HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 16 May 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
15th 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

John Aldridge (Scottish Executive Health Department)
Susan Deacon (Minister for Health and Community Care)
Gerry Marr (Scottish Executive Health Department)

THE FOLLOWING ALSO ATTENDED:

Malcolm Chisholm (Deputy Minister for Health and Community Care)

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 16 May 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:33*]

Budget Process 2002-03

The Convener (Mrs Margaret Smith): Good morning, everybody, and welcome to this meeting of the Health and Community Care Committee. I welcome the Minister for Health and Community Care, who is accompanied by John Aldridge and Gerry Marr. We are continuing to look at the budget this morning. We have a number of questions for the minister and her officials, some of which have arisen from the budget document itself and some of which have arisen from evidence that we have taken over the past few weeks.

Would you like to begin by making a statement, minister, or shall we just kick off with questions?

The Minister for Health and Community Care (Susan Deacon): I am happy to go straight to questions.

The Convener: You will remember that when we dealt with the budget last year, we had some comments to make about the manner in which the document was laid out. It is likely that we will have comments along those lines again this year. There seems to be a general feeling that there has been some improvement in that respect, but that there is still quite a long way to go in terms of transparency. However, you will find that the questions that are addressed to you are about substantive policy and spending issues, rather than about the look of the document.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): My question is for Mr Marr. When the director of finance, John Aldridge, gave evidence to the committee, he made several references to the performance assessment framework as a way of monitoring health performance. Some of us are aware of the process that was used in the past—I still have the scars from that—and, last week, Unison representatives referred to the accountability review as a secret meeting. How do you intend to ensure that the performance assessment framework demonstrates openness, is not overly bureaucratic, and provides details of qualitative data on critical success areas?

Gerry Marr (Scottish Executive Health Department): We are in the process of building the performance assessment framework. That was a commitment in the health plan. The performance assessment framework will be available to the new national health service boards so that it comes into force in the autumn.

I would like to set out one or two of the principles that have already been established for the performance assessment framework. It will be objective, fair and evidence-based, and it will address the issues that are important to the patients and the public. It will be outcome-focused and will examine the quality of care as well as the efficiency and value of the resources that are made available to the NHS. It will encourage continuous improvement through benchmarking and sharing good practice.

You may recall from "Rebuilding our NHS" that the responsibility for performance management rests with the NHS boards. We expect to see a process of performance management that is absolutely open and transparent. I shall say more about that when I talk about the accountability review process. In our consultation on the health plan, it became clear that many stakeholders were concerned that there had been an over-emphasis on how the money was performing rather than how the health service was performing. It was a very narrow focus, and a limited number of criteria were used to make that assessment.

It is important to point out that the performance assessment framework will be built in seven key areas. Let me remind the committee of them. We will measure performance in health improvement and reducing inequalities. We will measure fair access to health services. We will be concerned principally with clinical governance, quality and the effectiveness of health care, but we will also consider the patient's experience, including service quality. We will measure the NHS's involvement with the public and in the communities that it serves, so that will be built into the performance assessment framework. For the first time, we will require, through the partnership arrangements that are already well established in Scotland, that the health service is held to account locally for how it performs as an employer in terms of staff governance. Finally, we will look at organisational and financial performance and efficiency.

As ever, the devil is in the detail. We are coming to the close of some internal work in the Executive. Consistent with our approach to the health plan consultation, we intend to engage not only the health service but key stakeholders in consultation on reasonable measures that will give us the answers that we want. Building a

performance assessment framework is all very well, but it must give the public, the staff, the committee and the Executive confidence in what we are really measuring. That way we can use the performance assessment framework to answer questions about how well the NHS is performing and how accountable it is to its local communities.

I will touch on the accountability review if you like, but I think that I should stop, as you no doubt have other questions for me.

Margaret Jamieson: I would certainly like to ask further questions. We are well aware of what the accountability review was like in the past and of how many people ran around for a few months before that process putting the ticks in the appropriate boxes. Can you assure me that we are moving away from that bureaucratic nonsense, whereby a tick in the right box means that everything in the garden is rosy as far as the people at the centre are concerned? When the performance assessment framework is under way, if a health board says that it has wonderful measures in place, involves its staff in the process and has education at every level of the organisation, can you assure us that we can go to the porter and ask, "What is your development plan? What training are you getting to ensure that what the unified board is saying is correct?" From years of experience, I still have a significant doubt that it works from the top down to the bottom.

Gerry Marr: I understand that, but what breaks the cycle in what we are planning in the accountability review process is that each of those domains will have an element of independent assessment. On clinical effectiveness and clinical governance, for example, the clinical standards boards will publish their reports on adherence to clinical performance. That process will form part of the clinical standards review that will be shared with the Executive in the accountability review.

On staff governance, we will ask the area partnership forum to report on the performance of the NHS as an employer. As Margaret Jamieson has said, in the past there was a tick box for preparation and a private meeting took place between the managing executive and the local health service. However, the plan is for the Executive to have independent assessment to some extent as well as self-assessment from the performance assessment framework from key stakeholders such as the clinical standards board and the partnership forum. In each domain, we are looking to consult on how we can build assessment in, to have independent assessment and a much greater degree of objectivity.

Our commitment in the health plan that the annual reports will change consistent with our approach to performance assessment and the accountability reviews so that the reports will not be largely financially based also breaks the cycle. The system will be required to report to its community on the outcome of the accountability review and performance assessment, including the action that has been committed to be taken to move on in a continuous improvement cycle. Those elements make the process fundamentally different from what may have been experienced in the past in the local health systems.

Dr Richard Simpson (Ochil) (Lab): I welcome what you have said because it represents a radical and fundamental shift in the way that we assess the boards. The difficulty has always been for the centre to hold the periphery accountable and yet allow the periphery to act in a way that is sensitive to local needs.

