation to butcher licensing, the consortium represents all the major multiple retail outlets in Scotland. All of them are in our membership. We estimate that in excess of 500 multiple retail outlets will be affected by the butcher licensing regulations, which the committee is considering.

The committee has already seen our briefing note, which sets out our detailed concerns on butcher licensing regulations as they are currently worded. I stress that the consortium's concern, and that of our members, is not to undermine the regulations but to ensure that they are workable for our members and enforceable for the licensing

and enforcement bodies.

We have fundamental concerns about the wording and intention of aspects of the regulations. Our fundamental concern is that they have been drafted with the intention of applying to stand-alone butcher shops. We are not convinced that multiple retail outlets have been taken into account in the drafting, especially when it is considered that multiple retail outlets tend, in the main, to sell a range of goods—a much broader range of products than raw meat and pre-packaged food products.

In the context of a multiple retail outlet, the regulations apply to the whole floor space in the store, not just the butchery part of the business. If members examine how a butcher's shop is defined in the regulations, we believe that that is the impression given by the regulations—if not the intention—as they are currently drafted.

Our members have some difficulty understanding why butcher-licensing regulations should extend to the whole of their stores instead of being focused on the relevant butchery parts of their premises. The issue of stores operating a mixed retail business has been addressed in the English and Welsh regulations; we have suggested a possible amendment to the Scottish regulations, which is included in the briefing note.

Our second concern relates to the definition of a proprietor. The regulations refer only to a business run by a "person" and imply—if not state—an issue of ownership of the business. Given that our members include plcs and private limited companies, we suggest that the definition needs to be amended—for the sake of clarity, if nothing else. That is particularly important in relation to concessions operated by one company in a different company's stores.

The issues of a mixed retail business and proprietorship are particularly problematic in the case of Kwik Save stores. I ask Roger Hammons to speak briefly to the committee on that specific point.

Roger Hammons (Scottish Retail Consortium): Somerfield and Kwik Save are the same company. We operate more than 100 supermarkets in Scotland. Some fresh food operations in those stores are run by separate local businesses that rent space from us. That brings a local flavour to our stores, under a multiple banner. Under the regulations, the whole premises would be licensed. It seems, therefore, that Somerfield or Kwik Save would have the job of running concessions to ensure they complied with the licence. We think that concessions should be treated as separate businesses and that they should hold a licence for those things for which they are responsible. If we fell within the scope of the licence, we would also apply for one.

Another concern relates to the size of stores. The meat operation, to which the regulations apply, comprises a very small proportion of total store space. In some superstores, the meat operation amounts to less than 10 per cent of the total store. All current legislation covers the whole store and these regulations would create another layer of legislation that might get in the way of the others.

Patrick Browne: Bob Jamie would like to make a specific point about the status of proprietors in Scotland.

Bob Jamie (Scottish Retail Consortium): There is a third category of business ownership that is peculiar to Scotland and needs to be referred to specifically in the regulations. A Scottish partnership or firm is a legal entity quite separate from the individual partners. The regulations need to stipulate that the existence of such a firm should be referred to when a licence application is being made.

Patrick Browne: Our third concern relates to the training requirements that are set out in the regulations. I stress that the consortium is not questioning those requirements; indeed, many of our members already train their staff to these or higher levels. The complication is that training is often not accredited externally, as the regulations would require. We ask for the regulations to be amended to allow in-house training programmes, conducted to a level equivalent to the standard required by the regulations, to be accepted for licensing purposes. Given the number of staff involved, for reasons of business efficiency, many of our members conduct meat-handling training in-store and do not use external training bodies or send people on individual training courses.

Our last concern, as is set out in the briefing note, relates to the appeals process. We have consulted our members again on that point and they now accept that the appeals process as set out in the Food Safety Act 1990—which is the appeals process set out in the regulations—is adequate. They feel that, rather than introduce another appeals process, it would make sense to accept the process outlined in the regulations. Our members are prepared to withdraw their concerns on that score, but we hope that the committee will take into account our concerns about the other points that we have highlighted. We will do our best to answer any questions. Thank you for taking the time to listen to us.

Margaret Jamieson: Thank you for giving us such a broad outline of the consortium's position. I have some reservations. As someone who does not normally use a butcher's shop, but shops at a multiple retail outlet, I would like to know whether

the current wording of these regulations would have an effect on jobs. How do you think the regulations could be changed to deal with the issues that you have raised this morning?

