HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 2 May 2001
(*Morning*)

Session 1

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Wednesday 2 May 2001

HEALTH AND COMMUNITY CARE COMMITTEE
13th Meeting 2001, Session 1

CONVENER

Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Nicola Sturgeon (Glasgow) (SNP)

*attended

WITNESSES

Andrew Carver (Scottish Association of Health Councils)
Malcolm Chisholm (Deputy Minister for Health and Community Care)
Danny Crawford (Greater Glasgow Health Council)
Andrew Gardiner (Scottish Association of Health Councils)
Professor Phil Hanlon (Public Health Institute of Scotland)
Chris Lambert (Ayrshire and Arran Health Council)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERKS

Irene Fleming
Peter McGrath

ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 2 May 2001

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 09:30*]

Budget Process 2002-03

The Deputy Convener (Margaret Jamieson): Good morning. I welcome Professor Hanlon and thank him for coming to the committee to assist with its deliberations on the budget. Would you like to make any comments before the committee asks you questions, Professor Hanlon?

Professor Phil Hanlon (Public Health Institute of Scotland): Yes. Andrew Walker was good enough to tell me that there would be an opportunity to set the scene.

Massive debates are going on about how best to spend money in Scotland to improve health. It is gratifying to see so much scrutiny. I was struck by a letter in *The Herald* this morning from a Dr Moore from Inverness-shire. Dr Moore is a general practitioner and is, doubtless, very informed. He makes a number of very good points in the latter part of his letter, but I am very concerned that he begins his letter by saying that health in Scotland is getting worse. As evidence of that, he points to the increased number of cancers, admissions for heart disease and the rising tide of diabetes.

He is right about the rising tide of diabetes and we need to be concerned about that. However, there are more cancers because people are living longer and are healthier. They live to ages at which they can get more cancers. That is terribly good in a way, although the fact that they end up getting cancers is of concern and it is a care issue that we need to address. There are enormous complexities, even for someone in general practice, for example, who deals with such data.

I understand that my good friend, James Dunbar, spoke to the committee last year about Finland. I am a fan of what is going on in Finland, but simplistic conclusions can be drawn. Forth Valley Health Board's annual report shows improvements in heart disease figures that are every bit as good as what Finland has achieved, but no summer schools are run in Stirling on how that board has achieved such improvements. The committee will take my point.

Many things in Scotland are getting better. Heart disease figures are getting better and cholesterol and AIDS-specific death rates are falling. The story can be spun positively. Alternatively, rising obesity, diabetes, asthma, depression and suicide in younger men can be pointed to. The story can be spun either way. In such a complex situation, we do not want to over-elaborate; people need to understand what we are doing and why we are doing things. However, we do not want to grasp simplistic solutions to complex problems. That is my main point.

Dorothy-Grace Elder (Glasgow) (SNP): Thank you for coming to the committee, Professor Hanlon. What are your views on the current level of expenditure on health promotion? What are the most pressing needs in developing health promotion activities? Will you comment on the disability proofing of any of the plans, perhaps with particular reference to categories such as deaf people? We know from a Greater Glasgow Health Board report that 23 per cent of deaf or hard-of-hearing people leave GP's surgeries without knowing what is wrong with them because of a lack of visual help. Furthermore, there are major communication problems in hospitals.

Professor Hanlon: On Dorothy-Grace Elder's first question, if you are talking in narrow terms about expenditure on a professional activity called health promotion, the amount that is spent is probably about right at the moment, because it is a small part of our entire endeavour to improve health. For example, in last weekend's *British Medical Journal*, an article from the University of Glasgow showed that students of my generation have lower blood pressures than those who were students 10 or 15 years previously. That is almost certainly due to post-war improvements in housing and other factors from which I, and the rest of my generation, have benefited. The period when people are born affects their blood pressure levels when they are students and after. As a result, investment by the post-war Governments yielded a benefit that could be measured 20 years later and which is still having an effect on our lives. Such impacts on health often take that length of time to manifest themselves.

As a result, the big question about Scotland's health does not centre on the amount of expenditure on a narrow area called health promotion—that activity is carried out professionally at the moment—but on how that spend impacts on the way we use the rest of our national and local resources. There is less cause for satisfaction about whether we are having as much of an impact on the big factors that influence health as some of our European counterparts.

Dorothy-Grace Elder: What are the most pressing needs? Furthermore, could you address

my point about disability proofing, particularly in relation to deaf people?

Professor Hanlon: The most pressing need is to find some effective methodologies to confront the effects of social exclusion on health. Although there is some evidence of modest improvement through social inclusion partnerships, demonstration projects and various initiatives from the Westminster Government, there is much more evidence that the health inequalities in Scotland are continuing to worsen. It is probably still quite early to make such a judgment; however, we are certainly seeing no rapid improvements. Although this is an old story for the committee, we cannot lose sight of that issue.

Scotland's problems reside largely in the 20 per cent of people who live in relative poverty. If they were taken out of the population figures, we would compare rather well with other European countries. As the majority of the country's health problems lie in Strathclyde and other pockets of deprivation, we will not crack Scotland's health problems until we solve that problem.

As for disability proofing, one of my masters students was involved in some of the work that Dorothy-Grace Elder quoted, so I am quite familiar with it. Frankly, the situation is a scandal; it is as simple as that. That we have not focused on those problems is down to a historical legacy. It is not right that someone should have poorer access to a health service facility because they cannot hear what is being said or cannot see what is being done to them.

However, there is no easy answer. Dorothy-Grace Elder mentioned deaf and blind people; I have a slightly better example. I was involved recently in the case of a young man who has muscular dystrophy and who needed to be examined by his GP—it does not matter what for. Because the young man is now older and bigger, he needs the use of a hoist to get onto the couch. His GP told him, "There's nothing I can do about it. I don't own these premises; they're rented from the health board."

Dorothy-Grace Elder: Shocking.

Professor Hanlon: It is shocking. The GP had not thought the situation through; he did not know that the social work department would have lent him a hoist for the afternoon. However, the GP felt disempowered. I suspect that he had had such hassles over the years with his health centre that he felt that he could not do anything to make things work better. The issue of staff disempowerment is at the heart of the problem. Many members of staff want to do things better, but they are frustrated because they feel that they are part of a big system and cannot get access to translators, signing and so on.

Dorothy-Grace Elder: There are only 16 fully registered signers in Scotland. The deaf and hard-of-hearing population is about a seventh of the population of Scotland. At hospital level, there does not seem to be deaf awareness training. There are many examples of consultants coming into a ward and speaking nicely to everyone else who is about to have an operation, and then going up to the bed of the deaf person and just making a thumbs-up gesture.

Professor Hanlon: Indeed; and with the population getting older, that problem will grow. I concur—but I am only as familiar as members are with the research. We are only just taking the lid off the problem, and we probably need to go back to base 1 to think about how to solve it.

Dr Richard Simpson (Ochil) (Lab): At the moment, the Executive is putting money into three demonstration projects. Should we wait for those projects to be completed before we go out and spend money on the areas that are concerned, or should we be budgeting now? Do you have any evidence that the Executive is budgeting now to roll the projects out if they appear to be successful? Is there any forward planning on that that you have found, either in the health improvement plans or in the community plans, as they will be known?

Professor Hanlon: The short answer is that I do not think that we should wait. We are rolling out the main lessons. The main evidence that has informed the work on heart disease and early intervention is accessible by other parts of Scotland, and other parts of Scotland are considering their versions of the lessons that have been learned. The major question that the demonstration projects ask, and have to answer, is whether additional expenditure—above the level that is normally made available to health boards—yields markedly greater results. We should wait for the answer to that before we throw more money more intensively into defined areas. I do not know the answer to the question now—we need to wait for it.

Dr Simpson: Those projects are obviously being evaluated, as they are demonstration projects; I presume that they are being monitored carefully. What about the more general approach, to which you alluded in your first answer, on healthy living centres and community schools, both of which are supposed to have an input into deprived areas and tackle the issues of social exclusion?

Professor Hanlon: Some of the smaller-scale projects are doing well, and some not so well. I think that our biggest lack is of larger-scale interventions. Let us consider the various housing projects in which Scotland has invested over the years. We do not know what impact those have on

health. We do not and will not know what impact the whole social inclusion partnership programme, which is a large programme, will have. If you ask me whether a breakfast club works, I can say that work has been done that will tell you the answer. If you ask me about exercise referral schemes, I can say that evaluation has been carried out on them. Usually, such schemes work a little; they have marginal effects. What we are really ignorant about is the results of the large programmes of expenditure and the impacts that those have on health.

Dr Simpson: Do you think, therefore, that the Executive, through its central funding, should ensure that the health impact of the social inclusion programmes is being evaluated?

Professor Hanlon: I will say something controversial in reply—although I have not thought this through fully. I will quote Sally Macintyre of the Medical Research Council unit at the University of Glasgow. She makes the point—which I am also thinking about and which I will now put into the committee's court, so that members can think about it—that, to take the debate out of the Scottish context, if a lot of money is to be spent on health action zones, and given that health action zones are being set up in 30 locations around England and Wales, they should be randomised. If they are being allocated fairly arbitrarily anyway, why not randomise them and do a proper study and consider the areas that got the additional investment, compared—over a defined time scale—with those that did not?

If they really work, health action zones could be set up in other areas; if they do not work, then it is discovered that money has been wasted, but only in some areas. That does not mean that the problem has gone away and can be ignored; it means that that is not the route to go down. We should consider whether the big blocks of the Scottish Parliament's expenditure should be subject to a similar method of appraisal.

Janis Hughes (Glasgow Rutherglen) (Lab): I want to probe further on the evaluation of health promotion schemes. We all think about the schemes that we know, for example the west of Scotland coronary prevention study, which was long and involved, and we think about the time scales and diverse outcomes of the schemes. I know that the evaluation process is difficult, so can you suggest ways in which targets can be set, so that evaluation is more easily definable? Are you satisfied that the data that come out of the studies, particularly the more long-term, diverse studies, are sufficient to monitor the studies effectively?

09:45

Professor Hanlon: The answer to that could be the subject of a two-hour seminar, but I will try to give you a 30-second reply.

Take the example of smoking. The amount of people who smoke in Scotland has fallen by 1 per cent or 1.5 per cent every year for the past 15 to 20 years. That is a remarkable success, particularly because the number of smokers in eastern Europe and Asia has been rising. That has happened not by magic, but because of action that we have taken. What action, however? Was it the Health Education Board Scotland campaign? Was it work place schemes? Was it the smokebusters club? When an individual evaluation is conducted on any one of those initiatives, it is found that each had some effect, but that the effect was usually quite modest. Sometimes, it can be found that the initiative appeared to have no effect. However, the combined influence of all of the initiatives of the past 20 years has reduced the amount of the population who smoke from the mid-40 per cents to the high 20 per cents. That is a considerable success, but I cannot say which specific initiatives caused it. That is what the Parliament will have to grapple with.

If you asked me whether I could give a defined scientific answer to the question of how we can confront inequalities in health, I would probably have to say no. Political judgments that are made on the best scientific evidence we can muster will have to be made. That is not an excuse for not doing good science with what is left, but it would be oversimplifying a complex problem to say that we can ever get to a point at which we are able to determine the two or three measures that would remove health inequalities.

Janis Hughes: I understand that it is hard to evaluate individual studies but, in that case, how is the spending on a particular project justified?

Professor Hanlon: We can do two things to add rigour to such an exercise, if not proof. We should conduct defined scientific studies on particular interventions. One might ask whether a Starting Well intervention increases parenting skills and improves child health and child education. Such questions have defined answers and we are in the process of working them out.