My question is about targets. Last year, we said that the targets that are set out in "Investing in You" did not relate to the time period in question, did not cover the full range of NHS activities and were not related to outcomes. In this year's document, we feel that the same thing occurs to a large extent. If targets are not tied to the budget, we cannot make a proper judgment on what is happening. For example, 23 targets are set out in the chapter on health in "The Scottish Budget" only five of which specifically relate to 2002-03, namely, two capital projects, reductions in waiting time, moves to the Arbuthnott targets in real terms and the implementation of the ECCI—electronic clinical communications initiative—IT system.

The problem for us is that we are hearing—and we heard last week—that a lot of funding goes into uplift in salaries, meeting working time directives, the hours of junior doctors and the new consultant contracts. Not a lot of money is left and we cannot see where it is going in target terms. Next year, can targets be set under the new performance management review to ensure that, at least, minimum standards will be met across the board?

Susan Deacon: I apologise, convener, that I am not a picture of good health today. I am croaking at the committee.

Richard Simpson's question touches on a range of important areas. We believe in the importance of greater transparency in all that we do. I am pleased that Richard has welcomed the arrangements that are being developed for the new performance assessment framework as a radical and fundamental shift. That is certainly what we want to achieve. We recognise the importance of relating the budget process at national and local levels and spending priorities to stated targets, but we are conscious of two things.

First, we must get the level of reporting right. We have discussed that previously in the committee. We do not want to create an industry that gathers lots of financial data at the centre or, for that

matter, have the NHS spend a lot of time submitting financial data that could or should more appropriately be reported at a local level.

09:45

Secondly, we set out many of the targets in the programme for government and have refined and developed those further through the health plan. Although the attainment of those targets requires spending and investment on specific aspects, many of them will not be achieved simply by increasing spend in that area. For example, you mentioned waiting times targets and the target to reduce the maximum time that anyone should have to wait for in-patient treatment, from the current maximum of 12 months to nine months. In some parts of the service and some parts of the country that will require, to varying degrees, investment in staff and equipment, and also changes to working practices.

We are aware that, no matter how effective we become in linking our reports on spending to targets, the amount of money spent on a specific matter does not mean that the target will be achieved. As John Aldridge said when he attended the committee previously, and I reiterate, we remain happy to receive inputs and comments from the committee on how it thinks further improvements could be made. We are striving for the same goal.

Dr Simpson: We have been using multiple sclerosis as an example—it is an example and I do not want to get hung up on it—because it was debated in Parliament recently. The Multiple Sclerosis Society in Scotland has said that five boards had MS nurses in place and 11, or whatever the number is nowadays, do not. Will a minimum standard that people can see arise from the performance management review? Will the information be collated nationally so that we can say that within a certain period—not necessarily in one year—nobody in Scotland will not have access to an MS nurse, if that is regarded by the Clinical Standards Board for Scotland as the appropriate service that should be provided? Will that also apply to epilepsy and the chronic diseases, where nurses can make a huge difference?

Gerry Marr: It is about the building bricks. One of the commitments on performance assessment is that we will underpin the publication of the cancer plan, review coronary heart disease and review the mental health framework in a way that will produce what we describe as service frameworks. Those will define exactly what patients can expect of a service and what is required of the boards.

In the past, if the management executive had published a policy, there was perhaps a sense that there was not sufficient follow-through on implementation. We want to draw that into the performance scheme, so the framework will state specifically the minimum standard for services in cancer or coronary heart disease once the policy has been ratified and published by ministers. One can take this to the n^{th} degree and it is difficult to get right down to the detail, but the principle is established in the first stage of the performance assessment framework—that is important.

Dr Simpson: Are you going to get rid of some of the activity data? The process is quite interesting, because it shows the vast increase in productivity that has occurred. It is important for the staff to realise that they are doing so well, but it takes a huge amount of time for a health visitor to tick boxes every week. I question whether it is meaningful. Will that process go or will it be changed?

Gerry Marr: I have two comments to make on that question. First, I accept that often in the past we have been far too concerned with inputs. That is reflected in pages and pages of data. Secondly, we are setting ourselves the task of not falling into the trap, when designing the framework, of starting by saying, "What data do we have available?" That is not the starting point. The starting point is to ask, "What do we need to make a reasonable assessment of the performance of the NHS in local communities?" If we start at the other end, we will simply produce a different book from the one that we had before. We are very clear about how we are trying to construct the framework.

Susan Deacon: Richard Simpson has talked about minimum standards. It is important to reiterate how much our approach to redefining the relationship between ministers, the health department and the NHS is based on the principle of establishing national standards. The previous prevailing philosophy, with the system that underpinned it in the NHS over the past couple of decades, was the antithesis of that approach. According to that philosophy, different parts of the system could, often rightly, have variable practices and standards as long as they operated within the constraints of their budgets. We are explicit about the fact that we are now trying to establish national standards.

We must still be clear, in our political discussions and in discussions with the NHS, that we must prioritise within those standards. The question is often asked, "When is a priority not a priority?" The answer is, "When there are 250 of them." In the health plan, we have sought to be much clearer about what patients and the public have clearly expressed as being their priorities. We are seeking to reflect those priorities in the performance framework that Gerry Marr has

described.

Shona Robison (North-East Scotland) (SNP): In response to Richard Simpson's question about targets not being tied to the budget, you referred to the national plan. However, the national plan contains 232 action points, of which only 13 have a time limit of 2002-03. I am not sure whether referring to the national plan answers our questions concerning joined-up thinking and whether targets and budgets will coincide.

Susan Deacon: Let me make the matter absolutely clear. We are unequivocal in our desire to improve patients' experiences. Several committee members have made the point that we need to leave behind the tick-box culture of the past. That applies equally to the way in which we formulate Government policy.

Although I share the view that it is important to be precise and specific in setting targets and time scales for targets where that is possible, I think that it is also important not to become preoccupied with that process. Many of the actions that are set out in the health plan reflect work that has been initiated. We state in the health plan that we want to be absolutely clear about the direction that we expect the NHS to take, but that we are not dotting every i and crossing every t regarding what should be done and when.