Patrick Browne: I will deal with the question about the possible impact on the operation of stores and, ultimately, on jobs. The regulatory impact assessment that accompanies the regulations indicates that their introduction will entail significant one-off costs. The schemes that are outlined in the document suggest initial costs of around 8.5 per cent of turnover in individual butchers' shops. We suspect that the cost will be higher in multiple retail outlets. I am sure that multiple retail outlets will absorb those costs and that they will not have implications for jobs. Stores would not want staff to suffer because of regulations that people have decided to introduce and that our members have accepted.

In the briefing note that we supplied to the committee, we made specific suggestions for amendments to the regulations. A particular concern relates to the definition of applicant; we think that it must include companies. It is crucial that we deal with the issue of a mixed retail business. We are concerned that the regulations as currently drafted will pull in parts of the store that are not meant to be covered. For example, catering premises are specifically exempted from the regulations but, as members will be aware, many multiple retail outlets and supermarkets contain coffee shops. If the regulations extend to the total floor space in a store, a coffee shop in a supermarket could end up being covered by them, despite the fact that there is a specific exclusion for catering premises.

We accept that improved regulations for butcher licensing are necessary, but we ask that the regulations be focused on the relevant parts of the store.

The Convener: Your concerns relate not to the regulations as a whole, but to some of the practicalities.

Kay Ullrich: You made a point about in-house training. How would the standard of that training be verified? In-house training can mean many things.

Roger Hammons: There is a syllabus for training in basic and intermediate food hygiene. We would have to show to the local authority's satisfaction that the company's in-house training covered all the elements of that syllabus. Although we might not follow exactly the format of courses with external accreditation, we would get to the same point by a different route.

Kay Ullrich: Would you envisage outside accreditors coming into a store, as they do in the case of Scottish vocational qualifications, to verify that the required standards are being attained?

Roger Hammons: Many of the companies to which we are referring employ people in-house to check that the store managers and people in the store are carrying out the company's policies.

Kay Ullrich: But that is all in-house.

Roger Hammons: Yes, but they have to produce a separate report. Under the legislation on pricing and date marking, we have to be able to demonstrate reasonable caution and due diligence to the satisfaction of the local authority.

Kay Ullrich: Do you have any objection to external verifiers coming in to ensure that in-house training is meeting the required standard?

Roger Hammons: We would object to a third party coming in. The external invigilators should be the local authority enforcement officers.

Irene Oldfather: Kay Ullrich has already asked my question, which was about who would decide what was equivalent training, how it would be monitored, and what the quality control on that would be.

Margaret Jamieson: Have the trainers in your organisation been validated as qualified to discharge that duty?

Roger Hammons: Yes, they have. There are basic, intermediate and advanced levels of hygiene training, and the regulations require certain people to have basic and intermediate training. The people who carry out the training must have been trained to an advanced level.

Kay Ullrich: Is that external training?

Roger Hammons: Yes. It is carried out by environmental health bodies.

Margaret Jamieson: So the trainers are qualified.

Roger Hammons: Yes, they are.

Malcolm Chisholm: I have a general question. I am not entirely clear about the practical effect of passing these regulations. There seem to be references in them to specific areas of shops, so it seems that your concerns are dealt with. If the regulations are passed, what will happen in practice in non-meat parts of the shop that you think is unnecessary or undesirable?

Patrick Browne: The issue is to ensure that the regulations apply to the parts of a store to which they should apply. As I said, our fundamental concern is that the regulations have been drafted to apply to stand-alone butchers' shops and not to—

Malcolm Chisholm: What are the practical effects on other parts of the shop, given that most

of the regulations are specific to those parts of the shop?

12:15

Patrick Browne: The practical effect is the one that I addressed earlier in relation to catering premises in a store. If a coffee shop is part of a retail floor space and is classed as that by the local authority, it will come under the terms of the butcher licensing regulations, despite the fact that the regulations as drafted seek to exclude catering premises.

Malcolm Chisholm: What would have to be done in the coffee shop that would be undesirable?

Patrick Browne: The second issue is the point Roger Hammons made about concessions operating within stores. In trying to resolve that point, one has to deal with the mixed retail business argument. There is also the question of the status of proprietors.

Dr Simpson: I am still not clear about this. If the regulations were passed without the amendments that you propose, can you give specific examples of the changes that would have to be made in a catering establishment within a mixed-use area? What staff changes would be required? How would that unit be affected?

Roger Hammons: There would be problems with creating recipes in the rooms and kitchens in which food is prepared and cooked. A lot of separation would be needed. We have not studied that issue in great detail because it occurred to us belatedly as we scrutinised the regulations. However, we think that there will be an impact. In catering establishments, people handle food that has to be cooked on the premises. For example, to achieve the proper separation, we may find that double-sided ovens are required so that food can be put in the oven from one side and taken out the other. Potentially, there are many problems, but we need to study this issue further.