We should also measure a sufficient number of broad outcomes in the areas about which we are most concerned. For example, if we are worried about Pollok, we should measure a series of indicators around the physical and social environment, health and well-being functions. You should be able to ask me or people like me how Pollok is doing and whether the action that is being taken to help Pollok is making a difference. As I said a second ago, I might not be able to say what is making a difference, but we should be able to give you accurate data on whether we are moving in the right direction. The neighbourhood

statistics project, which the committee will be aware of, will help with that. It is an important endeavour that needs proper encouragement and scrutiny. Once those data come out, we should be able to point at any local authority area, neighbourhood scheme or whatever and ask what progress is being made. That will add to our knowledge and our ability to scrutinise.

Mary Scanlon (Highlands and Islands) (Con): Earlier, you mentioned Forth Valley Health Board. Did that health board do anything specific that led to better health outcomes?

Professor Hanlon: I do not think so. What happens in Forth Valley Health Board's area is an indication that middle Scotland—I call it that because it is geographically in the middle of Scotland—does not have the extremes of deprivation that some other parts of Scotland have and is doing quite well. It is doing well because of all the things that we have been doing. The success is due to a combination of GPs giving advice, health visitors doing their good work, schools doing what they do and so on. All the social programmes that we are working on are having an impact on issues such as heart disease. We must praise them for that as well as acknowledging the problems that we have.

Mary Scanlon: People in that health board area have not been eating more berries and so on, have they?

Professor Hanlon: No. I am not sure whether a berry initiative could be done in Scotland. We should learn the lessons from Finland that are applicable to Scotland rather than simply imagining that we can transplant the initiatives wholesale.

The Finns tried to take fat out of the food chain. However, even if you take all of the fat out of milk and feel good about drinking low-fat milk, you will not remove fat from the food chain if you then go and eat luxury ice cream, which is what the cream in Finland is made into. If Scotland wants less fat in its diet, it has to remove fat from the food chain. That will not happen by accident or by wishful thinking; it will happen because of a combination of consumer choice and the production factors that are outlined in "The Scottish Diet: Report of a Working Party to the Chief Medical Officer for Scotland". We are probably not pushing through the recommendations of that report with the vigour that we might.

The Deputy Convener: There will be a public health input into community planning and health partners will be involved in that plan. Will that bolster those plans sufficiently to ensure that we can secure the outcomes?

Professor Hanlon: I agree that community planning is an important and terrific opportunity for public health. It brings local authorities and health boards together, and we should maximise it. It is an advance. There are some things that we can do, but other things require national co-ordination, such as the issues in "The Scottish Diet". People must look at what is happening to the diet of Scotland, so that the benefits that we are beginning to see in places such as middle Scotland are pressed home in other parts of Scotland. Community planning is part of the answer, but it is not the whole answer.

Mary Scanlon: While local health promotion activities must be tailored to needs, there appear to be large variations in spending on health promotion between health boards. How does that tally with your perception?

Professor Hanlon: I saw those data, and I was surprised by them. They have to be examined to see what is being counted in and counted out in different parts of the country. Since taking up my new role at the Public Health Institute of Scotland, I have travelled around Scotland meeting lots of people. My impression is that health boards do different things. There are different styles and priorities, but there is a core that is similar; for example the commitment to social inclusion, local partnerships, community planning and targeting key groups, such as community schools and young people. That core is common throughout the country, but there are issues that are particularly pertinent to Dumfries and Galloway, Glasgow, or wherever.

I am not sure whether I believe that there is as much of a discrepancy in spending per head of population on health promotion as it would appear. Some boards are counting more in and others must be counting more out, because when one goes round it does not seem that Dumfries and Galloway is spending markedly less than any other health area.

Mary Scanlon: You have been invited along today as part of our examination of the budget process, because we are committed to better public health in Scotland. You have talked about many things—for example, social inclusion partnerships, deprivation and inequalities—but you have not mentioned healthy living centres. I was shocked when I received a copy of a 22-page application from doctors on Skye to the lottery new opportunities fund. I will not go through it with you, but it is about patients and self-help, health empowerment, information technology, professional support, bringing together the voluntary sector, and heart disease, stroke and diabetes. The document is about stopping telling ourselves that we are sick, and taking ownership.

There is an energy within the document, which comes from a remote part of the country. When you talked to Janis Hughes about randomising the

siting of health action zones, I could not help thinking that it would be wonderful to include the Isle of Skye in that experiment.

The local doctors spent more than three days submitting the application, but it was rejected because it did not fit strategically. I am not a medical person, but what are the local barriers to giving health promotion higher priority? It is difficult for us to find out what is spent on public health, because so much depends on lottery funding. It is not much of an incentive to local doctors if they pull together but are rejected. When people want to make a commitment to public health, they get this kind of treatment. I am sorry for being negative, because you put forward a positive point of view, but I want you to be aware of the barriers that exist in Scotland.

Professor Hanlon: All I can do is agree that it is terribly dispiriting. One of the things that the committee could do is define what should go into what we call core public health promotion expenditure, so that that can be monitored over a longer period of time. That has never been asked of health boards. It is a simple thing that would increase transparency.

Mary Scanlon: It is difficult for us to find out what is spent on health promotion and public health when there are doctors who have to depend on lottery funding to achieve national priorities. I ask for your advice. How can I go back to my constituent and say that the Scottish Parliament is committed to public health, although that application has been rejected?

Professor Hanlon: I hesitate to comment on that specific application. However, I would have thought that people who are motivated enough to get such an application together might be able to make quite a lot of those things happen without the lottery funding. There are good examples of people in all parts of Scotland who have failed to get lottery funding, but who have made 40 per cent of what they wanted to achieve happen, and got 60 per cent of the impact.

I am not trying to belittle the issue that the Skye doctors are confronting and I will not comment on it because I do not know the details. However, it seems to me that the sorts of things that Mary Scanlon mentioned are important to every community in Scotland. We ought to get that kind of activity going in every community. I recently visited a GP down in Dumfries and Galloway who had equipped part of his surgery as a small gymnasium. In such a rural area, that is the only access that some of his patients could get to such facilities, and he had made that investment from his own practice fund.

There are all sorts of innovative approaches that can be made. I am not disagreeing with Mary Scanlon—I agree with the fundamental point, but I would encourage the doctors who contacted you, if they can, to do as much of what they propose within the resources that are available.

The Deputy Convener: Some of the improvements are not resource-based, but spring from new ways of working and from working in partnership with other organisations. A lot of what Mary Scanlon has described is actually happening throughout Scotland, and people are sharing good information on how to go about doing that.

Professor Hanlon: Primary care in Skye has a good track record of doing such things. That is presumably why those doctors were able to put such a good project together.

Mary Scanlon: The GP has already spent more than £20,000 on the project, so the financial commitment exists.

I return to my other question. Do you feel that there are any local barriers to giving health promotion higher priority that we should be aware of?

Professor Hanlon: There are two very different things. All too often, the old conundrums of the health service and the pressures on it swamp the agenda and take people's eyes off the longer-term goals. Even issues such as disability access are affected. The firefighting just swamps managerial time, and that is a real barrier.

The second issue is more ephemeral, and has to do with just what Mary Scanlon was alluding to when she acknowledged the good practice in Skye. A sense of "can do" is needed, among staff and among patients. I firmly believe that we need to raise our sights and encourage each other to do what is achievable. I am trying to be positive and I am not trying to downplay the difficulties, but failure to have a sense of "can do" is a true barrier to improving health in Scotland.

Mary Scanlon: I will try to stay on a positive note. I read Highland Health Board minutes that said that the board had appointed five public health practitioners. I am not sure whether they are nurses or doctors, but they will be allocated to local health care co-operatives. Is it necessary to have new people? Should not we be using the skills of the people who are there already? Is that the way forward throughout Scotland? Do we need additional public health practitioners?

Professor Hanlon: I do not know for sure the answer to that question. That initiative arises from the nursing review, which did the fieldwork. The conclusion of the review was that that skill was lacking. It is a question of bringing people together and mobilising staff, particularly in the nursing work force. You will have heard the phrase, "It's happening already." Yes—there is lots of it

happening already, but it is not happening systematically, and that is what will be key to the success or otherwise of the new public health practitioner grade. If those people can work systematically, they will be a great success. If not, we will have to think again, but they have three years to experiment.

Mary Scanlon: How will those public health practitioners drive forward the agenda?

Professor Hanlon: That will vary from place to place. For example, there are the demonstration projects, which Richard Simpson talked about. Great efforts have been made to bring pilot projects, such as Starting Well, to Glasgow. Who can take the lessons that are learned from such projects and apply them locally? Who can orient local health visitors to a new way of working and encourage them, for example, to abandon the old practices of weighing babies and measuring their heads and to try new things? Skills and drive are needed to make such new initiatives happen. That is the sort of work that the public health practitioners will do.

The public health practitioners will be judged by whether they can make new, innovative and modern things happen in places where such things were not happening before. If they can, they will be a great success; if they cannot, we will be back to asking whether we can use the existing resources more effectively.

10:00

Shona Robison (North-East Scotland) (SNP): Will criteria be put in place to measure the outcomes of the public health practitioners' input?

Professor Hanlon: Our organisation, the Public Health Institute of Scotland, is just being established. We are recruiting staff at the moment, but they will be in post in the next month or so. We have called a meeting of practitioners and we are considering a way of evaluating what the practitioners will do and what the outcomes will be. I cannot report the detail of that, because it is yet to be formulated, but it is on the agenda.

Mary Scanlon: Do you not have a job description yet?

Professor Hanlon: A model job description is available.

Mr John McAllion (Dundee East) (Lab): Everyone accepts what you say about the importance—if we are ever to improve the health statistics in Scotland—of the spending programmes on housing and social inclusion and to tackle and eliminate poverty. I will go back to what you described as the narrower or professional definition of health promotion and what we spend on it, which you said you thought was adequate. Is there a danger that spending from that budget is likely to benefit the most affluent and motivated sections of the population and to miss the poor?

Professor Hanlon: Yes.

Mr McAllion: Could you expand on that?

Professor Hanlon: What you have outlined is a perennial problem in public health. The implementation of any new ideas, ways of thinking or way of working requires effort. Of course, if someone has a good job and has resources, their ability to take on board such new concepts is greater.

What you outlined is a problem, but I reassure you that every public health department in Scotland is genuinely committed to targeting its activity at those who are most in need.

Mr McAllion: Diet, after smoking, is probably the most significant contributor to deaths from the big three in Scotland and most affects the poor. A constituent recently came to me because he had been refused a loan to purchase a cooker. I took up the case with the Benefits Agency, which told me that direction 3 of the social fund directions prevents any loan being given to any individual unless it is the only means by which their health and safety can be preserved. The Benefits Agency—and indeed the appeals tribunal—has ruled that a cooker is not essential to a single person who lives alone because they have access to takeaway meals, salads, fresh food and long-life foods.

To me, that seems counterproductive to what we are trying to do in Scotland. What relationship is there with Westminster that would allow you to say that those rules should be changed because they are making the poor in Scotland ill? There is no point in you spending money on health promotion if the man cannot get a cooker and cannot access decent food.

Professor Hanlon: We have various networks in public health to make such advocacy points. I would be happy to feed that example into the networks, if that would make any difference.

Unless we can join up the policy, advocacy and advice go nowhere. I can only agree with you on that. I assure you that the public health and health promotion community in Scotland is genuinely committed to targeting those who are most in need, although it acknowledges the problem that you raised.

Mr McAllion: I am all in favour of removing fat from the food chain in Scotland, despite my appearance. However, producing leaflets and distributing them through, for example, libraries will not help the poor to remove fat from their diet.

Professor Hanlon: I am not suggesting that we do that.

Mr McAllion: Should not we be spending money on establishing food co-operatives and helping them get access to healthy food?