In certain key areas, national targets have been set—waiting times is an example—but our prime concern is to ensure that there are improvements in practice and in the patient experience. There must be a continuing process of improvement, which will be measured and monitored through the performance assessment framework as described.

The approach that we have taken has been generally welcomed by a range of stakeholder groups and by the health service. They recognise that spending more time, energy and resources in simply refining our measurement systems will not necessarily improve the quality of what we do. I have often been told that we should spend less time proving and more time improving, and that is what I want to happen in the NHS in Scotland. We aim to strike the right balance, and we are open to suggestions about how we can do that.

Margaret Jamieson: Let us return to the issue of the performance assessment framework. My concern is that that framework will be a retrospective look. Having spent from 2 o'clock to 6.30 last night in the Audit Committee, I do not want to go down that road again. It is because we were considering matters retrospectively that we found ourselves in difficulty in Tayside.

How do you envisage marrying the national plan with the three-year guaranteed budgets that the unified boards will have? Are you going to be in a position to say that that is the base level from where they start this year and that that is how they are going to increase their performance in order for it to be measured? At the end of the day it is the bit in between that I am unsure of—if there is a mistake in that process, situations like that in Tayside will spring up all over Scotland. How are you going to ensure that the local plan meets the national plan, which will underpin the performance assessment framework that we are so desperately awaiting?

Susan Deacon: The question identifies effectively and precisely the issues with which we are grappling. Gerry Marr might want to come back with some of the details of how that might be encapsulated within the performance framework.

I want to comment on Tayside, which is an excellent example of the way in which things need to change and are changing. It is helpful that the Tayside situation over several years has now been thoroughly investigated, through the work of the task force that I appointed, Audit Scotland and the Auditor General's recent report and the Audit Committee's inquiry. There are enormous lessons to be learned from that experience, many of which we have already sought to learn and transfer into the health plan.

Much of the content of the health plan results from my experience as Minister for Health and Community Care in relation to the health care bodies in Tayside. Margaret Jamieson is right: by the time that many of the warning signs were coming through to the health department that aspects of that system were in trouble, it was too far down the line. That does not just relate to financial performance; there were other indicators that there were difficulties in the system.

I want to emphasise, as was highlighted in the audit process, that the quality of clinical care in Tayside has remained very good. It is important that we remember that. Many elements of the system were dysfunctional and badly managed. There was poor leadership and poor financial control. As a minister, my desire for better early warning systems is absolute in relation to the changes that are being implemented in the department. We do not want to be breathing down the system's neck week in, week out. However, we need to know when problems emerge so that we can take action. That may be supportive action—providing people and resources to assist the local system in improving. However, the monitoring process is key and it must be much sharper and faster than it has been in the past.

Gerry Marr: That policy framework means that I have had to change our managerial relationship with the health service. That is part of the commitment in the plan. We have a new health department; we have moved away from the previous management executive. The

performance assessment framework is multifaceted but is based on continuous assessment, not sitting down at the end of the year and saying, "Gosh, we didn't do very well, did we?" The relationship that John Aldridge and I have with the service through managerial monitoring has changed as a consequence of the health plan and the lessons that we learned in relation to Tayside. We are required to satisfy our minister that those arrangements are very different from those under the internal market.

Margaret Jamieson: I am well aware of what you are saying, but I still have concerns. Although there has been some reorganisation and Gerry Marr and John Aldridge have a better relationship with the service, I am concerned about whether that flows throughout the department. People were working in little boxes for a long time.

Susan Deacon: We have made a significant start in redrawing that relationship.

It is essential that a fundamentally different relationship be mapped out between the department and the service to reflect the situation following devolution and the end of the internal market. We are required to close some of the gaps that have existed. A great deal has been achieved to make that change in various areas of activity in the department—finance, performance management, human resources and so on. We still have a considerable job to do.

As you will be aware, Trevor Jones began as the new combined head of department and chief executive of the NHS in Scotland at the end of last year. In the scheme of things, his appointment is still relatively recent. For a period before then, there was no one in that post. Trevor Jones is focused on ensuring that those changes are put in place throughout the department. That cannot be achieved overnight, but progress is being made. In the future, the committee may wish to invite Trevor Jones to discuss some of those managerial issues in greater detail.

10:00

Dorothy-Grace Elder (Glasgow) (SNP): Thank you for attending. Further to Richard Simpson's mention of MS patients, are you sure that the performance assessments and the national standards will include all categories of health problems and will not leave some patients out in the cold, such as the 500,000 people in Scotland who suffer from chronic pain? I am referring not to palliative care services, but to those in the community who have non-terminal but nonetheless quite awful problems such as back pain and arthritis. I see no mention of chronic pain, yet it is a bigger problem than cancer and coronary disease combined. Do you have any plans for performance monitoring in that area?

Susan Deacon: We have highlighted chronic disease management in the health plan, in recognition of the fact that the people who suffer from chronic conditions often have the greatest need of support from the NHS throughout their lives or for a prolonged period. However, because they require access to different parts of the service, they can often fall through the gaps. Although chronic pain has not been featured in quite that way in the health plan, the recognition of the need to have a genuinely patient-centred service, which is truly responsive to individual and often changing needs as people move through different parts of the service, is at the heart of what we aim to achieve. We recognise that changes are required at a number of different levels to ensure that that happens. This is not simply about what we monitor, measure and test. A great deal of the action that must be taken to make improvements for people suffering from chronic conditions must be at a local level.

I hope that through the strategic framework, the additional investment that we are making nationally and the wider changes to the system and culture that we are supporting in the NHS, we will create an environment that is much more conducive to meeting the needs of those individuals. There are many good examples in Scotland of those needs being met effectively—we need to build on those examples.