Dr Simpson: You said that the regulations would affect mixed shops. In what other ways would they be affected?

Roger Hammons: All ready-to-eat food in the supermarket is caught by the legislation.

Dr Simpson: You are saying that food that is sealed and packaged should be exempt, because it will not be handled and there is no possibility of contamination, whereas under the regulations as they stand, you will have to train staff in food handling?

Roger Hammons: Yes.

Dorothy-Grace Elder: Correct me if I am wrong, but I think your submissions are made against a background of feeling in the trade that some hygiene regulations are over the top and harmful to business. For example, seven or eight years ago, new bakery regulations put many small bakers out of business; they were forced to spend £30,000 or £40,000 on chill counters, which were unnecessary in the fresh bakery trade. Do you feel that it is in the public interest for all possible hygiene precautions to be concentrated in the raw and cooked meat selling area because you fear that in practice people might get slacker if there is a general rule? Would you rather that hygiene regulations were concentrated on the butcher's counter?

Patrick Browne: That is a valid point. The butcher licensing regulations are aimed at the parts of premises in which raw meat and pre-packed foods are dealt with at the same time. Our argument—I am not trying to turn this around or avoid your questions—relates to why the regulations should apply to parts of a store in which there is no butchery business. That is a more fundamental question. Our concern is that by extending precautions to the whole of a 30,000 sq ft store rather than restricting them to the butchery part of the business, people become less conscious of standards. The English and Welsh regulations have addressed the point that we make.

Mary Scanlon: Are you saying that we are gold-plating these regulations? I want to pick up on what Dorothy-Grace Elder said. There may be stand-alone butchers' shops with very low turnovers. I am thinking about equipment that costs £10,500 and significant increases in staff costs. Are you concerned that the regulations—necessary though they are—will increase the cost of the product and that some butchers' shops, perhaps in rural areas, may be threatened?

Patrick Browne: When we responded initially to the consultation, we expressed concerns about the additional costs the regulations would impose on businesses, and on small businesses in particular. I guess that we still have those concerns, but the argument has moved on and the regulations have been drafted and are before Parliament. We now seek to ensure that the regulations are workable and enforceable.

The one-off costs are significant and complying with the regulations will certainly impose a burden on small businesses, but we have to comply with the law and meet any additional costs. We will do our best to ensure that the impact is minimised.

Ben Wallace: I will pick up on a point Richard Simpson made about mixed stores. Would many more employees of mixed stores, such as those working with pre-packed food, have to receive training, perhaps unnecessarily?

Roger Hammons: Employees already receive a significant amount of training and would have to have more.

Ben Wallace: There would be a cost.

Roger Hammons: Yes, there would be a cost. It might not be necessary for them to receive that training.

Ben Wallace: On the cost of licences, do you have a view on whether it is fair that bigger stores such as Somerfield should pay a similar price for a licence as a single proprietor of a local shop?

The Convener: You are stuck in the middle.

Patrick Browne: That is a difficult one. The regulations have been drafted so that there is a flat rate for everybody. I accept that superstores tend to operate larger butchery premises than other shops, but there are individual butchers' shops that have larger butchery businesses than those in superstores.

Ben Wallace: I will phrase the question differently. Do you think that more could have been done to reflect the volume of sales in the cost of the licence?

Patrick Browne: I will duck that question. It is one for the Scottish Executive.

Ben Wallace: I know—the Scottish Executive is next.

Patrick Browne: Our concern is about additional costs on business. This requirement is being introduced by the Government, although we accept that it has invested money in local enforcement and training initiatives for local councils. I will have to duck the question.

Ben Wallace: Does Somerfield have a view on that?

Roger Hammons: Our earlier private view was that there should be a scale according to the size of stores. I do not like ducking questions.

The Convener: You are very public minded.

Ben Wallace asked about the requirement for extra staff and extra training for people who do not have to handle raw meat. Have you quantified the cost of that in your stores in Scotland?

Roger Hammons: We did not cost it out fully, and I could not say with any degree of accuracy what the costs are. Our figures would be a deal different to those of some of the other retailers.

The Convener: Would it be quite difficult for us to get a quantifiable figure, because of the differences in staff turnover, size of store and so on?

Roger Hammons: I would be very willing to investigate that and to respond at a later date. If that is acceptable to you, and if you give me a few days in which to do so, I will be happy enough to consider that.

Mary Scanlon: Training costs are mentioned at paragraphs 31 and 32.