Professor Hanlon: Absolutely. I do not want to be misunderstood. The James report on the Scottish diet deals with all that. It is the best analysis that we will get of the problem of food in Scotland. It uses the phrase "from plough to plate".

In a poorer community, issues such as food co-operatives and what we do in school dinners are key. Giving people leaflets is certainly not the answer; everyone knows that. I was trying to say that it is necessary to join things up. The Scottish diet action plan is supposed to be about addressing production, distribution and promotion, as well as about supporting individuals and linking that to social inclusion.

There are areas for which we have good analysis and a good set of solutions that we need to drive home to people. I am not convinced that we are driving home even some of the well-established matters as well as we might.

Dr Simpson: The fundamental problem for the Executive is its relationship with the health boards. The Executive gives the health boards the money and, until now, it has performance managed them on finance, but the bottom line is, "Do what you want with the money".

In relation to the public health agenda, are you comfortable that there will be adequate performance management of the new money that is coming through?

Professor Hanlon: To be honest, no, although I am not being critical when I say that. I will not be comfortable until the broader determinants of health are included in the performance management framework of a health board and its accompanying local authority and both are held to account. For example, housing and diet in poor areas should be key issues. Until indices of improvement in those key areas are part of the accountability framework, for both the council and the health board, who will ensure that the community plan and all the other fine documents hit their targets? We should do something about that.

Dr Simpson: So, you think that the community planning process should be involved—

Professor Hanlon: I would include performance management in health plans, community plans and the accountability mechanism—Gerry Marr's accountability framework and the Audit Scotland accountability framework for local authorities. Joint targets could be set on key health areas around the determinants of health; that would draw the agenda sharply into focus. Those areas are as important as waiting times or overspend in acute trusts when we come to an accountability review.

The Deputy Convener: Given the Arbuthnott funding and the specific allocations to cover deprivation, I feel that there is a greater requirement for clarity, within the health boards in particular. Greater clarity would ensure that funding that has been allocated centrally filters through to deprived communities. There may be an opportunity for such clarity and for performance management to be undertaken following the conclusion of the budget process. Is it clear from the budget process that that opportunity exists?

Professor Hanlon: I agree that it is clearer—we have made progress on that.

I am not sure whether my role is to challenge the committee, but it seems to me that the newspapers are full of reports of parliamentary debate on issues such as expenditure in acute trusts and waiting times. Let me be clear: unless those important issues are dealt with correctly, the health service will never move on to the agenda that we are talking about today. I would love people to be as exercised about the rising rates of suicide or of people who suffer from stress or depression in the workplace, because those issues are as material to the lives of people in Scotland, in a real way, as are waiting times. We say that we are concerned—certainly, I am concerned—about people who have to wait too long for an operation, but I am as concerned about people who are off work for a year and a half because of chronic depression. Such issues are as important as waiting times.

The Deputy Convener: Could you recommend any specific steps to the committee, given our short discussion today and your expertise in the field? What should we be saying to the Scottish Executive to make the budget process much clearer and better at targeting specific areas?

Professor Hanlon: I return to the point that we just discussed. The introduction of a high-quality performance management system that ties finance to health and health care outcomes and a transparent system of accountability for both local authorities and health boards would be a real advance.

The Deputy Convener: Thank you for your contribution this morning, Professor Hanlon. I am sure that committee members found it interesting.

I welcome the witnesses from the Scottish Association of Health Councils. We have received your short report, but do you wish to add anything?

Andrew Gardiner (Scottish Association of Health Councils): Thank you for the invitation to

participate in this debate; I welcome the opportunity to do so.

I want to highlight some of the issues that we identified in our submission. We welcome the improvements that have been made to the accessibility of the information in the light of previous statements that we made to the committee—thank you. We also acknowledge and welcome the overall above-inflation funding across all health board areas. However, we have some concerns that the announced levels of increase may lead to some false expectations of what we will be able to achieve; pay awards and other cost pressures may impact on the process.

We welcome the opportunity that the Arbuthnott formula will give to provide equitable funding across Scotland. However, in the light of previous implementation processes, we are keen to see a tight timetable for implementation. We acknowledge the good winter planning that took place, but we point to the increase in emergency admissions, which places intense pressure on acute beds. The impact on waiting times is a matter for concern, particularly in relation to some of the diagnostic assessments in cancer care, which can be a matter of life or death for individuals.

We ask the committee to note our comments about hospital-acquired infections and our concerns about targeting cleaning services for efficiency savings. We would like the committee to consider training across the board for both nursing and cleaning staff to try to improve the situation.

We welcome the clinical governance steps in the Scottish Ambulance Service. We also welcome the additional funding for the state hospital at Carstairs, although there is grave concern about medium-security facilities at local level. That issue has been raised in the past.

In the light of some of your discussions with Professor Hanlon, I want to raise the issue of moving towards a more integrated service. I have great aspirations that the health plan will achieve steps towards that goal. We need to learn from history and move away from situations where expensive equipment was put into local areas without the infrastructure—staffing and running costs—to support it.

The Deputy Convener: You referred to the implementation of the Arbuthnott report, for which, clearly, there is a specific time scale. However, towards the end of last year, health boards received initial moneys and we have reports from all over Scotland that such moneys have not been used to address rurality and deprivation. I will use the example of Ayrshire and Arran Health Board, which did not use that money in the form in which it was intended. That health board is not alone. Do you think that that situation will continue over the five years or will communities in rural and deprived areas see their health improve over the piece?

Andrew Gardiner: That relates to performance management, which has been under discussion. Perhaps one of my colleagues can comment on that.

Danny Crawford (Greater Glasgow Health Council): The money has been allocated to certain areas in recognition of the extra costs that are incurred in rural and deprived areas. It is important that that money be spent to tackle the problems that arise in communities as a result of deprivation or rurality. We are aware of the cost pressures on the health service and there is a fear that money might be shifted to help meet the costs—overspends or underallocations, depending on how you want to look at it—of acute services. That is a serious concern. It is important that health boards ensure that the money reaches those areas for which it was intended. It is important that that process is performance managed and that health councils and other bodies are involved in that performance management.

The Deputy Convener: It was helpful that Mr Crawford talked about the involvement of health councils. What are the witnesses' views of consultation with the general public about the health plan and how budgets are set for individual health boards areas?

Andrew Gardiner: From my position as convener of the Scottish Association of Health Councils, I have links through the health councils to individual communities in Scotland. We need to build on that, as it is a great strength. We do not want to lose the contact that we have with the people.

The general issue of public involvement is a major item on the Health and Community Care Committee's agenda, as it is for the association. We need to work at how we develop the links that we have made. We cannot assume that because we have made those links, things will happen. We will not always be on top of things and will not always ask the right questions. We need to continue to develop the strategies and to look at the issue from a number of different angles.

10:15

The Deputy Convener: Should that be part of the performance management review of health boards and trusts?

Andrew Gardiner: Yes. The Government's clear priority is, in a sense, one of giving the NHS back to the people. It is crucial that we have the ability to influence what happens at NHS board

level. We must continue to do that through the involvement of health councils. Part of that process is to give those councils the right to comment at every point down the line. In the past, we have had a variable reaction to public involvement across the country. We need to have something at the performance management level so that we can take things forward equitably across the country.

Janis Hughes: Your submission mentions comparisons between the figures in "Investing in You" and the 2002-03 budget. Will you elaborate on how the budget compares with "Investing in You"?

Andrew Carver (Scottish Association of Health Councils): The document refers to the past two years' figures. As Andrew Gardiner said in his introduction, the information is more detailed and accessible than it was last year. At a meeting that was held at the same time last year, virtually to the day, our organisation criticised the previous year's figures, saying that much of the data had been aggregated into quite broad bands. We welcome the detail in this year's figures. That has led to greater transparency.

We have picked up some specific points that would make the information further accessible. The second paragraph in our submission highlights that. The explanatory notes to a table are spread over 20 pages, which means that people can very quickly lose sense of what is being referred to. We welcome the improvement in the level of detail that is available this year.

Dorothy-Grace Elder: Will you give us advice on how public consultation could be fed into the Scottish budget and is there any recognised good practice in that field? After you have kindly answered that question, perhaps you could comment on the disability-proofing of budgets.

Danny Crawford: I think everyone would agree that the health service has not traditionally been good at consultation. We should welcome the fact that the health plan sets out the requirement for health boards to account for how they will consult people. We look forward to the publication, later this year, of the document that will give advice on consultation. As that document is about how to consult, I hope that consultation will be built into its production. That would seem to be a reasonable first step and a good example to set. The document has been long awaited and we look forward to it with interest.

The health improvement plan and budget documents are not issues that galvanise populations. People do not find them interesting or easy to discuss. The reality is that many of the things that find their way into the plans have been the subject of detailed discussion at the local level. People should not, therefore, be surprised at changes that are made in patterns of expenditure. A lot of discussion has taken place with stakeholders at the local level, including discussion of maternity strategies and a whole range of services including mental health services.

The association recently conducted a survey to ask health councils about good practice in consulting on such matters. Pages 3 and 4 of our document, on priority setting, refer to that. Although much discussion about individual strategies informs the overall plan, health board officers often decide the overall plan and its relative priorities. Dumfries and Galloway Health Board, Argyll and Clyde Health Board and Shetland Health Board have practices that are fairly good examples of how things could be done and improved. There are lessons to be learned.

Dorothy-Grace Elder: The Scottish budget does not seem to be disability-proofed—should it be in future? For example, it is generally agreed that communication throughout the health service is severely disadvantaged in attempts to communicate with the deaf, because there is not enough visual communication or deaf awareness.

Andrew Gardiner: We need to move with the times and take on board the wider disability issues. We have done that more in recent years. We need to continue to work with experts to ensure that the needs of all disabled people are included in the NHS's spending plans.

I am from Highland and I work locally with several groups. Links with the local community care forum enable us to put such issues on the agenda. In other ways, the development of the voluntary health network is important and we must continue to tap into that expertise. We must look for advocates who will give the picture of what impacts on people. We must use the communication skills that many people have. There may be only 16 registered interpreters, but many other people have the ability to communicate with deaf people. We must listen to those people and use their expertise.

Dorothy-Grace Elder: Should a health board budget contain a heading for disability-proofing? Should a sum of money be set aside for that, or is there another effective way of helping?

Andrew Gardiner: We must be careful not to create structures that do not deliver. We could go as far as appointing, in each health board area, an individual with expertise, but I am not sure whether that would deliver the necessary breadth of knowledge and information to make informed decisions. We must look at the big picture and try to obtain information locally to reflect a range of disabilities, not just deafness, blindness or multiple sclerosis. We should put everything into the pot

and make progress. We have been getting better at that, but we must still work at it.

Dr Simpson: I wonder whether I could ask the witnesses to write to us on a couple of issues, so as not to take up too much time now. Item 8 in the SAHC's submission says:

"We are concerned at the revenue consequences for Trusts of … the capital charges associated with capital investment projects."

I do not particularly want to go into that huge issue. Perhaps you could write to us about your concerns in a little more detail, particularly if the issue relates to resource accounting and budgeting and the 6 per cent capital charges that half a dozen trusts failed to meet in the most recent audit. Does the issue relate to depreciation or public-private partnerships? I would like some amplification on that.

Amplification of paragraph 18 in the submission would also be helpful. It says:

"There is concern that cleaning services have been targeted for efficiency savings."

In light of the Audit Commission's report on cleaning and the recent study published by the North Glasgow University Hospitals NHS Trust showing that measures can be taken to halve the rate of hospital infection, can you come back to us with some specific evidence of the targeting of efficiency savings? I think that we share your concerns.

My general question is on the presentation of the budget, which you spoke about. It seems to us that things have moved on but there is a problem about identifying what might be termed new money, particularly for investment in bringing staff up to the right level. Item 5 mentions the "new deal" for junior doctors, consultants' intensity payments and above inflation pay awards for staff. Those items are part of appropriate investment in staff, but take a big tranche of any increase.