Mr John McAllion (Dundee East) (Lab): I am pleased to hear you say that you are trying to improve the way in which performance is assessed in the NHS—that is vital. At yesterday's meeting of the Audit Committee, the former director of finance of the old Dundee Teaching Hospitals NHS Trust recounted what happened when the previous Government at Westminster made a significant investment in cancer services at Ninewells hospital. A professor was appointed, who opened up a service. However, there was then an upward curve in expenditure for which no allocation had been made. That contributed to a deficit problem that Tayside University Hospitals NHS Trust eventually had to deal with.

To cut back the money would have meant that patients with cancer in Dundee and Tayside would have had what the director of finance described as "suboptimal treatment". Financial performance can sometimes get out of kilter because real patient need is being met. Not meeting that need but simply meeting targets to improve managerial performance and so on would mean that patients would suffer. How will your new framework stop that kind of thing happening?

Susan Deacon: The example that you have raised and other examples that have surfaced of certain practices, particularly in Tayside, over a

number of years illustrate the changes that need to be made. I will highlight two areas where I hope that our changes will guard against similar occurrences. The first is improved accountability, which involves both accountability at a national level, including reporting and other issues that we have discussed at length, and local accountability and greater transparency in the boardroom. Having one unified NHS board that includes staff, local authority and clinical perspectives around the table means that we can rebuild systems and have cultures that are far more open with regard to decisions that are being taken locally. Such openness was sadly lacking in Tayside for a considerable time, and I am pleased that the new chair of Tayside Health Board has gone some way towards turning that situation round.

The second area is better management. We must work to build management capacity in the NHS in Scotland. We have only recently launched a new leadership programme to ensure that the necessary skills and expertise are in place to run a high-quality modern national health service. Management of the NHS is a demanding task at any time. Furthermore, we are changing the job that we require of managers in the future; we know that they need support in that effort.

Mr McAllion: Would it be good management on the part of those new managers not to treat patients in order to keep within their budget? I know that difficult decisions have to be made, but patients in Dundee were suffering from cancer and they required services. Even though the Tayside trusts spent money that they did not have, at least they treated patients. Was the alternative not to treat those patients?

Susan Deacon: I am loth to comment on the specific case that you have mentioned, because I have not been party to many of the details. However, the general point is that in any public service—including the health service—there is always a need to manage within available resources. As we are in a period of expansion and investment, the resources that are available to the system are increasing, but there will always have to be decisions about managing within budget. It is disturbing that occasionally there is no connection between good financial management and good service planning. As a result, there is sometimes a stop-start situation; a new service might be curtailed or withdrawn because there is not enough sustainable funding to support it. As I have said, through improved accountability and better management, it is possible to have much better planning processes to avoid the problems that have arisen.

Gerry Marr: In the case of Tayside Health Board, the warning signs came late. However, if there is an early warning, it is not good management to cut patient care as the first port of call. It is taking a very limited view of the total budget to cut cancer services if you have overspent on those services. If £300 million is available, we should find out why things are going wrong and what can be done to reverse the situation. The last port of call should be taking decisions about direct patient care services.

On the Executive's relationship with the service, we would ask why things had gone wrong and what actions were proposed. We would not be happy if the first response was to cut patient services. As a manager in the NHS, I have faced budget pressures and would never take that approach as a first port of call. We must always scrutinise total resources and try to balance the pressures in the system.

Mary Scanlon (Highlands and Islands) (Con): I will continue on the same theme. We always tend to focus on spending, instead of trying to move the focus on to the measurement of outcomes of patient care. Florence Nightingale classified her patients as relieved, not relieved or dead, yet 150 years later, despite our sophisticated information technology, we do not have anything as sophisticated as she had. As John McAllion said, we are trying to gain a measurement of patients' health. I contacted the health boards about hospital-acquired infections, which are costly not only to the NHS, but to patients' health, and discovered that there is not even a commonly agreed definition of such infections in Scotland.

The cinderella of the health service is probably mental health. How are patient outcomes in mental health measured? We do not even have a Scottish intercollegiate guidance network on depression. How can we measure unmet need in mental health? What about care in the community for the elderly, the disabled and the mentally ill? Last year, we tried to make sense of the budget for that. I have scrutinised the Accounts Commission documents; basically, it is asking local authorities to bring forward information next year. I am sure that the minister must be concerned about the level of resources that go towards the mentally ill, the elderly and disabled people.

Few of us would disagree with the priorities and targets within the NHS plan, but additional training will be required. In some health boards, the annual training budget per nurse is £5 a year; in others, it is £100 a year. How can the minister be sure that people can attain the targets if they are not receiving training?

Mr Marr mentioned measuring inequalities. I have been as consistent on spending under Arbuthnott as Dorothy-Grace Elder has been on chronic pain. The Highlands benefited greatly from that formula, but that money has been spent

mainly on assisting with financial deficits in the acute hospitals. There has been no additional money for local doctors in remote parts of Scotland, so that people who cannot afford to put petrol in their cars to drive to Raigmore hospital can access better health care. Outcomes have been mentioned, but will the minister address enhanced patient care?

The Convener: That short question covered outcomes, mental health and training. The measuring of inequalities is an interesting hot potato, but the main part of the question concentrated on Arbuthnott.

Susan Deacon: The other matter that was raised was hospital-acquired infection. I will comment on a couple of matters and Gerry Marr and John Aldridge may also wish to say something on the subject. A great deal of work has been undertaken on hospital-acquired infection by the department and the NHS, but notably also by the Scottish Centre for Infection and Environmental Health, or SCIEH. In fact, the Scottish infection control manual was cited by the Audit Commission south of the border as an example of best practice. However, there need to be further improvements to both practice and surveillance. I am sure that Mary Scanlon is aware that further work is under way to develop a national surveillance system.

Hospital-acquired infection is the product of many different issues. It is a global problem, and problems such as methicillin-resistant staphylococcus aureus are compounded by growing anti-microbial resistance and so on. We must strive continuously to improve standards of cleanliness, which is why great priority has been placed on that in the health plan. We do not accept the contract culture of the past. Cleaning arrangements for hospitals must be based on the best value and service, not the cheapest price.