The Convener: Which paragraph? I remember seeing some reference to a cost in the order of 8 to 10 per cent.

Mary Scanlon: It says that basic level training will cost £25 to £50 and that intermediate training will cost £100 to £250.

The Convener: I am trying to put those figures into a quantifiable percentage of extra costs falling on companies for training of staff who are not directly covered by the regulations. I do not think that anyone is arguing against having that level of training, whether in-house or otherwise, for people who handle raw and pre-cooked meat directly.

However, as I understand the position, the argument is now about the licence covering a whole store. People who stack shelves and who are not in direct contact with two different types of meat will also have to be trained. I am interested in those extra training costs, over and above those for people who handle the meat. There does not seem to be much to be gained from heaping extra costs on to businesses unless there is an impact on public health and food safety.

Ben Wallace: I am concerned about the small, rural mix shops, such as the Spar or the Co-op, which do a bit of everything. Somerfield is vast and, in any event, it probably has a great big training scheme for nearly all its employees, while there will be a knock-on effect on some of the small village shops where the meat counter is a tiny wee thing in the corner.

The Convener: Ben Wallace's concerns highlight the fact that it is quite difficult to introduce regulations that cover those two greatly different situations.

Roger Hammons: Yes, but we have stores in relatively rural areas. I had a nice holiday in Scotland last year, when I visited some of our stores that I had not been to before. They are more rural than our other stores, although they are not as rural as some of those mentioned by Ben Wallace, on which the regulations will impact.

The Convener: As there are no more questions, I thank the witnesses for answering our questions and giving us some food for thought on these regulations.

I now ask the representatives from the Scottish Executive to come forward.

Ben Wallace: I am always carping on about Scottish statutory instruments coming before us without any notice. This example shows us how

important it is for us to be given enough time to take action. We see so many SSIs and, without the debate that was initiated by the Scottish Retail Consortium, we may well have just watched the regulations go through. We may not even have seen them in enough time.

The Convener: I believe that the regulations have also gone through a European procedure. However, it may be that we are looking at them from a peculiarly Scottish angle, given the comments made by the Scottish Retail Consortium about Scottish partnerships and so on. Perhaps some of the rural dimension to the issue is more obviously Scottish.

Ben Wallace: I would also like to ask the clerk if we could acquire a copy of the English regulations. As the consortium's submission says that those regulations deal with the issue of mixed business premises, we could see how the wording—

The Convener: Yes. Can we have some clarification on the situation in England and Wales?

I ask the witnesses to give us an indication of the Executive's position on butcher licensing. We will then ask you questions based on what you said and on what we heard from the Scottish Retail Consortium witnesses.

Lydia Wilkie (Food Standards Agency in Scotland): I should say that we are here from the Food Standards Agency rather than the Scottish Executive—this is the first time that we have represented the agency at one of the Parliament's committees. I have with me Steve Lindsay, who was involved in developing the regulations as a lawyer in the Executive, and Jennifer Howie, who is one of my policy colleagues and who has been involved with many of the organisations and consultations that have taken place over the past few months.

12:30

As members recognise, the butcher's licensing scheme is designed to improve hygiene practices in butchers' shops. It has arisen specifically because of the tragic deaths from the E coli outbreak in central Scotland. The regulations bring into effect the last of the Pennington report's key recommendations. The Scottish scheme brings into effect all the recommendations from that expert group. The proposals in Scotland were subject to three separate, wide consultation exercises over a period of three years. The exercises covered 300 to 400 different organisations representing the industry, enforcers and consumer interests. Ministers from at least two Administrations supported the SSI because its emphasis is very much on improving consumer safety and confidence.

I will turn to the main points made by the Scottish Retail Consortium. It is useful to have that dialogue, because we want to move in partnership with the industry. The consortium suggested that the definition of "butcher's shop" affected only stand-alone shops—that is not the case. We carefully considered how to define the premises in Scotland. Because this is a licensing matter, the model that we followed was that of Scottish liquor licensing laws, where the whole premises are defined. It also provides an example of businesses, particularly those with a mix of business interests, that are used to dealing with a licence. While the conditions that relate to the butcher area cover the whole shop, it is important to note that they are directed towards the areas of risk that are identified in the SSI—the risk is that of cross-contamination between a raw meat product and a ready-to-eat food.

While I will not go through all the conditions, because they are detailed, almost all the important conditions mention raw meat and unwrapped or wrapped ready-to-eat food specifically. Therefore, the conditions do not apply to the sale of a bucket and spade, because they can only apply to those areas where cross-contamination could occur. A different approach is taken by our colleagues down south, but our approach was taken in partnership with enforcers and with the main trade body of the butchers organisations.