Do you want a further change in the way the budget is presented to try to split off the money that is required for such things—which are an annual element—from new developments in, for example, cancer, mental health or cardiovascular disease so that we see what money is allocated in the budget as new money? I think that there is a desire in the committee to go more down that line, but I would be very interested to hear your views.

Andrew Carver: Such a change would be very useful. We are concerned about not knowing what proportion of the additional money is in effect already allocated to additional staff costs. The model that you describe would be welcomed.

Dr Simpson: I do not know if that would be feasible, but we can at least ask for it.

The Deputy Convener: It would be helpful to have a national picture because each of us is made aware of what is in each of our health board areas. It would be helpful to find out if the local story is actually true.

Mary Scanlon: Paragraph 10 says that table 4.3 in last year's "Investing in You" report estimated an average increase in expenditure of 10 per cent. I will not go through all the figures, but table 5.3 in "The Scottish Budget: Annual Expenditure Report of the Scottish Executive" estimates, according to paragraph 10, an average increase of 21 per cent. Are you saying that there is some misleading information in the document?

Andrew Carver: There did not seem to be an adequate explanation. The figures are actually 0.1 per cent and 0.21 per cent respectively rather than 10 per cent and 21 per cent. That is important.

Mary Scanlon: The figures are still double.

Andrew Carver: Having said that, 0.1 per cent of the overall budget is still a large sum. I was seeking an explanation, which is not available here, I guess. I was not sure about the likely explanations of the different method of accounting or the new research that has led to the figures. However, I think that some explanation as to why there is such a big change in the figures between the estimates from two consecutive years will certainly be sought.

Mary Scanlon: We will ask our advisers about that later.

I want to come back to the point that the convener made. Given that Andrew Gardiner is based in the Highlands, I would like to direct it at him. The Highlands did very well out of the Arbuthnott formula, mainly because of rurality. We are looking at how that money is directed towards inequality, access, deprivation and rurality. When I ask questions of the Highland Health Board and the trusts, they say that any money that is spent on any health services will benefit everyone. It will benefit all the areas that I mentioned. What is your health council looking for? How should the money be allocated to address those issues?

Andrew Gardiner: We need to look in particular at people for whom the main acute hospital is not really accessible. Most of the spending is in the acute hospital sector and primary care. There is a primary care component, but we need to ensure that the transition between primary and acute care is as good as it can be for individuals in the more rural areas.

I would like more, and more accessible, information to come out of the remote and rural initiative, which is based in the Highlands but covers the more remote areas of Scotland. People working on that could perhaps be charged with

doing more research into the question that you have asked about how best the money can be spent to ensure it is spread equitably across the country.

10:30

The Deputy Convener: Surely that information is available in certain areas. When we start digging below the surface, we see the disproportionate spend among local health care co-operatives. One LHCC in my area—in the East Ayrshire part of Ayrshire and Arran—sticks out like a sore thumb in terms of deprivation and rurality, yet when we consider the affluent areas such as Alloway, the spend is huge. Does the money go to the wean that cries the loudest? That seems to be the only explanation: if you are articulate in your bid for money, you will get it, but if you are in a remote area and do not have public transport access to where stakeholder conferences are being held, tough luck, you will not get any money.

As Mary Scanlon said, the Arbuthnott funding was for specific purposes. This committee spent a long time on ensuring that we had the indicators right. We hoped that we would be able to trace the funding from the centre right down to the small hamlets in whatever area. The problem that we have found is that the path of the money is blurred once it leaves the centre. Professor Hanlon has spoken about how tracing the money should be part and parcel of performance management. I would like this committee, as well as the health councils, to be involved in that.

Andrew Gardiner: That is very important. We are still living with the cycle of deprivation. It has not gone away. In a sense, given the situation that you have just described, convener, when it comes to continuing to feed it, we are still culpable.

Chris Lambert (Ayrshire and Arran Health Council): The new community health plans will lead to opportunities for tying in local authorities' spending with the health boards. If that is as transparent as we would like, I hope that we will be able to trace where the money is going.

Mary Scanlon: I was concerned when a significant sum of Arbuthnott money went towards paying off the deficit at Raigmore hospital—I think I am right in saying that it was £2.8 million. As the convener has mentioned, there is no money for the LHCCs in the Highlands. Do you share my concern about the doctors in, for example, Helmsdale? People there do not have local access to their doctors, who are being centralised, and petrol is very expensive. Will you keep monitoring the Arbuthnott funding to ensure that it is used to address the issues that it was meant to address?

Andrew Gardiner: Yes, we will continue to do that. I share your concerns. A large proportion of that money has been hijacked to deal with overspends from previous years. That is tragic.

Health councils will continue to monitor and try, as far as we can, to keep tabs on what is happening to the Arbuthnott money and to the general pot of money that is available. We can continue to do that only if we have a place at the table. I think that that will come with NHS boards at local level. I think that we will be there and that we will continue to ask questions.

Mr McAllion: If you respond to Richard Simpson's point about hospital-acquired infections and the role of the cleaning services, would you comment on whether the competitive tendering of such services has had an impact? Have you any views on the centralisation of laundry services in a limited number of locations in Scotland? Has the consequent transport of laundry around the country contributed to the problem?

I have just two brief questions, the first of which concerns ordinary people's involvement in holding health boards to account. I was privileged to be present when the Audit Committee held Tayside Health Board and the two trusts to account at a meeting in Dundee. Although the meeting was very effective, it was necessarily a one-off; no parliamentary committee can simply travel throughout the country doing a similar thing. Is there room for a local mechanism, perhaps in the style of a select committee, which would be made up of local health council members, councillors and staff members and which would meet annually to hold unified health boards to account for the way they spend their money?

Andrew Gardiner: I welcome that suggestion.

In answer to an earlier question that we might have missed, the important point about hospital-acquired infections is that we should not under-resource the cleaning services. I do not have any specific comments about the implications of transporting laundry across the country or whether it poses any additional risk. I mentioned training earlier. There should be training not just for cleaning staff but for medical nursing staff on the wards, because some of the stories about people moving from patient to patient without taking the necessary hygiene precautions beggar belief.

Chris Lambert: As members are aware, the health council's role is under review. As for local mechanisms, I hope that we will be able to engage with that issue in future. Returning to budgets, I should point out that serious public involvement is expensive. My health council's current total spend is less than 1 per cent of the total health spend in Ayrshire and Arran. I am sure that the same is true for health councils in the rest of Scotland. Serious public involvement requires serious money.

Mr McAllion: Do you think that it is healthy for

health board chairmen to appoint health council members?

Andrew Gardiner: No, not particularly.

Mr McAllion: Do you want that to be changed?

Andrew Gardiner: Yes.

Mr McAllion: Who should appoint health council members? Should they be elected instead?

Andrew Gardiner: There is no other way round the matter. If we want to be accountable to the community—the people we serve—there should be local elections.

The Deputy Convener: That is interesting.

I thank the witnesses for their evidence and their answers to our questions. We will write to you asking for further evidence on Richard Simpson's points. From some of your comments, it seems that we require to take further evidence from particular individuals about performance management.

10:37

Meeting adjourned.

10:48

On resuming—

Regulation of Care (Scotland) Bill: Stage 2

The Deputy Convener: I welcome the Deputy Minister for Health and Community Care and his team to the meeting. Before we start, I will apologise, as this is the first time that I have had to chair the committee when it is dealing with legislation at stage 2. I apologise in advance for any mistakes I make—please bear with me.

I advise members of a printing error on the marshalled list of amendments. At the top left of page 2, the number 147 should be disregarded. The first amendment on the page is amendment 182, in the name of Richard Simpson. I also advise members that we should cover only up to section 27 today, not to section 28 as we had anticipated.

Section 21—Inspections

The Deputy Convener: Amendment 207 is grouped with amendments 145, 208, 161, 181 and 148.

The Deputy Minister for Health and Community Care (Malcolm Chisholm): This group of amendments relates to the powers of the proposed Scottish commission for the regulation of care to inspect and interview. I want the commission to put at the heart of its work the voice of the person using the service and that of the people caring for them. Therefore, it will be essential that inspectors can take a wide range of views on the quality of the services that are provided. It is not only the view of the person using the service that counts, but the views of other people close to them. That covers a range of people, from informal carers to the formal representatives of those who are not able to articulate views for themselves. Amendments 207 and 208 ensure that it is clear that inspectors have wide powers to conduct interviews as they consider appropriate.

I move amendment 207.

Do you wish me to speak to the other amendments in the group?

The Deputy Convener: Yes, please.

Malcolm Chisholm: Amendment 145 does not take account of the confidential nature of medical records or of the potential breach of human rights that would arise if the commission had the power that the amendment would grant. Inspectors are able to see medical records if the individual

concerned consents. There is no need for statutory provision to achieve that, so I ask John McAllion not to move amendment 145.

Amendments 161 and 181 seek to add to the list of groups whom inspectors can interview in private. Amendment 161 would add carers and amendment 181 would add parents, carers, guardians and welfare attorneys. I welcome the principle behind the amendments, but there is no need for a provision to allow the interviews of such people to be held in private. They are not part of the care service and could well be interviewed off the premises and separately from the rest of the inspection. However, I make it absolutely clear that the inspectors' powers include being able to interview all relevant people. That is provided for by amendments 207 and 208, which I covered a moment ago. On that basis, I ask John McAllion not to move amendment 161, and Richard Simpson not to move amendment 181.

Although I have sympathy with an amendment that seeks to give people help with information technology, I consider amendment 148 to be too broad. If it relates to a need for staff training, that matter is being considered elsewhere in preparation for the setting up of the commission. If the intention is to require the provider to provide all the necessary assistance, I believe that the provision is too open-ended. Accordingly, I ask John McAllion not to move amendment 148.

Mr McAllion: I lodged amendment 145 on behalf of the National Association of Inspection and Registration Officers, which is the union that looks after inspectors in the care services sector. Its members believe that "(other than medical records)" should be deleted, because inspectors should see all records that are relevant to the care of a person who is receiving care. It is important to be clear about the difference between GP records, which will not normally be in a home, and care records, which will include GP and nursing advice that is essential to the good care of an individual and must always be in a home. Those records must be accessible to all authorised officers in the commission. That is the view of the practitioners.

Amendment 161 was inspired by the Convention of Scottish Local Authorities, which believes that inspectors should have the right to interview in private—with consent—any carer, and that that should be made explicit in the bill.

Amendment 148 was also inspired by NAIRO. It argued that such an amendment would prevent well-meaning but technically incompetent inspectors being unable to make use of the access offered or, worse, damaging the equipment or inadvertently deleting or amending records. That is NAIRO's view, not necessarily mine—it seems to know more about the matter than I do.

Those are the arguments behind the amendments that I have lodged. If the minister responds to them, I will consider what he suggests.

Dr Simpson: Amendment 181 and, indeed, amendments 182 and 183 in the next grouping deal with the same issue: persons with incapacity. My concern is that the role of such individuals and people associated with them as under the Adults with Incapacity (Scotland) Act 2000 should be specified in the bill. The role and rights of people with incapacity is not clear enough. That is why I have lodged amendment 181 and—for slightly different reasons—amendments 182 and 183, which I will address when we come to the next grouping.

Malcolm Chisholm: To some extent, in winding up I am repeating points that I have made, but I remind members that amendment 207 makes it clear that the inspectors can conduct any interview. That was always implicit, but amendment 207 makes it explicit that they have the power to interview the people to whom Richard Simpson and John McAllion have drawn attention. No one can doubt that "any interview" covers the people who have been referred to.