I refer now to mental health. The Clinical Standards Board for Scotland is developing a standard on schizophrenia, which is evidence that mental health has not been forgotten. The Executive has worked hard to give mental health the third-stated priority that it deserves. For a long time, cancer, coronary heart disease and mental health were spoken about in the same breath, but mental health did not have the same priority.

10:15

Mary Scanlon's opening remarks were important, but I think that we have quite a number of nurses in the NHS like Florence Nightingale. While we are moving into a period of investment and modernisation, making best use of modern technology and providing new infrastructure, it is important not to lose sight of the human qualities of our NHS staff. We want to put alongside financial and clinical governance the responsibility for staff governance. It is a key role for NHS employers. We value our staff resources, because the NHS is a service for people. We must not lose sight of the fact that 136,000 people provide that service in Scotland and 5 million people use it.

Gerry Marr: Both hospital-acquired infections and training will be reflected in our performance assessment of the NHS. We have already published "Learning Together" and have made a central investment to pump-prime. The relationship between training and clinical governance is apparent. It is incumbent on local systems to make that investment wisely.

Mary Scanlon: I also asked about Arbuthnott.

John Aldridge (Scottish Executive Health Department): I shall talk about the Arbuthnott report and how the Highland Health Board is carrying it forward. The implementation of the report and reaching the right levels of spending in each area will be a five or six-year programme to which the minister is committed. We should not just look at what happens in an area over one year. Although Highland has done well this year from the move to Arbuthnott, its share of the resources that are available to the NHS in Scotland will continue to grow during the coming years until it reaches the appropriate Arbuthnott level.

This year, Highland is investing its extra resources in three chunks, the first of which is to establish a sound financial base throughout the system. That is legitimate because the Arbuthnott formula seeks to relate the amount of resources going into an area to the relative costs of providing the services in that area. That applies to the acute sector as much as to the primary care sector. The second chunk concentrates on dealing with the new financial pressures emerging in the system in both the acute and the primary care community sectors. The third chunk will be used for new development. Highland has three years' allocations, and it is intended that the proportion that will be available for new developments and the issues to which Mary Scanlon referred will increase in future years.

Mary Scanlon: The minister referred to the assumption that competitive tendering had led to hospital-acquired infections. Earlier this year, my mother was in hospital in Tayside. The hospital operated an in-house tender for cleaning, but it was dirty. If we consider the statistics throughout Scotland for private and in-house tenders, we can see that there is little difference between them. Would it not be better for the minister to concentrate on the standards and adherence to the SCIEH guidelines rather than the question of private or in-house tendering? I complained

several times to the hospital about the lack of cleanliness. I was surprised that it operated an in-house tender. I now come to the best-kept secret: local authorities are very involved in care for the elderly, disabled and the mentally ill. How can we scrutinise their contribution to health care?

Susan Deacon: The health plan makes it clear that we are not prescriptive about how cleaning services should be provided. They must be provided on the basis of best value. That may mean that they are outsourced or that they are provided internally. It has been demonstrated to me from many quarters that there has undoubtedly been a move over the past 10 or 20 years towards routinely outsourcing such services and that price alone was regarded as the key consideration. That should not be the case—cleanliness is too important to be dealt with on such a basis.

Our relationship with local authorities is clearly different from our relationship with the NHS, because they are democratically elected bodies. They are held to account and scrutinised by local electorates at the ballot box.

Mary Scanlon: But the electorate does not have the information.

Susan Deacon: I accept the issue about gathering information. We have closed the gap in respect of the information that we gather from local authorities about community care. We have worked closely with them and have monitored areas of increased investment in services for older people and delayed discharge. I welcome the fact that local authorities have been co-operative. We have to remind ourselves that, as locally elected bodies, they are accountable to their electorate.

Mary Scanlon: If the Health and Community Care Committee cannot obtain information, how can local people obtain information to help them decide which councillor to elect? Where is the democratic accountability in that?

The Convener: I think that the minister was saying that bridging that information gap was an on-going process. Let us move on. Mary Scanlon has had a fairly good crack at the whip.

Shona Robison: The Finance Committee asked us to determine whether the objectives and targets set out in "Investing in You" have been met. Were the targets achieved? If not, what progress has been made towards achieving them?

Susan Deacon: Do you want me to focus on any specific targets?

Shona Robison: Will you give us an overview of what has and has not been met?

Susan Deacon: Do you want me to clarify the targets that are set out in "Investing in You", which reflect the Government's commitments?

Shona Robison: Yes.

Susan Deacon: John Aldridge spoke about the issue at a previous meeting. In the main, progress towards stated targets and time scales has been on course. However, there are certain projects for which that has not been the case either because of unforeseen factors or because, as projects have developed, other needs may have been identified, and we have had to realign resources accordingly. In general, progress towards attainment of targets has been relatively good.

Shona Robison: Can we receive a written response with more information about progress towards the targets? I appreciate that it is difficult to explain in detail all the projects in the committee.

John Aldridge: We can certainly provide information about progress with the targets. I emphasise that, because of the way in which the system works, the targets set out in "Investing in You" were for 2001-02, so we would not have expected to have completed all the projects by now.

Shona Robison: Are we on target?

John Aldridge: We can certainly say where we are on target and, as the minister has said, the vast majority of the objectives have either been achieved or are on target. One or two have had to be delayed, for whatever reasons. We will write to the committee on that. Some of that information is in the document before members.

Shona Robison: From the evidence that we have heard, it appears that the three-year minimum guaranteed budget has been welcomed, particularly by local decision makers. The question that arises is whether it is possible to extend that budget. Could it be changed in other ways to promote more long-term, outcome-focused planning?

Susan Deacon: I am intrigued by the question whether the three-year budget can be extended, as we have been very clear on our spending plans over the lifetime of the Administration. We recognise that there will be an election at some point and—although we hope that we will be able to continue in the same direction with regard to investment and reform in the NHS—we know that we have to turn to the electorate in 2003. It is right and proper that our planning horizon is linked to that, and it is crucial—if we want effective management, good planning and so on, as we have discussed today—that we operate to a longer time horizon than has often been the case.