A possible problem with catering premises in large retail stores that have a butchery counter was mentioned. The regulations specifically exclude catering premises, the definition of which is

"premises, or parts of premises".

My legal adviser might like to come in on that point, but we do not believe that that definition creates a problem in stores, because the catering side of that business is excluded from the regulations.

Steve Lindsay (Food Standards Agency in Scotland): The definition provisions, which are contained in paragraph 1 of the regulations, describe first what we mean by a "butcher's shop". Immediately after that, they define what we mean by "catering premises". From my reading of the blending of those two definitions, it looks to me as though catering premises are intended to be excluded from the butcher's shop and that catering premises can form a canteen or restaurant on other premises. That means if they provide food for consumption by the public or staff and are not used as an intermediate processing stage to send prepared food on to other premises, they are classed as catering premises and are exempt from the requirements.

The Convener: Is that paragraph 1 of schedule 1A?

Steve Lindsay: That is right.

Lydia Wilkie: The consortium was also concerned that, where there was a concession, there could be a problem for the host premises. The SSI has been designed so that the secondary business or the host premise can apply. Naturally, a concessionary business would also involve a contract and conditions would be dependent on that situation.

That links in with the use of the term "proprietor", which, under Scots law, does not have to be a single person. In other words, Safeway Stores plc is as much a proprietor as Joe Smith the local butcher. As the term "proprietor" is used in the Food Safety (General Food Hygiene) Regulations 1995, the SSI also keeps a continuity with earlier legislation. If the committee needs more information on the legalities of that, Steve Lindsay will happy to supply them.

On concerns that in-house training would not be allowed, we have specifically amended an earlier version of the regulations to ensure that the phrase reads "training equivalent to". I should make it clear that enforcement officers will decide whether training is equivalent to statutory levels, as they decide whether a premise can be licensed. Although in-house training will be acceptable, it does not have to be specific exam-led training. We are currently producing guidance notes that will go into more detail on the training elements.

There was a further concern about handlers, which was very much related to mixed premises or businesses. In response to comments from the consultation—in fact, I think that the consortium itself raised them—we amended the terms to meat handlers who have to be trained. That means anyone who handles wrapped or unwrapped meat, because that is where the risk lies. Someone who stacks shelves, for example, and does not handle either raw meat or ready-to-eat foods would not need that level of training.

The Convener: Will someone stacking fridges with packaged, ready-to-eat meat require training?

Lydia Wilkie: If they were not separate staff. In other words, they would require training if they were also going to touch unwrapped, raw meat. That is a reasonable safety measure as far as training is concerned.

Finally, I am glad that the Scottish Retail Consortium is now happy with our response to its concerns about the revocation of licences. I think that that is as much as I can say, and I am very happy to field any questions.

Margaret Jamieson: You talked about the legal definition, which is a term that concerns me, as it leads me to believe that the SSI is not as clear as it is intended to be. Furthermore, I think that Mr Lindsay said "It appears to me", which makes me think that if there is a court case, the final decision will be down to the determination of a particular sheriff. That is not the way we should pursue legislation of this nature. In order to ensure that everyone is aware of the exact definitions, perhaps the definitions should be drawn from people who are not legally qualified. It never ceases to amaze me how six lawyers can come up with six different viewpoints on one piece of legislation, with each of them raking in large amounts of cash.

Mr Hamilton: Like politicians.

Margaret Jamieson: Maybe.

Steve Lindsay: I suppose that six lawyers give six different answers because they all have families to feed.

I am sorry if I sounded too much like a lawyer when I was explaining the legislation. If I said "It appears to me", I meant that that is what I tried to do. I am pretty clear about the instructions that we wanted to exclude. Although you are right to say that it will always be up to the court to decide these matters, we strive to make the legislation say what it means. I think that these regulations say what they mean, and I would be happy to stand up in a court and say so.

Margaret Jamieson: However, it will be a proprietor who will have to answer that question in court, not you, and the local environmental health will put its own spin on it. That is not helpful to anyone. Is there any possibility of reconsidering that part of the legislation to ensure that there is no dubiety about its intentions?

Lydia Wilkie: I have a great deal of sympathy with the vagaries of Scots law and I do not think that we can totally turn the system on its head over this issue. However, we are currently finalising detailed enforcement guidance to provide consistency across Scotland for enforcers. Furthermore, we are involved in and facilitating the development of industry guidance, which will be in much plainer language. Although the enforcement guidance is only guidance, the courts will take it very much into account if a case comes up.