That an interview may take place "in private" needs to be specified only in relation to people who are in a care service. Section 21(4)(c) makes it clear that a provider does not have the right to say, "You will not interview that care service user without my being present," and that private interviews are allowed. However, no uncertainty arises in the case of the people to whom John McAllion and Richard Simpson referred, as there is no question of a private interview not being allowed. It is not necessary to make "private" explicit, as we expect that interviews with such people will be in private.

On amendment 145, care records will be accessible but medical records are a different matter. There are human rights issues in relation to the confidential nature of medical records and consent would be required for inspectors to see them.

On amendment 148, inspectors will be trained in information technology. Staff training is being addressed elsewhere. That is the way to deal with the issue, rather than have a wide provision that appears to require the provider to provide all the necessary assistance. It would be reasonable to expect that inspectors will have been trained in IT prior to doing their work.

Mr McAllion: I accept what the minister says about amendments 161 and 148. Given that the GP and nursing advice that will be kept in care records in a home will be accessible to inspectors, I am happy not to move amendment 145.

Dr Simpson: Amendment 181 is probably covered, so I am happy not to move it.

Amendment 207 agreed to.

Amendment 145 not moved.

Amendment 208 moved—[Malcolm Chisholm]—and agreed to.

Amendments 161 and 181 not moved.

The Deputy Convener: Amendment 146 is grouped with amendments 182, 13, 147, 183, 209, 210, 184, 14 and 211. Under the pre-emption rule, if amendment 146 is agreed to, amendment 182 cannot be moved, and if amendment 147 is agreed to, amendment 183 cannot be moved.

Mr McAllion: Amendments 146 and 147 are in essence the same amendment dealing with, respectively, medicine and dentistry. They relate to inspections under section 21, where the authorised person is a medical practitioner or a registered nurse.

NAIRO's position is that it is no part of an inspector's duty to carry out a medical examination, nor should some inspectors be able to access medical records and others not. However, different parameters may be appropriate in the inspection of independent health services, where the service being regulated is explicitly and mainly medical. That does not apply to nursing homes. With amendments 146 and 147, NAIRO seeks to establish a level playing field for all inspectors, rather than single out those who are authorised medical practitioners, registered nurses or, indeed, dental practitioners.

I move amendment 146.

11:00

The Deputy Convener: Do you wish to speak to amendment 147?

Mr McAllion: The argument for dentistry is the same as for medicine.

Dr Simpson: Amendments 182, 183 and 184 are to do with incapacity. Amendment 182 makes it clear that if someone

"is incapacitated, but does not express, indicate or demonstrate any unwillingness"

to be examined, an examination can be conducted. It is important to state that clearly in the bill. Amendment 183 applies the same argument to dental care. Amendment 184 links the presence of third parties at examinations to the Adults with Incapacity (Scotland) Act 2000, so that the bill is aligned with that act.

Malcolm Chisholm: I will speak to amendments 13, 209, 210, 14 and 211 and respond to the other amendments in the group.

Amendments 146 and 147 would prevent suitably qualified inspectors from making immediate examinations of individuals whom they believe are not receiving proper care. That does not make the best use of time or available expertise and undermines the main thrust of the bill, which is to provide better protection for the public. If an inspector who happens to be a qualified doctor or nurse has serious concerns about the condition of an individual in, for example, a care home, it is unnecessarily bureaucratic to require them to send for another doctor or nurse before determining whether their concerns are justified. Accordingly, I invite John McAllion to withdraw amendment 146 and not to move amendment 147.

Amendments 182 and 183 raise complex issues. They attempt to provide for examinations to take place when a person is incapacitated but does not demonstrate any unwillingness. In such circumstances, it would not always be possible to determine the motivation behind any expressions of willingness or unwillingness.

If medical treatment, including any related examination, is necessary for an incapable person, part 5 of the Adults with Incapacity (Scotland) Act 2000 allows it to be carried out in the absence of the consent of the patient or an authorised person, but subject to stringent safeguards. It would be inappropriate to bypass those safeguards on examinations without consent. Such examinations could constitute assault. In addition, they might be contrary to article 8 of the European convention on human rights. However, I recognise that it would be helpful to clarify in the bill that the most vulnerable people can be protected by examination, subject to any safeguards the law might require. That is my fundamental point. We just need to follow part 5 of the Adults with Incapacity (Scotland) Act 2000, rather than change the bill as Richard Simpson suggests. Amendment 211 provides clarification on that point. Accordingly, I ask Richard Simpson not to move amendments 182 and 183.

Amendment 184 would allow the decision on whether a third person can be present at an examination to be taken by someone authorised to do so under the Adults with Incapacity (Scotland) Act 2000, or by a parent or guardian. That would not be appropriate. The intention is to allow a comforter or supporter to be present, but not to require one to be present, and certainly not to set up bureaucratic arrangements to secure consent for such a presence when the service user cannot give it themselves. However, we propose that section 21(9) should be extended to allow a third party presence at the request of the inspector, provided that the service user consents. That might be useful, for example, when an inspector

examining a service user of the opposite sex wishes a third party to be present. Amendments 209, 210 and 211 achieve that aim. I commend them to the committee and ask Richard Simpson not to move amendment 184.

Amendments 13 and 14 are technical amendments that are proposed as a result of consultation with interested professions. Strictly speaking, a nurse cannot carry out a medical examination—only a qualified medical practitioner can do that. We want to provide for an inspector who happens to be a nurse to be able to conduct a physical examination with the consent of the person cared for. Amendment 13 deletes "medical" and replaces it with "appropriate" to allow for a medical practitioner or nurse to use his or her skills when necessary. Amendment 14 simply defines the meaning of "appropriate examination", when the authorised person is either a medical practitioner or a nurse.

I invite the committee to agree to the Executive amendments.

Dr Simpson: Provided that the minister is totally convinced that the alignment between the Adults with Incapacity (Scotland) Act 2000 and the Regulation of Care (Scotland) Bill is clear and that there are no risks to those who are most vulnerable, I will accept that the links do not need to be spelled out.

Mr McAllion: I accept the minister's comments about unnecessary bureaucratic hurdles.

Malcolm Chisholm: The alignment is clear and in such situations we must follow what is outlined in the Adults with Incapacity (Scotland) Act 2000.

Amendment 146, by agreement, withdrawn.

Amendment 182 not moved.

Amendment 13 moved—[Malcolm Chisholm]—and agreed to.

Amendments 147 and 183 not moved.

Amendments 209 and 210 moved—[Malcolm Chisholm]—and agreed to.

Amendment 184 not moved.

Amendments 14 and 211 moved—[Malcolm Chisholm]—and agreed to.

Section 21, as amended, agreed to.

Section 22—Further provision as regards inspections

Amendment 148 not moved.

The Deputy Convener: Amendment 162 is grouped with amendments 163, 164, 165, 149, 166, 214, 212, 150 and 215. If amendment 212 is agreed to, amendment 150 will be pre-empted.

Mary Scanlon: The basic principle that underlies amendment 162 applies to amendments 165 and 166.

Amendment 162 provides that following an inspection the commission will produce, in the first instance, a draft report. The reason is that although the bill provides for appeals against non-registration or deregistration, there is no right to review or appeal in connection with the outcome of any inspection. An adverse inspection report could have significant consequences for care provision and may ultimately lead to deregistration. A negative report that was unfairly compiled could have a detrimental effect on a person's livelihood, particularly within the private sector. It is essential, therefore, that the constitution and operation of the commission in the determination of those issues should comply with article 6 of the ECHR, which deals with the right to a fair hearing. To that end, I ask that a draft inspection report be prepared initially, allowing the service provider 14 days within which to make written representations. The service provider could make a formal request to have the report changed in areas in which he or she perceives there to be inconsistencies. If the commission rejects the service provider's comments, provision should be made to enable the provider to appeal against the terms of the report. Amendments 162, 165 and 166 seek to put such procedures in place.

Amendment 164 alters the terminology of section 22 in relation to the service of the inspection report. It ensures that consistent terminology is used in the bill in relation to the serving of reports and notices. The serving of the inspection report will conform to the rules that are set out in section 27.

The amendments were suggested by the Law Society of Scotland.

I move amendment 162.

Mr McAllion: Amendments 163, 149 and 150 deal with access to inspectors' reports.

Amendment 163 is inspired by COSLA. Although COSLA welcomes the provisions under section 22, it points out that the commission should have a responsibility to make reports available in other formats and, where required, in minority ethnic languages. COSLA also argues that, while the committee and the minister have often referred to the need to make copies available in either large print or Braille, which are well-known alternative formats, local authorities have developed other formats, such as graphic reports for those with learning disabilities. COSLA believes that amendment 163 would enable the commission to make reports in all possible forms.

Amendments 149 and 150 are inspired by NAIRO. Their intended effect is to increase the

profile of the commission's duty to give priority to the need for service users, carers and their representative groups and those with responsibility for purchasing those services to have ready access to the inspectors' reports.

The Deputy Convener: Amendments 214 and 215, which are in my name, are self-explanatory and I will not speak to them, as I do not want to take up the time of the minister or the committee.

I call the minister to speak to amendment 212.

EOF: XX turn AV>

Malcolm Chisholm: Section 22(5) requires the commission to prepare a report on the inspection of a care service and to send that report to the service provider as soon as is practicable. The main purpose of that is to allow the provider to act on the report as soon as possible. It was also intended to give the provider the opportunity to comment on any inaccuracies in the report, with a view to having them corrected by the commission before the report is finalised and published more widely. I agree that it is fair to allow providers to check for errors or omissions in inspection reports, and we would expect the commission to do that. However, amendments 162, 165 and 166 would provide for a more elaborate scheme of commenting on draft reports.

As I understand it, amendment 149 would mean that comments on reports could be made only after the reports were in the public domain. There would be no obvious advantage in an approach whereby providers could be subject to embarrassment and their commercial viability could be damaged through the publication of a report containing a significant error or omission. There is nothing in the bill to prevent the commission from showing the report to a person if the commission considered that that person should have the opportunity to comment. I assume that amendment 149 is about sending a report before publication and that amendment 150 is about sending it after publication.

11:15

The detailed process and timing issues are operational matters for the commission to determine. To set them out in the bill as has been suggested would be inappropriate and unnecessarily inflexible. However, a simpler amendment that makes specific what the amendments intend—providing for the commission to send a draft to the provider—would be helpful. Amendment 214 is such an amendment, and I am happy to accept it. On the ground that I am prepared to accept amendment 214, I ask John McAllion not to move amendment 149 and I ask Mary Scanlon to withdraw amendment 162 and not to move amendments 165 and 166.

Amendment 164 suggests that the commission's staff would personally have to present reports to providers, rather than sending them by post, e-mail, courier or other means. In many cases, the inspector will produce the report on site at the end of the inspection, but other reports may require some time for consideration. Having to present them by hand would lead to unreasonable logistical pressures on the commission for no obvious benefits. Accordingly, I ask Mary Scanlon not to move amendment 164.

Section 22(6) requires the commission to make inspection reports available to the public at its offices and allows for the commission to take any appropriate steps for publicising such reports. The effect of amendment 150 is essentially the same. Users, carers and the public are already covered by the term "any person" in section 22(6), but amendment 150 would give the commission a duty, rather than a power, to publicise reports. I agree with John McAllion that there should be such a duty and have accordingly lodged amendment 212 to that effect.

The commission should also be required to ensure accessibility of reports. I am happy to accept what I take to be the principle of amendment 150 on publicising reports. The same point is covered in amendment 163. However, I believe that John McAllion's concerns are covered by amendment 215, in the name of Margaret Jamieson, which will ensure that copies of reports are

"made available or provided in such a form as the person may reasonably request."

I believe that that amendment is clearer. I am therefore happy to accept amendment 215 and I ask John McAllion not to move amendments 150 and 163.