A criticism of the old internal market is the extent to which it focused on the year-end bottom line on the balance sheet. That militated against longer-term investment and thinking. Much of what we

now have to do with regard to investment and capital is a function of that. Could we improve the situation? I am sure that there is always room for improvement.

We should be aware of the constant tension—I hope creative tension—between the desire among politicians, the public and the media for quick fixes and quick results and the need for a much more sustainable, long-term approach compared to the past. The NHS has been blighted by quick fixes in the past, and millions of pounds have been squandered on them. I have worked hard over the past two years to resist the temptation of quick fixes. They may deliver short-term results, but they often adversely impact on the capacity of the service to deliver long-term results. It is difficult to get the balance right, but if Shona Robison has specific suggestions for improvements, I would be pleased to hear them.

Shona Robison: Give us an example of one of the quick fixes that you have been uncomfortable with under the present Administration.

Susan Deacon: As I said, the NHS has been blighted in the past by a mindset of quick fixes. I have already given an example: the whole construction of the NHS internal market in the late 1980s and into the 1990s was geared to a 12-month cycle and a financial bottom line at the end of that. Mary Scanlon and I will have to agree always to disagree about that, but I reiterate my concern about the effect that it has had.

Over the past couple of years, we have worked towards delivering immediate improvements in areas where immediate improvement was required, for example by making much-needed injections of resources into equipment. At the same time, we have tried to align that investment to longer-term planning. As I said, I think that it would always be possible to do that better, and, again, I would welcome Shona Robison's observations on that.

Janis Hughes (Glasgow Rutherglen) (Lab): In one of our evidence-taking meetings, Unison claimed that the Executive had made commitments that were not matched by additional funding and cited last year's pay award as an example. Last year, when the Health and Community Care Committee took evidence on the budget, it was apparent that there were similar examples, such as one-stop clinics, which had not been fully costed when a national commitment to them was made. Do you see that as a problem? If the Executive continues to make commitments that are not being fully funded, it will be open to criticism and there will be problems. How much scope is there for local decision making if the Government carries on making uncosted proposals?

10:30

Susan Deacon: I reject the assertion about uncosted proposals and I do not support the concept of fully funding everything from the centre. The key issue is that where major national decisions are taken on issues such as pay—Janis Hughes is right to mention that issue—there needs to be a degree of certainty that the resources are in the system to meet those commitments. The minimum increase that any health board will get is 5.5 per cent in the current year, 6.5 per cent next year and 7.4 per cent in the year after that. The NHS and health boards have not experienced increases in allocations to that extent for a very long time—if ever.

The Unison submission welcomes additional investment but expresses concern that that investment is often earmarked for targeted initiatives. It is not possible to argue both that money should not be earmarked and that it should be put into the system for specific things. We have aimed to strike a balance in our commitments for the next three years by putting the increased allocations into the system, rather than holding money in the centre and giving it out in pockets for specific initiatives. Clearly there will be some exceptions to that—projects that, rightly and properly, are nationally led. However, we have struck the right balance. Resources have been allocated into the system and we are backing our priorities. We see pay and investment in staff as an investment priority for the service both nationally and locally.

Janis Hughes: Gerry Marr suggested that trusts and health boards must balance their budgets and that any cuts in patient care must be a last resort. I agree with that completely. However, pressures are put on health boards and trusts to provide services that are supported or proposed by the Executive—a local example is digital hearing aids. If trusts try to provide such services and balance their budgets, but cannot do so because the budget is not enough, what else can they do? One can balance a budget only if the budget is adequate.

Gerry Marr: Those are pressures that exist in the NHS—they have existed in the past and will continue to exist in the future. However, as the minister has said, the level of investment presents an opportunity to make different decisions around those issues. The example of one-stop clinics is interesting. We have exceeded the target that we set because the local systems knew that that was what they wanted to give their patients. They found money within their local priorities and resources to exceed by far what we had set as a national target. In many cases, the creation of a one-stop clinic is a matter of redesign—it is not a resource issue, but is about being more effective

and efficient.

One of the big drives of the health plan over the next two or three years is the section relating to the patient's journey and modernisation. It is not always an issue of resources. We may be organising our clinics ineffectively. They are not patient-focused and perhaps are not even financially efficient. Other equations are involved. The straight-line equation between money and what can be done in the service is a false analysis. We will achieve much through redesign and modernisation.

Janis Hughes: I agree. After spending 20 years in the health service, I know that what is important is not how much money is put in but how that money is managed. However, given that up to three quarters of the new money for health boards is used for pay and other cost pressures, how much extra do you estimate that health boards will need to meet the targets that you have set?

Susan Deacon: For all the reasons that have been given, that is an unanswerable question, not least because the targets that have been set are not achievable just by spending money. That takes us back to the point that was made, but that is important.

As I said, we must make priorities clear to those in the service. The health plan sets a direction of travel for many aspects, but as I said to Shona Robison, we do not say that the health boards must achieve those targets by, say, next May or two years from now. That is because although we want the service to move in those directions, we recognise that not everything can be done at once.

As I said in relation to mental health, if a stated priority is agreed on, it is not enough for it to be a paper commitment; it must be translated into practice. We want the increased additional investment for the system to be matched by greater clarity from us about priorities and objectives and by appropriate freedom and flexibility for those in the local system to exercise sensible judgments. If everyone tries to do everything, nothing will improve. We want focused efforts on improvement in the key areas.

Shona Robison: I wonder whether the minister has had a chance to read "The Real Scope for Change", produced by Arthur Midwinter and Jim Stephens. They say that as three quarters of the money for the NHS goes on labour costs, an increase of 4.8 per cent is required for the situation to stand still. That puts the 5.5 per cent average increase into some perspective.