Margaret Jamieson: Could such guidance be included in the legislation to ensure that there are no arguments and that legal minds are not trying to make some money by finding ways to challenge it?

Steve Lindsay: The point is well taken. We increasingly strive to make legislation say what it means. In this case, we think that we have made it say what it means.

Margaret Jamieson: It is not enough just to

think.

The Convener: I do not think that committee members are satisfied with that answer.

Mary Scanlon: I want to turn to paragraph 9 of schedule 1A, which deals with the suspension of revocation of licence and appeals procedures. If I understand the Scottish Retail Consortium correctly, that provision is already contained in the Food Safety Act 1990 and there is no need for further legislation. How would you respond to that comment?

Steve Lindsay: Is that the point about appeals?

Mary Scanlon: Yes. Paragraph 9 of schedule 1A.

Steve Lindsay: The SRC's initial representations indicated that we had failed to make provision for appeals. The answer to that is that there is no need to make provision for appeals in these regulations because the Food Safety Act 1990, under which these regulations are made, automatically engages an appeal process. However, the appeal for any challenge to the regulations will be to a sheriff court, not a specialist tribunal.

Lydia Wilkie: This procedure is very much in line with all other subordinate legislation. As the appeals procedure is contained in the primary legislation, any subordinate legislation pertaining to the act does not have to refer to a specific process.

Mr Hamilton: My point has been very largely covered by Margaret Jamieson. However, schedule 1A states that

"'butcher's shop' means the premises of a food business".

Will such a wide definition cause any problems? Surely the phrase "food business" could relate to the very concerns that have been raised.

Steve Lindsay: Mr Hamilton again refers to the schedule. We have defined butcher's shop to mean premises of a food business because that is the typical expression used to describe places that sell food. It could be said that that stretches the scope away from the narrow, wee bit of a big store that could be regarded as the butcher's shop to the whole premises but, as Lydia Wilkie said, the detailed conditions imposed by paragraph 5—in what I would imagine are expensive and staff-focused ways—focus on the handling of raw or other meat.

12:45

Paragraph 5(1)(b), for example, refers simply to the fact that people who handle raw meat require training. Paragraph 5(2)(a) says that raw meat should be kept separate from other things. We are talking about the quality of the conditions, which focus on the handling of raw meat, those who handle it and their level of skill. A certain amount of record keeping is associated with that.

I am not clear what the specific arguments against the conditions or their application are. It occurs to me that some of the provisions may have been expressed in a way that makes it look as though they apply to a whole store, but unless raw meat is being kept everywhere in the store, the conditions will not bite.

Mr Hamilton: I want to come back to the point about guidance. You said that the guidance has no legal status. Does that answer Margaret Jamieson's point? What exactly is the status?

Lydia Wilkie: The guidance has a status in that the enforcement authorities have to consider it when taking action, but it is the statute itself that has the basic legal status. Any authoritative guidance issued by the Government will naturally be considered closely and taken into account when court cases arise.

Mr Hamilton: The guidance could not be relied upon on in court though, could it? If there were a court case involving a dispute about the definition, what status would the guidance have?

Steve Lindsay: It would be one argument. As Mr Hamilton probably knows, guidance is usually fairly elaborate on points such as this, so if there is more than one argument it will pose them all, but it will attempt to explain what the purpose of the legislation is. That is all that can be done. We cannot tell the sheriff that he must accept the guidance and deliver convictions or penalties based on it.

Mr Hamilton: On a separate point, courts can sometimes rely on guidance from Parliament as being binding in some way. What is the position with guidance from a devolved administration, on the grounds of the different issue of sovereignty?

Steve Lindsay: Many things might conceivably be considered in the new devolved era. The courts may concern themselves greatly with proceedings such as these, for example—there is some history in England of courts choosing to do just that sort of thing. It is difficult to say how far they will run.

I do not think that the courts will necessarily say in every case that they accept Government guidance—which is a Government's expression of what it intends to be the case—as full and final if someone can demonstrate a cogent argument that shows why it would be ridiculous for that view to be taken. I do not think that the new regime in Scotland will necessarily affect the evidential values—as lawyers call them—of such things, but the courts usually treat guidance as persuasive. When courts have dealt with other forms of food

regulation, they have been very interested to see what guidance there has been.

Dr Simpson: As I read it—although I have perhaps not had the time to give it the attention it deserves—schedule 1A seems to define a lot of things in terms of the premises, but one subparagraph talks about persons handling meat without defining meat. Does it mean both wrapped and unwrapped meat?