Mary Scanlon: What is the difference between amendments 162, 165 and 166, in my name, and amendment 214, in Margaret Jamieson's name? Amendment 214 states:

"Before finalising a report … the Commission shall give the person providing the service inspected an opportunity of commenting on a draft of the report."

Is that significantly different from the amendments that I lodged?

How much is up to the discretion of the commission? Will all providers have an opportunity to comment on the draft of a report before it is finally published and in the public domain? That would cover all my concerns.

Malcolm Chisholm: I certainly accept the principle behind the amendments that Mary Scanlon lodged, but I feel that they are a bit

bureaucratic and that the details are too explicit. However, the principle is important. A draft report should be available so that the provider can comment, particularly on inaccuracies. Other issues may be involved; the provider may disagree with a judgment that has been made, for example. However, providers should certainly have the right to draw inaccuracies to the attention of the commission and, if the point was objective, the commission would take it on board. That seems fair to the provider, which is why I do not think that reports should be widely distributed in draft form. A report should go to just the provider in draft form, so that inaccuracies can be sorted out. Afterwards, other measures in the section would come into play for the wide dissemination of an accurate report.

Mary Scanlon: Will it be standard practice for each provider to be given that opportunity?

Malcolm Chisholm: Yes. Each provider will be given the opportunity to see a draft of the report. That is the effect of amendment 214.

Mary Scanlon: That would meet my concerns.

Dr Simpson: I welcome amendment 212 and the fact that the minister will accept amendments 214 and 215. However, I want to be clear about what "available for inspection" and "publicising the report" mean. Do they mean that a member of the public who is interested in the report can ask for a copy to be sent to them? The phrase "available for inspection" does not make it clear whether it is up to the commission to say whether the report will be publicised in any other way. As a member of the public, can I write to ask for a copy of the report?

Malcolm Chisholm: You could, or—I know that you are an information technology person—you could find it on the web.

Amendment 162, by agreement, withdrawn.

Amendments 163 to 165, 149 and 166 not moved.

Amendment 214 moved—[Margaret Jamieson]—and agreed to.

Amendment 212 moved—[Malcolm Chisholm]—and agreed to.

The Deputy Convener: We cannot deal with amendment 150 because we have agreed to amendment 212.

Amendment 215 moved—[Margaret Jamieson]—and agreed to.

Section 22, as amended, agreed to.

Section 23—Regulations relating to the Commission, to registration and to registers

Amendment 66 moved—[Malcolm Chisholm]—and agreed to.

Section 23, as amended, agreed to.

Section 24—Regulations relating to care services

The Deputy Convener: Amendment 151 is grouped with amendments 152, 153, 15, 218, 154 and 20.

Mr McAllion: Amendments 151 to 154 deal with the right of Scottish ministers to make regulations that impose conditions and requirements on care services. Amendments 151 and 153 substitute the word "may" with the word "shall". I would be interested to know why the minister does not want all the requirements under section 24 to be imposed through regulations. He has already conceded that, in section 22, "may" should be replaced by "shall", so I do not see why he cannot concede that in section 24.

Amendment 152 would insert the word "registered" before the phrase "care services". I am sure that that is what the minister intends. Amendment 154 would remove the word "or" between section 24(2)(k) and section 24(2)(l) and replace it with "and". It would be interesting to know why the minister thinks that the requirements set out in paragraph (l) should be an alternative to those set out in paragraph (k) rather than supplementary to them.

I move amendment 151.

Malcolm Chisholm: Before I speak to the amendments that I lodged, I will deal with amendments 151 to 154.

There is sometimes a case for changing "may" to "shall". I did that with amendment 212 in the previous grouping, but I do not think that logic demands that every time "may" appears in the bill it should be changed to "shall". Section 24 enables ministers to make regulations that will apply to care services. Subsection (1) provides a general power to make regulations, imposing any relevant requirements. Subsection (2) amplifies that, providing for regulations to be made that will be key to the registration of care services. The regulations will ensure that care services are suitably managed, staffed and equipped and that premises are fit for their purpose.

Amendment 151 would require ministers to make regulations under section 24. Amendments 153 and 154 would require that the regulations made under section 24(2) cover all the aspects set out in that subsection. On the word "or" in section 24(2)(k), paragraphs (k) and (l) are not alternatives. With such a list of requirements, there has to be an "or" rather than an "and"—the word "and" would mean that the regulations must cover everything in the list. The use of the word "may"

means that word at the end of the list has to be "or"—that is the nature of the list.

It is not necessary to place a duty on ministers to make the regulations. We are committed to introducing regulations under the section. Together, the regulations and the national care standards will underpin the new regulatory system. It is not necessary for the regulations made under section 24(2) to cover each of the areas set out in that subsection. The subsection gives examples to ensure that the regulation-making power is sufficiently wide. As I have said, the regulations will link closely with the national care standards. The detail about what the care standards should cover and what should be covered by regulations has still to be finalised. What is decided about the balance between standards and regulations may be reviewed and changed in the future. Ministers therefore need a flexible power, rather than a duty, to make the regulations, to enable them to respond to changing circumstances.

The care standards will constitute an important document. I am sure that members have examined the ones that been issued already. The care standards contain a vast amount of detail, which makes it inappropriate for them all to be included in either primary or secondary legislation. Members will probably have recognised that it would be difficult to capture some of the care standards in legislation. The standards may, for example, say that care service users should have a tasty breakfast; it would be difficult to translate that into secondary legislation.

As members know, the commission for the regulation of care will, under section 5, have to take the care standards into account in making its decisions. Even making all the regulations mandatory would not necessarily secure John McAllion's objective, as that would not determine what was covered by the regulations. We could end up with regulations that covered only one or two points. In the bill, we are proposing a balance between the regulations and the care standards. A different view could be taken over time about which of the care standards should be translated into regulations. No doubt the committee, among others, will have a view on that. I hope that John McAllion will not press amendments 151, 153 and 154.

Amendment 152 is unnecessary. All care services, as defined in section 2, must be registered with the commission or they will be operating illegally. All such services will be caught by the provisions of the bill and must comply with the relevant regulations. If a service does not fall within the definition in section 2, it would not need to register with the commission or meet the requirements of regulations under section 24. Moreover, the use of the word "registered" before "care services" is not consistent with the rest of the bill; to insert "registered" here would mean that it had to precede all other references to care services. On those grounds, I hope that John McAllion will not move amendment 152.

Amendment 15 deals with day care for children. The decision to regulate fully day care for children up to the age of 16 was announced in December 2000, so it is now appropriate to require that any person in a childminder's household should be fit to be in the proximity of children up to the age of 16 rather than just children up to the age of eight. The amendment corrects that anomaly.

11:30

Amendment 20 will allow regulations to be made under section 24 that apply to, or exclude, certain services. For example, regulations in relation to a childminder may be different from those in relation to a large care provider. The amendment gives the flexibility that is necessary so that not all regulations need apply to all care services. For example, regulations under 24(2)(i) may not require the commission to examine the financial position of childminders. However, we will want the commission to assess in detail the financial position of those providing care home services. The amendment will allow greater flexibility and ensure that services are governed by appropriate regulations. The provision is sensible and I hope that the committee will accept it.

Amendment 218 is unnecessary. There is no need to have regulations to allow the commission to issue guidance. The commission will already be able do so under its general powers provided in the bill. If the commission were to be required to issue guidance, the appropriate mechanism would be by regulations under section 23(1)(a), conferring an additional function on the commission. The commission might want to issue case studies that illustrated how good-quality care services met the costs of the national care standards. However, that is rather different from the guidance that Richard Simpson is proposing in amendment 218.

The commission will be a powerful body for change. First, it will comment from its unique viewpoint on the state of the care market in general and on overall trends, so that the Parliament, ministers and local authorities can take its views into account when considering funding issues. Secondly, it will focus on ensuring that only care services that meet the national standards are able to operate. That will be a powerful lever for change. Local authorities will not be able to meet the needs of their areas unless they enable care providers to meet the required standards and so be allowed to operate. If the commission tries to balance funding and quality

issues itself, it will be hamstrung and the drive to improve care services for users will run into the sand. That argument also relates to amendment 219, which we will debate in a later grouping. I hope that Richard Simpson will agree not to move amendment 218.

Dr Simpson: Having heard the minister, I will reserve my arguments for amendment 219, which will be debated shortly.

The Deputy Convener: I seek clarification from the minister on the registration of childminders. Will the provision cover all the people who live in the home of someone who is applying to be registered as a childminder? I am concerned about individuals living in the household who might hold a firearms certificate. Given the experience in Dunblane, some authorities, such as South Ayrshire Council, have taken that on as a specific policy issue.

Malcolm Chisholm: The provision should cover that. I know that a councillor in Ayrshire has concerns about the issue and I will look into it in more detail.

The Deputy Convener: Thank you.

Mr McAllion: I accept the minister's comments on amendment 152 and I understand the technical nature of the word "or", which amendment 154 deals with.

I seek an assurance from the minister that the examples of areas in which ministers may introduce the regulations that are set out in subsection 24(2) are not optional. The fitness of employees to provide services, the fitness of premises and the welfare of the users of the service are not optional things that ministers may or may not regulate about. I seek reassurance that there will be regulations to cover all those areas.

Malcolm Chisholm: Basically, there will be regulations and there will be care standards. What might change over time is which care standards are translated into regulations. Care standards will cover all the matters that you mentioned.

Mr McAllion: Are you saying that some of the areas detailed in section 24(2) might not be covered by regulations?

Malcolm Chisholm: That is clearly why the word "may" is used in section 24(2). If it were not, I would accept amendments 151 and 153. That said, there is no doubt that regulations will be introduced to cover the persons and premises mentioned in 24(2)(a), (b) and (c).

Mr McAllion: Why detail those aspects in the bill and then say that you might not issue regulations on them after all?

Malcolm Chisholm: We must specify them in the bill in order to give the Executive the power to make regulations through subordinate legislation. However, that does not mean that we are immediately required to make those regulations.

Mr McAllion: Which of the areas mentioned in section 24(2), paragraphs (a) to (l), may not be covered by legislation?

Malcolm Chisholm: I knew that you were going to ask that question. If I had been sensible, I would have had an answer ready. [*Laughter.*]

As I said in my opening remarks, the question is the balance between care standards and regulations. For example, I am not sure whether the stipulation in section 24(2)(i) to

"impose requirements as to the financial position of a provider of a care service"

would require regulation. On the other hand, some measures such as making

"provision as to the fitness of premises to be used for the provision of a care service",

which is outlined in section 24(2)(c), will be regulated on. People might not think that regulating on

"the financial position of a provider"

was quite so fundamental, although it is included in that section of the bill.

Mr McAllion: Who will monitor whether or not you should regulate on such areas?

Malcolm Chisholm: Obviously, John, you are part of the monitoring process in the new Scotland, so I am sure that you will keep a careful eye on things.

Mr McAllion: For the moment, yes.

Although I am not completely satisfied by the minister's answer, I am prepared to withdraw amendment 151 because the committee will continue to monitor what ministers get up to.

Amendment 151, by agreement, withdrawn.

Amendments 152 and 153 not moved.

Amendment 15 moved—[Malcolm Chisholm]—and agreed to.

Amendments 218 and 154 not moved.

The Deputy Convener: Amendment 16 is grouped with amendments 17 and 18.

Malcolm Chisholm: Amendment 16, in my name, ensures that regulations can be made on the provision of NHS services in premises where a care service is provided. For example, such regulations might require care home providers to arrange for residents to receive services from chiropodists, physiotherapists and so on. Amendment 17, in my name, is a technical amendment that removes unnecessary wording.

Amendment 18, also in my name, is also a technical amendment and has been added for the avoidance of doubt. It ensures that palliative care—which includes hospices—is regulated by the commission as independent healthcare provision.