Bearing that in mind, I return to the original question on Unison's concerns about not only junior doctors' pay, but the working time regulations and new drug costs, which Unison asserts have not been fully funded. It is all very well to talk about priorities and decision making, but if those requirements are not fully funded, that will inevitably mean a loss elsewhere. There are some difficulties with relying on local decision making to try to cover the costs of the additional burdens, because that will open up gaps elsewhere.

Susan Deacon: I would never describe better pay and conditions for staff as an additional burden. If we are serious about investing in the NHS, we must invest in its staff. I do not say that as a play on words as it is an important point. The fact that about 70 per cent of the NHS budget is spent on staff costs is all the more reason why, alongside increasing investment in the system, we must consider the way in which we organise human resources, as well as equipment and other available resources.

Sadly, some aspects of practice in the NHS owe much more to 1948 than they do to the 21st century. The new practices avoid duplication of effort and frustration for staff. They avoid intolerable delays and anxiety for patients. The issues do not have simply a monetary solution. For example, one-stop clinics are transforming the patient experience in many areas. That transformation often relates to how existing human and other resources are organised. Services should be organised around the patient, instead of having the patient trail round different parts of different hospitals, different buildings and different professionals.

Gerry Marr mentioned redesign more generally. For example, when I visited the new Hairmyres hospital recently, the cardiologist there gave me a presentation on how cardiology services had been reorganised. The time for the patient journey from start to finish has been reduced from 46 weeks, if my memory serves me correctly, to around 12 weeks. I asked whether that reduction was simply a function of the fact that there was a new hospital and a new building. The cardiologist said that the reduction could have been achieved in the old facilities, although building a new hospital obviously provided a catalyst to conduct the exercise.

It is important that we move on in the debate about the national health service. It is also important that we stop believing that every problem has a monetary solution, as there are deep-rooted system problems in the NHS. If those problems are not tackled robustly, the patient experience will continue to be poor in many areas.

Shona Robison: Perhaps you need to take a leaf out of your own book on that. The press releases that emanate from your department quite often talk about the headline-grabbing figures of investment, which, when we peel away the spin, are not real. Perhaps you need to talk about

restructuring to free up resources rather than give the impression that there are tens of millions of pounds of new investment, which, when the spin is peeled away and pay awards and price increases are examined, is not the case. You raise, by your department's presentation, expectations that can never be met.

The Convener: I do not think that anyone present would say that investment in pay is not an important investment in the NHS.

Shona Robison: Neither did I, but my point was—

The Convener: You said something about investment and peeling away pay. I am just commenting that pay is an important investment in the NHS.

Shona Robison: No one is saying otherwise. The point is that, when we examine the investment in new development and services, we see that it is limited. That is what I was saying.

Susan Deacon: It is a simple statement of fact that there are record levels of investment going into the NHS and that we have made a commitment to that for each of the next three years. I quoted the minimum increase for health boards. The average increase will be 6.5 per cent, 6.9 per cent and 7.8 per cent. That is real, substantial, additional investment.

Alongside that investment, there are many competing demands and priorities and there are many pressures. The Administration has worked hard to make investment in the NHS a real priority. However, that must be matched by meaningful reform. In many areas of service there is duplication—never mind gaps. That must be resolved.

It is often all too easy in the cut and thrust of political debate—even in much of the debate within the NHS—to say that it is not possible to do something because we do not have the money to do it. That is simply a misrepresentation of the challenge that faces the NHS. As politicians, we would be letting the public down if we suggested that they could get the service that they need, deserve and tell us that they want simply by spending more money. We are spending more money, but we have to spend it better and we have to organise services better.

Nicola Sturgeon (Glasgow) (SNP): I agree with many of the points that you have made in the last few minutes, particularly your last point. Nobody would argue that more money is the whole solution to the problems in the NHS, but equally there is a need to recognise that many of the stresses and strains that local trusts are under are rooted in financial problems.

I wonder whether you recognise one of the problems that I find is often raised by local managers—it goes back to issues that Janis Hughes raised. When you make an announcement about extra funding for a specific commitment, the extent of the funding that you announce often does not accurately reflect the true cost to local NHS organisations of meeting that commitment. One such instance that has been reported recently is your announcement of capital funding for magnetic resonance imaging scanners, which trusts had claimed they could not afford to run.

There are other examples. The employment cost of taking on extra consultants does not take into account the cost to trusts of extra administration staff or additional theatre space. The minister's announcements often raise expectations, but the funding that goes with the announcements does not reflect accurately the cost to local organisations of meeting the commitments that are announced. That limits local decision making, as local organisations have to find the extra funding from elsewhere in their budgets.

There is no easy answer to those problems. The minister should not stop trying to make additional funding available to do all the things that she wants to do. However, there is a need to recognise the problems that local organisations experience. Does the minister recognise those problems? How will she help local organisations manage that process?

10:45

The Convener: I am glad that Nicola Sturgeon has mentioned that issue, as I was going to do so in connection with the Western general hospital in my constituency. When the minister makes an announcement, does she communicate with the people on the ground? Does she ask them whether it is what they want and whether they are able to sustain the service? Perhaps the minister will answer Nicola Sturgeon's question and mine together.

Susan Deacon: The issue of communication is pivotal. We have spoken a lot about changing relationships with the service. In my regular dialogue with the service, that issue has been at the top of our action list. We must continue to work to improve communications. I venture to suggest that the NHS and the Government are not the best communicators. I share the local services' frustration when they have not had enough notice of something. Conversely, I get frustrated when we learn about things that are going on in other parts of the NHS of which we should have been notified.

Communication must be improved so that there is regular dialogue and information is passed in

both directions. If we are to have an efficient, effective, modern NHS that works for patients, there has to be good communication. Last but not least, communication has to be improved with patients. We all know of constituents who complain that they have not been kept informed of what happens to them throughout their journey of care. Communication must be improved.