From the point of view of safety, the issue is to separate these two things. Somebody who handles only wrapped meat—meat that is wrapped in such a way as to prevent the passage of micro-organisms and so on—would not be covered by these regulations, as they do not handle raw meat that might contaminate wrapped meat.

Lydia Wilkie: They would not be covered if there was an area of separation between staff.

Dr Simpson: Would it not have been better to include, as a definition of a person who handles meat, someone who handles unwrapped meat?

Steve Lyndsay: We have included a definition, but one sometimes has to use a magnifying glass to follow these regulations. Persons who are handling meat are the ones whom that provision covers, regarding training to a certain level. Meat is defined in the first paragraph of the schedule as fresh meat, by which raw meat is intended. However, I regret to say that a bunch of other regulations must be read to determine the precise definition.

The provision is intended to cover both raw meat—the bleeding meat on the palm of the store assistant—and vacuum-packed or wrapped raw meat. It does not cover cooked meat.

Dr Simpson: I am not sure that that clarifies the definition. As long as you are saying that in stores in which both raw and cooked meat is sold, staff who do not handle raw meat—which could pass on contamination—will not be subject either to the enforcement orders or to these regulations, that is okay. That is now on the record. If not, the matter needs to be clarified.

I have a legal point to make to Steve Lyndsay. You say that there should be equivalence, in terms of training, "to at least the standard of", which, in law, would be interpreted as meaning equivalence. Therefore, that paragraph does not need to be amended to say "at least the equivalent of standards".

Lydia Wilkie: Yes.

Dr Simpson: My last point follows an earlier answer from Lydia Wilkie. Will the term "the proprietor" include the Scottish concept of partnership?

Steve Lyndsay: It will include a Scottish partnership.

Dr Simpson: Thank you. That concludes my three questions.

Ben Wallace: I would like to follow on from the points that Richard Simpson and Duncan Hamilton raised. You said at the beginning that you followed the model of the liquor licensing laws in the definition of premises and their licensing. However, there is a difference. There are many different types of meat, such as raw meat, raw meat products, meat products and pre-cooked meat. In liquor laws and the licensing of the selling of such alcohol, there are no ambiguities or different levels of product that might confuse the handlers of those products or the premises on which they are handled.

Meat is defined as "fresh meat" in schedule 1A, but regulation 5(1)(b) talks about persons handling and preparing raw meat or meat products. Do we therefore understand that the meat in the meat products is raw meat? Or should we talk about persons handling raw meat or raw meat products? Or just meat products, which could be pre-packed, pre-made or frozen? The lack of clarity in such definitions is the kind of problem that will create confusion on mixed premises.

Lydia Wilkie talked about buckets and spades. Somebody who handles buckets and spades would obviously be in a different area of the store and would therefore not require to be covered by the regulations. Who defines those areas? Are they defined by proximity—the bucket and spade counter might happen to be next to the raw meat counter—or by product? In a small mixed store, those sorts of things could create all sorts of problems.

I return to the point that "butcher's shop" means the premises. If you had inserted "the premises of part of a food business", you could have helped to narrow the definition; a butcher's shop would be the whole of the food premises. That helps to narrow it down for a large store, but there is such a lack of clarity and so much confusion of definition, I would be minded to reject these regulations. Other members would have to come to their decisions.

Finally, why did you differ from your English colleagues? On what particular point?

Lydia Wilkie: I will return to that point as well.

Our regulations are based on trying to improve hygiene in relation to the risk of cross-contamination. That means recognising that a risk of cross-contamination exists in many types of shop. As has been said, they range from the big supermarkets, through single butchers, to small mixed premises. We agreed with that and

instructed our lawyers to define things that way. That is more flexible and allows us to get our conditions to take the risk into account. We can ensure that where there is no risk of cross-contamination between ready-to-eat food and raw meat, the conditions need not apply. Where there is a risk—there may be a risk in a small shop if there is just one handler—it would, in safety terms, be logical for such handlers to be trained to ensure that they are aware of cross-contamination.

Ben Wallace: It is the risk assessment that will bring people into conflict and confusion and which will give rise to a lack of consistency across the country. Who does the risk assessment? The local authority?

Lydia Wilkie: Yes. They—

Ben Wallace: And the authority will have different interpretations of what the risk is?

Lydia Wilkie: Yes.

Ben Wallace: And the authority will service many different shops with many different needs.

The risk is so much of a grey area that, in my view, these regulations are not defined clearly enough.

Lydia Wilkie: It is the job of the environmental health officers who go round food premises to assess risk. They have had training on hazard analysis and critical control points—or HACCP. They have been advising us at the Scottish food co-ordinating committee level on how the proposals should be developed. They have been strongly involved—as were all councils—as we developed the regulations. They are largely in support of the regulations and of the way in which they have been developed.