I move amendment 16.

Amendment 16 agreed to.

Amendments 17, 18 and 132 moved—[Malcolm Chisholm]—and agreed to.

The Deputy Convener: Amendment 19 is grouped with amendment 167.

Malcolm Chisholm: Section 24(10) deals with consultation on regulations that are made under section 24. Amendment 19, in my name, will strengthen the Executive's commitment to continued consultation. It will require ministers to consult anyone whom they consider appropriate on all regulations that are made under section 24 and it will remove ministers' powers to decide not to consult on amending regulations that do not effect substantial change.

We lodged the amendment in response to concern that the Subordinate Legislation Committee expressed at stage 1, that what constituted substantial change would be unclear. The amendment will mean that all regulations that are made under the section shall be subject to consultation.

Amendment 167 would require ministers to consult local authorities and health boards on regulations that are made under section 24. At earlier meetings, we discussed the virtues of requiring those organisations to be included in consultations. I am sure that John McAllion will not be surprised to hear that I remain opposed to the wording of the amendment. Regulations under section 24 will affect all care service providers, not just local authorities and health boards. It would be wrong to single them out in the suggested way.

Amendment 167 also suggests that the views of providers are more important in this context than the views of service users. Ministers already have a duty under section 24(10) to consult all those whom they consider it appropriate so to do. That will include service providers. We are committed to the consultation process and will ensure that, as part of it, local authorities and health boards have the chance to comment on the regulations.

I remind the committee that the Executive will consider all the consultation provisions in the bill before stage 3 to ensure that they are consistent and appropriate. I made that promise at previous meetings. On that understanding, I hope that John McAllion will not move amendment 167.

I move amendment 19.

Mr McAllion: Amendment 167 was inspired by COSLA. It seeks a guarantee that ministers will consult local authorities and health boards. I hear what the minister says about the technicalities of restricting consultation to some bodies and about the fact that those bodies will have the chance to comment. Will the minister guarantee that the Executive will consult local authorities and health boards before making the regulations?

Malcolm Chisholm: Absolutely. We will consult them and many others. We are studying all the consultation provisions to ensure that they are consistent and make it clear that local authorities and health boards will be consulted, among others.

Mr McAllion: The word "guarantee" is now on the record. On that basis, I will be happy not to move amendment 167.

Mary Scanlon: May I seek further clarification of section 24(10)? It says:

"Before the Scottish Ministers make regulations … they shall consult any other person they consider appropriate."

If it is appropriate for local authority providers to consult local authorities and health boards, may I take it from what the minister says that private, voluntary and charitable-sector providers will be consulted, as well as carers' organisations? What is the definition of appropriate?

Malcolm Chisholm: In speaking to amendments 19 and 167, I said that the regulations will cover all providers. We are considering whether the bill is drafted to be clear and consistent about who will be consulted. We will conclude that consideration before stage 3.

Mary Scanlon: Will users, as well as providers, be consulted?

Malcolm Chisholm: Absolutely. I made clear the importance of consulting users.

The Deputy Convener: Do you wish to wind up, minister?

Malcolm Chisholm: I dealt with John McAllion's point in my brief exchange with him. I gave him the guarantee that he sought, so there is nothing further to say.

Amendment 19 agreed to.

Amendment 167 not moved.

Amendment 20 moved—[Malcolm Chisholm]—and agreed to.

Section 24, as amended, agreed to.

After Section 24

The Deputy Convener: Amendment 219, in the name of Richard Simpson, is in a group of its own.

11:45

Dr Simpson: Amendment 219 seeks to insert a new section into the bill. It both gives the commission power and places a requirement on it—the word "shall" is included—to examine and comment on contracts.

There are a number of separate issues in the proposed section, but its main thrust is to ensure that, while care standards are set and maintained by the care commission and public funding continues to be made through the local authorities, some effort should be made to join those arrangements up so as to ensure transparency in the funding arrangements. Post-Sutherland, when nursing care and personal care are to be free, the local authority will effectively become a monopoly purchaser. I favour a scheme similar to the pharmaceutical price regulation scheme, as that type of arrangement creates broad agreement between the various sectors that are involved, including on levels of profitability. The local authorities will purchase care services from their own providers and from the voluntary, charitable and private sectors.

During evidence, concerns were expressed that there is an inequity between the purchase of provision from the local authority and purchase from the voluntary, charitable and private sectors. One of the aims of the new section inserted by amendment 219 is to achieve equity between the sectors. The facts of the current inequity are borne out in a number of different ways. One is the gap between occupancy rates in the public and private sectors; even the rates that are published are not accurate. I have recently learnt that, in the non-public sector, there are repeated changes in the level of registered beds. That is done to cope with low occupancy rates and the changes in staffing that are required to maintain the funding arrangements for the voluntary, charitable and private sectors.

My other main concern has also been expressed by unions such as Unison. They have expressed concerns about levels of remuneration and employment terms and conditions in the voluntary, charitable and private sectors. My concern is that there should be some mechanism to ensure that wage levels are maintained. It seems to me that a major gap exists. As no one is commenting on the contracting arrangements, we should put pressure on those involved.

Credence is given to suggestions that low wages are being paid by the complaints from a few owners about the introduction of the national minimum wage. Paying professional care workers something below the current or the future national minimum wage seems to me to be inappropriate. If we are serious about standards and about increasing the professionalism of staff, including their employment terms and conditions and training arrangements, we must ensure that standards of care are met in all respects and that funds are available for that.

I seek to give the commission the power to comment. The committee has had reports in evidence—and I have received private reports—that in the past few years some local authorities have given either no increase or below-inflation increases to voluntary providers. If that is the case, how can those voluntary and charitable-sector providers continue to provide an adequate standard of care without squeezing the wages of those who are employed in the sector?

The entire and rather complicated additional section is designed to ensure that there is transparency in funding arrangements. That will open up for debate the question of the examination of contracts for care services. Involving the commission in the way that I propose would allow us to do that.

I move amendment 219.

Malcolm Chisholm: Amendment 219 is interesting and raises important issues. It reminds me of earlier discussions that we had about the appropriate role of the commission and the appropriate role of local authorities. My feeling is that, once again, an attempt is being made to transfer the responsibilities of local authorities to the commission, which is inappropriate. The issue of wages is important, but clearly it is a matter for national Government to ensure that the minimum wage is observed. There are interesting aspects of the wage argument that overlap with arguments about best value.

We all want a fair and equitable system for the funding of care services, which is why I understand the principles behind the amendment. For many years, voluntary and private-sector providers have complained about inadequate funding from local authorities and other major purchasers of care services. At the same time, they see that local authorities' own services can be relatively well funded, and that sometimes local authorities' places are filled before they consider commissioning from other providers. Moreover, the need for a level playing field between local authority and other providers in relation to inspection was one of the main motivating factors behind the bill.

As members are aware, the care development group, which I chair, is examining all current funding streams for the care of older people and will recommend any changes that it thinks are necessary. Some of the streams referred to in the amendment are being considered, along with new factors, such as the cost of care standards. To help with that, a survey has been commissioned

from PricewaterhouseCoopers on the cost of care homes and the likely cost of implementing the new national care standards.

The Scottish commission for the regulation of care will have an important role in contributing to thinking on the funding of care, as it reports to ministers and Parliament through its annual report. As you know, it is intended that the commission will fulfil the recommendation of the Royal Commission on Long Term Care for the Elderly that there should be a national care commission to take a strategic overview of the care system and its funding, and advise on trends. The commission will be well placed to do that, as it will have detailed and authoritative knowledge of every care service.

However, it would not be appropriate for the commission to consider funding alongside quality issues when looking at an individual care service. It is for the democratically elected local authorities, which can consider the interests of their local population overall, to decide the proportion of their resources which should be spent on purchasing care. Local authorities must also take best value into account. The commission should not be attempting to second-guess such decisions in relation to any particular care service.

Richard Simpson's new section does not indicate what would happen if the commission looked at a particular care service and considered that the local authority funding was inadequate. There are no provisions in the proposed section to require the local authority to take any action to increase the funding, and it is presumably unlikely that it would do so, just because the commission suggested it. Having come to its view, the commission would not logically be able to impose any conditions on the care service or take any enforcement action. That is inconsistent with, and cuts across, the commission's overall function of applying and enforcing care standards. The commission will have accepted that the problem is financial and not within the provider's power to resolve, so there would be stalemate.

Moreover—and this is an important practical point—providers would quickly realise that the way to avoid conditions on their registration would be to require the commission to examine their contracts. We would find that every private provider with a grievance would immediately ask the commission to investigate the contract. The result would be a dilution of the value and importance of care standards and no improvement in the care service. That cannot be in the interests of service users.

I remind the committee of the phrase "a lever for change", which I used when talking about an earlier grouping of amendments. The commission's report will be a lever for change. The care standards will have to be met and in that sense local authorities will have to respond to what the commission says, because they will be obliged, in whatever services they commission, to ensure that the standards are met.

It is an interesting and quite complex argument, but I do not think that amendment 219 is the way to address the problem, which we are considering in the care development group. It is a big issue, but one to address in other ways. I therefore ask Richard Simpson to withdraw the amendment.

Shona Robison: Amendment 219 is important and I support it in the light of the evidence that we heard. The issue that voluntary organisations in particular voiced time and again was the instability of their funding streams. When the minister discusses funding and quality issues as not being connected, I disagree. I think that they are absolutely connected. That is the point of the amendment.

We are discussing cases where a voluntary organisation fails to meet standards for no other reason than the fact that they do not have the funds to maintain those standards. I would have thought that, even if it is only a matter of the commission highlighting that as the reason for a failure of standards—if there is no reason apart from funding—putting that into the public domain would itself be an important measure. When the minister mentions a lever for change, I would say that putting the lack of funds as a reason for failing on standards into the public domain may itself be a lever for change. It could be flagged up that a local authority is not providing adequate resources to a voluntary organisation, which may, up to that point, have provided a very good level of service. I think that amendment 219 is important, and have not heard anything in the minister's response that has satisfied me.

Mary Scanlon: I also fully support the amendment. I do not think that it would be right to wait for the care development group to be set up, irrespective of whether it is addressing the matter. Amendment 219 is a serious proposal that addresses many of the issues that we face.

The current system is not fair and equitable. As Stewart Sutherland said when he addressed the committee, there is "bad practice" but "also some good practice" in the public and the private sectors.

What we seek—and I agree with what the minister says about best value—is best value for the community care pound. For example, in the Highland Council region, private charities and the voluntary sector have been given a 1.8 per cent increase in funding. They are starved of referrals and funds, yet are faced with higher water rates and inspection costs, and need new investment in

order to meet standards. In the Highland Council region, it costs more than twice as much to have a person cared for in a council home as in a private home. It is not a level playing field. Council homes are fully funded, whether they contain one person, 50 people or are full; in the private sector, homes are funded only per patient.

The Highland Council's social work services operate on a home care basis, from nine to five. Any work outwith those hours is given to the private sector. People may have to go 30 miles up a glen to tuck someone into bed. They will get paid for one hour's work, but will not receive reimbursement for their travelling time. I ask the minister to re-examine amendment 219 because it addresses some of the serious issues that we are faced with. It is a reasonable amendment, and I ask him to reconsider it.

Nicola Sturgeon (Glasgow) (SNP): I echo Shona Robison's sentiments. There are two issues arising from this amendment, and I am not sure whether the minister, in his comments, has properly grasped the strength of feeling that has been expressed to the committee on this issue, nor—because of the problems of funding—the potential impact on what the bill is trying to achieve.

The first point, which has already been touched on, relates to the fact that it was raised with us time and again that the level of fees that local authorities have paid to private voluntary providers simply does not reflect the nature of the service that they offer. The impact of that is threefold. First, there is an impact on the viability of some of the providers. Secondly, there is the impact that Richard Simpson raised: that on the pay and conditions of staff working in care homes. Thirdly, unless the approach to the problem is realistic, we create a situation in which the translation of the objectives of the bill into practice will be difficult in some settings. There is a feeling that, if there are problems with the level of fees now, once the bill introduces standards that are—we hope—higher, those problems will only get worse. That is why it is important that we address the problems fully at this stage.

12:00

The second issue is the discriminatory treatment, on the one hand, of some local authority care homes and, on the other, of those in the private and voluntary sectors. I agree with Shona Robison that it is absolutely impossible to divorce funding from quality. The two are inextricably linked. If a provider—perhaps an excellent provider—is prevented from implementing the higher standards that the Scottish commission for the regulation of care might want it to implement simply because it does not have realistic funding streams from local authorities, there surely must be some way of dealing with that.

I have listened to the minister's objections. There may be valid objections to how amendment 219 is worded, but there must be a way of dealing with the problems. The minister's opening remarks did not convince me that the Executive has a full enough appreciation of the issue or that it is doing any real thinking about how we address the issue in the short term while the bill is going through the Parliament.

Mr McAllion: I accept that there is a genuine problem, particularly with the funding streams to the voluntary and charitable sector. I do not accept that amendment 219 addresses that problem effectively.

First, I am very unhappy with about notion that an unelected quango can be used as a weapon against a locally elected authority, particularly by the private sector. That causes me a great deal of alarm.

Secondly, I do not think that the use of the quango would be effective in addressing the problem. The fact that the commission would be able to write to a local authority to say that it did not think that it was funding a provider enough does not solve the problem; it just exacerbates what is already a difficult problem. Democracy then comes into the issue.

Thirdly, such issues are essentially political. They must be decided by elected politicians, whether locally or nationally. If local authorities are not funding the voluntary and independent sectors properly, that is probably because, the local authorities would argue, they are not being funded properly by the Scottish Executive. That then becomes a matter for the politicians in the committee and elsewhere in the Parliament. If the local authority is falling down on its responsibilities, that is a matter for the local electorate and the local councillors. A quango that has been appointed by ministers is not in a position to get embroiled in such political matters in any effective way.

I will resist amendment 219 because it would make a bad situation worse rather than better.

Mary Scanlon: One point that I did not mention is that the private, charitable and voluntary sectors are not getting a fair hearing. Amendment 219 would give them a fair hearing. I refer again to article 6 of the ECHR.

Malcolm Chisholm: I start by disagreeing with Shona Robison. I did not say that funding and quality are not connected—they self-evidently are connected. The issue is how we address that. Amendment 219 highlights a problem, but

although it is right to highlight the problem, it proposes the wrong solution. The amendment would simply not have the desired effect. It would not even have the effect that the private and voluntary sectors, who might ostensibly benefit from it, desire it to have.

As I indicated in my opening remarks, just because the commission could point out that, in its view, a local authority did not give enough money to a provider, that would not necessarily lead to the local authority giving more money. It might lead to the local authority deciding not to use that provider at all but to commission services from some other provider or use more of its own.

There is therefore no connection between what the amendment proposes and the solution to a real problem. I agree entirely with John McAllion, who put in even stronger language than I did my point about the distinction between the role of the commission and the role of local authorities. Some members perhaps think that the amendment would be to the benefit of particular providers or assume that it would improve wage rates. Who is to say that it would improve wage rates?

It may be the view of the commission that, as long as people have the minimum wage, that is all that they will factor in to meet the care standards and that they will not build in any other costs. Perversely, it could have a negative effect on the workers in care services. It is certainly not the role of the commission to express a view about an appropriate wage rate; that is the role of the unions and democratically elected authorities in response to the demands that are made.

I strongly resist the approach taken by amendment 219, although that is not to say that I do not recognise the problems that it addresses. The function of the commission is to ensure that we have new uniform standards throughout Scotland. That will be thoroughly beneficial for service users throughout Scotland. When it issues its reports, the commission will be a lever for change. When reports are issued, the status quo is not an option.

The commission will also be making general comments in line with its function as a national commission along the lines suggested by the Sutherland report. However, to move from that to commenting on individual contracts is a very big step. Mary Scanlon mentioned the ECHR, and I think that a right for the commission to examine individual contracts may well be against the ECHR. We should remember that it is not just local authorities that have contracts; individuals who use care services have contracts as well.

Finally, no appropriate regulations are listed under section 24(1) to cover what is proposed by amendment 219. In that sense, even if the amendment were passed, it would not actually work technically to achieve its intended effect.

Dr Simpson: Before I respond to the minister's comments, I have to ask whether I have to continue to make the declarations of interest that I made at the beginning of the bill's progress. I should draw people's attention to my written declaration and to the declarations that I have made on previous occasions.

The Deputy Convener: Please specify your declaration.

Dr Simpson: I am director of a nursing home company that operates in England and Wales, not in Scotland. I am also a member of the Manufacturing, Science, Finance union, although I do not know whether that is pertinent in this case.

I am not convinced by the minister's arguments. If he had undertaken to lodge another amendment to give powers, either to ministers or to the commission, to examine contracting processes within what will be a monopoly purchaser after the Sutherland recommendations are implemented, I would have been more prepared to withdraw amendment 219. However, as things stand, I am not prepared to do so.

The situation that we are faced with now is one of increasing complexity in relation to the purchasing arrangements. Until now, we have had residential homes registered, and they tended to be paid for at a specific level within the voluntary, charitable and private sectors. The arrangements vary from local authority to local authority, which may be appropriate for their individual circumstances, but there has been one level of purchase for residential homes. The same is true of nursing homes: there has been one level of purchase for nursing homes.

Now, we are going to move to a situation in which there is a single home registration and there will no longer be a differential. That has been welcomed by everybody who has come before us, but we will end up with individual care packages. Unless those care packages are costed properly and equitably between all providers, we will be faced with an extremely difficult situation. For the minister not to want to give powers, either to himself or to the commission, even to comment on those care packages is, in my view, a singular weakness of the bill.

I entirely accept the minister's point that the wording of amendment 219 may not be appropriate. It is my amendment, which I prepared without help from any outside group, and I do not have access to lawyers. If the committee agrees to the amendment today, it would be up to the minister to amend the wording further or to delete it at stage 3. However, it is inadequate that we have not had an undertaking from the minister to

introduce powers to scrutinise the contracting process and that he proposes to leave it to the care development groups.

Malcolm Chisholm: Let me make it quite clear that, if we were to give it the function of considering the purchasing of care services as well as their quality, the commission's impact would be greatly reduced. It would no longer be able to focus principally on the interests of service users, which is what the commission is fundamentally about. It would have to take account of a range of other factors and could not press for improvements in quality. It could not be seen as the guarantee that no service is allowed to operate in Scotland that does not enhance the quality of care and the quality of life for our children and vulnerable adults.

There are other mechanisms that can and will be used to consider the difficult issues around commissioning and finance. The bill was intended to address issues of quality. We must ensure that it does so in the most straightforward and effective way possible. The national care standards are of critical importance. They offer a way of ensuring that, for the first time, all services are designed around people's needs and wishes. That is a prize well worth achieving. The commission is not intended to and cannot be expected to resolve every problem with the care system in Scotland. Only the commission can resolve the issue of quality. We must let it do that simply and unequivocally. That will be the lever for change that I referred to earlier. The other mechanisms can then come into play to ensure that quality is raised and the other issues that Richard Simpson is concerned about are dealt with. I once again ask him to withdraw his amendment.

The Deputy Convener: Do you wish to press the amendment, Richard?

Dr Simpson: Yes.

The Deputy Convener: The question is, that amendment 219 be agreed to. Are we agreed?

Members: No.

The Deputy Convener: There will be a division.

FOR

Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Simpson, Dr Richard (Ochil) (Lab)
Sturgeon, Nicola (Glasgow) (SNP)

AGAINST

Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
McAllion, John (Dundee East) (Lab)

The Deputy Convener: The result of the division is: For 4, Against 3, Abstentions 0.

Amendment 219 agreed to.

Section 25—Transfer of staff

The Deputy Convener: Amendment 121 is grouped with amendments 122 and 156.

Janis Hughes: Amendment 121 is another example of changing "may" to "shall". Amendments 121 and 122 were lodged to take account of the first two paragraphs of section 25. Changing "may" to "shall" would more firmly enshrine in legislation the protection afforded to staff. The same argument was used previously that the word "may" implies "may not"; "shall" firms that up.

I move amendment 121.

Mr McAllion: Amendment 156 deals with the schemes for the transfer of staff. It would add an additional part to those schemes to include arrangements for time-limited secondments rather than permanent transfers at the date of transfer. It would also include voluntary redundancy or early retirement options. Schemes should also include arrangements for secondments or employee exchanges between the commission and local authorities, health boards and the independent sector organisations, where the commission considers such arrangements to be beneficial to recruitment for and development of its service. At present, the legislation appears to rule out, by not ruling in, a range of constructive options that will enhance employee security and remove the starkness of a choice of transfer to the commission or loss of employment.

What the amendment is getting at is that we do not want the situation to develop where those serving on the commission deal only with regulation and have no practical experience of good practice in the field. The amendment would allow and facilitate exchanges between providers in the field—people who have experience of good practice who could then serve on the commission to the mutual benefit of everyone concerned.

Malcolm Chisholm: Section 25 of the bill makes provision for the transfer of local authority and health board staff to the commission. As it stands, under section 25(1), ministers have the power to make a transfer scheme for staff moving to the commission but they are not required to do so. Amendment 121 will place a duty on Scottish ministers to make a transfer scheme. We fully support the principle that the terms and conditions of staff transferring to the commission should be protected by such a scheme. I am therefore happy to accept the amendment.

Amendment 122, although relating to the same issue, would have the effect of applying any transfer scheme to all staff currently employed on registration and inspection work. However, there are staff for whom registration and inspection form only a small proportion of their work. Such staff

are unlikely to transfer to the commission. Also, some staff may simply choose not to transfer to the commission. Any transfer scheme should not apply to those people. I therefore ask that amendment 122 be not moved.

Amendment 156 would provide for the transfer scheme to include arrangements for staff to be seconded to the commission, for staff exchanges and for the voluntary redundancy and early retirement of staff from the commission. Amendment 156 is not required because staff exchanges are covered by paragraph 6(1) of schedule 1, which provides for the commission to appoint employees. Staff should not be forced to take a secondment or transfer. Issues such as voluntary redundancy and early retirement are covered by employment law, which the commission would need to comply with, and are therefore not required in the bill. I hope that I have met John McAllion's concerns and that he will not move amendment 156.

Amendment 121 agreed to.

Amendments 122 and 156 not moved.

Section 25, as amended, agreed to.

Section 26 agreed to.

Section 27—Giving of notice

Amendment 67 moved—[Malcolm Chisholm]—and agreed to.

Section 27, as amended, agreed to.

The Deputy Convener: That concludes today's business. We are well within the time scale. I thank you all very much.

Meeting closed at 12:17.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the archive edition should mark them clearly in the daily edition, and send it to the Official Report, 375 High Street, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Tuesday 15 May 2001

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Meetings of the Parliament annual subscriptions: £500

The archive edition of the *Official Report* of meetings of the Parliament, written answers and public meetings of committees will be published on CD-ROM.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £3.75
Special issue price: £5
Annual subscriptions: £150.00

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £3.75
Annual subscriptions: £150.00

Standing orders will be accepted at the Document Supply Centre.

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0131 228 4181 Fax 0131 622 7017

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 020 7242 6393 Fax 020 7242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 028 9023 8451 Fax 028 9023 5401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 029 2039 5548 Fax 029 2038 4347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178