You asked me about the difference between the situation here and how things have proceeded down south. It is not for me to second-guess what my colleagues in England have done. We look to the circumstances in Scotland and consider the heightened concerns here, particularly among butchers. That is why butchers have been very supportive over the years as we have developed these proposals and are largely supportive of this approach.

Ben Wallace: Local authorities will have to do a new type of risk assessment to come into line with the guidelines. Before local authorities issue their licence, they will have to examine whether the areas and definitions are appropriate.

Are you aware of how many council environmental health departments are underfunded or in a satisfactory position? Do you know what the cost implications are? In the north-east region, butchers are spread out for miles—hundreds of miles. The cost implication of local authorities having to reassess is not mentioned in the regulations—I should think that that is more of an implication for the Executive.

The Convener: Can I ask—

Margaret Jamieson: Can I make a point here, convener?

The Convener: I will ask Margaret Jamieson to come in. We will then have to wind up the questioning to get some clarification on the way forward.

Margaret Jamieson: Initially, we sought clarification about meaning and so on. Every question has resulted in a legal interpretation. My understanding was that legislation presented to this Parliament was to be clear and concise and that there was to be no doubt about what was meant by it. I ask you to re-examine the regulations, because we should not be considering legislation that will evolve through every court action. Public safety is paramount, but should not be left to lawyers and courts to determine.

We need guidance from the clerks about how we deal with the matter. I am not sure whether the committee can ask for the regulations to be reconsidered or whether we must record the amendments that we think necessary.

The Convener: Okay. Before we do that, I have one straightforward question. Why is the consortium's proposed amendment to schedule 1A unacceptable? Having heard the discussion this morning, I can see no reason why it should be unacceptable.

Lydia Wilkie: We took a different approach from that taken in the English regulations. The amendment replicates the English regulations, which have an almost formulaic approach. We had detailed discussions with environmental health professionals from across Scotland and they were content with our approach.

The Convener: Thank you. I will now ask the clerk to tell us where we have got to in the process. As members will know, in the past we have made decisions on regulations on the basis that no member of Parliament has lodged an objection. This may be different; we require clarification on what actions are open to the committee and the timetable that such actions should follow.

13:00

Jennifer Smart (Clerk Team Leader): The committee would be considering a motion for annulment under rule 10.4 of standing orders. Any member of the Parliament can lodge a motion that the lead committee recommends that nothing further be done under the instrument. That would

lead to a debate on the instrument, which would take place at the next meeting of the committee. At that time, the committee can decide whether to recommend to the Parliament that nothing further be done under the instrument. If that were to happen, there would be a parliamentary debate on the instrument. The committee does not have powers to amend the instrument, although it can annul it.

The Convener: Is the first step that a member lodges a motion to annul the instrument, which would take us into a debate with the minister?

Jennifer Smart: Yes.

Ben Wallace: If I am not mistaken, if the minister does not concede any amendments in the debate, we have the choice to agree to or reject the instrument, but we cannot amend it. I hope that the minister will be open to the committee's view during a debate.

Irene Oldfather: Can I clarify whether a member must lodge the motion, rather than the committee? That seems anomalous, given that we are discussing the instrument as a committee.

The Convener: I can lodge the motion as the convener of the committee. Would that be a problem?

Margaret Jamieson: We will support the motion.

Ben Wallace: The committee will support such a motion.

Mary Scanlon: I would be happy to support that because not only are the proposals vague and ambiguous, so were the answers we heard this morning. The answers that we were given are open to a multitude of interpretations. We need proper clarification.

The Convener: Does the committee agree that I should lodge a motion asking for an annulment of the instrument? That will be debated and we will have the opportunity to question the minister at our next meeting. Is that agreed?

Members *indicated agreement.*

Ben Wallace: Convener, could you write to the minister on our behalf to let the Executive know our fears? That would allow the Executive to bring an amendment to the debate if it so wished.

Margaret Jamieson: The minister will be able to read the *Official Report* of the committee.

The Convener: The problem is that we often receive the *Official Report* of the previous week on the day of our next meeting. In the circumstances, we could maybe ask to make sure that the *Official Report* is available to the Executive and to the minister before that.

I would like to thank the witnesses from the Food Standards Agency. I would also like to thank the representatives of the Scottish Retail Consortium for their time.

Does the committee agree to consider the draft report on the budget on 23 May in private?

Members *indicated agreement.*

13:05

Meeting continued in private until 13:08.

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