I will move on to Nicola Sturgeon's point about decision making and investments. The issue of cancer equipment is an interesting one to unpick for a moment. Last year, a substantial additional investment in the region of £29 million was targeted at cancer equipment, which is a clinical priority for the service because the equipment has been run down over the years. We do not want to dictate to the service every last piece of equipment that should be bought. However, there was a general agreement that cancer equipment was an area for which we should say, "Here is a pot of money nationally and here is where it is going."

The chief medical officer and others had a dialogue with various cancer specialists in the service about the areas that were right for investment. Most parts of the service subsequently confirmed that the decisions that were taken at that time were the right ones. Some parts of the service said, "When we look at the issue in the round, that is not the best place for us to use that resource." Where that has happened, we have been flexible, as that is the right and proper thing to do in the best interests of patient care. However that can lead to the sort of exchange that we have just had when, in the cut and thrust of political debate, we are told that we did not get it right. We believe that it was absolutely right to identify cancer and cancer equipment as a priority. If, as the process of investment and improvement in services develops, there has to be refinement in how the investment is used to improve services, we will be pragmatic about that.

Nicola Sturgeon: For once, I was not saying that you did not get it right, which is a novelty. It is all very well if part of the services that are provided is not, in our opinion, the right way in which to use that money in the interests of patient care, but my problem is with funding and whether the additional money is sufficient—MRI scanners is only one example. Each time you announce additional funding for specific services, are you satisfied that what you are announcing allows trusts fully to do what you are asking of them? I have been told many times that that is not the case. Although you are giving trusts additional money, because of the hidden costs of doing what you are asking of them, often they cannot afford to take advantage of what you offer.

Susan Deacon: The concept of affordability is interesting. Often, the issue is not about affordability, but local priorities. As we become better at establishing the priorities for the NHS in Scotland and at narrowing the gap between national and local decision making, the scope for tension will be reduced. I challenge the notion about the ground of affordability, because sometimes others in the system do not identify a particular area as a priority. If we are serious about setting national standards for the NHS in Scotland, we must remove some of the ambiguity that has existed.

Nicola Sturgeon: I suppose that accountability is part of the problem. I had a conversation with a local NHS manager, who shall remain nameless, about additional consultants. He said that he could take the money that has been offered and employ an additional consultant. The money would allow him to pay the salary of the consultant, but it would not allow him to employ the extra administrative staff or nurses to support the consultant, nor would it free up bed space. He concluded that he could not employ an additional consultant. You announced an additional consultant, but that trust cannot deliver on that announcement. What are the public supposed to make of such a situation?

Susan Deacon: Often, what the public make of such issues is the same as what members might say about the issues in debate. That is why it is important that we are clear about the approach that is being adopted in the NHS in Scotland. It is right and proper that we should identify increasing staff capacity as a national priority, not in a vacuum, but through ongoing discussion with the service.

Sometimes, we need to target specific pockets of investment to make sure that expansion takes place. Nicola Sturgeon mentioned consultants, but we have recently made a commitment of £11.5 million to fund 375 additional junior doctors. We cannot and should not set a national level and say where each of those doctors should be deployed within a local system. We are giving 6.5 per cent, 6.9 per cent and 7.8 per cent increases over the next three years to the service, so that trusts have the scope within their budgets to match their local needs and priorities to the national decisions that have been taken about some key areas of expansion and investment. I do not disagree with the need to ensure that national-local balance and dialogue is effective, but it is sometimes a little misleading to suggest that the issue is one of local affordability.

Mr McAllion: The minister is absolutely right to focus on the need for priorities. After all, the founder of the NHS said:

"The language of socialism is the language of priorities".

It is nice that that part of that socialist analysis has reached various levels in Scotland today. It is

difficult to discover from the budget document whether priorities such as cancer and heart disease are being treated as priorities by health boards. Under the heading "Clinical priorities", the budget states that it is not possible to calculate what each health board is spending on different diseases. We accept that, but we have taken evidence from local decision makers who said that it would be possible to make an estimate of the hospital and drugs costs of providing different services throughout Scotland. Would it be possible for the minister to consider providing that information in next year's budget, so that we can better analyse whether money is being spent on the priorities?

Susan Deacon: If members make specific suggestions, such as the one that has been made by John McAllion, we are happy to investigate them. Changes that were made for this year's reporting arrangements were based on comments that were made last year. I sound the same note of caution as I did earlier, however, which is that we will never be able to measure exactly what is spent on particular areas, such as cancer. Many parts of the system might impact on patients during the course of their care arrangements from GP to acute services.

Mr McAllion: I would like a broad indication of hospital and drugs costs of providing different services, if possible.

Susan Deacon: If it were possible to make improvements in reporting and those improvements serve a purpose, and can be carried out without consuming a disproportionate amount of time, energy and resource, we shall be happy to explore them.

The Convener: It is about feasibility and the value of the exercise.

Dorothy-Grace Elder: Matters would be much more simple if we were truly pursuing the policies and vision of Bevan, rather than those of Thatcher, given such businesslike talk about budgets. We are running a health service, not a burger-bar chain.

Over the next 10 years, minister, your laudable aim is to cut cancer deaths by 20 per cent and deaths from coronary disease by 50 per cent. How can you do that in reality when the amount of new money to tackle those diseases is so small? The committee was surprised to read in the health improvement programmes that were published last year by various health boards that only £2 million was earmarked for new heart disease treatment, only £1 million was earmarked for cancer services and only £1.5 million was earmarked for children's services.

Is the minister surprised by how low those figures are when they are fed back from the health boards? Does it lead her to wonder whether some of the new money is being used by health trusts to cover their deficits from the previous year? How can she check whether the new money is being used to absorb old debts? How can she be sure that new money is going to the priority areas of most deprivation in Glasgow and the west coast?

I also have a quick private finance initiative question. About £355 million is earmarked for hospital development under PFI. A Treasury committee at Westminster found that PFI has not produced one example of a better deal in the hospital service than have public deals. Is the minister monitoring the new PFIs for hospitals in Scotland?

The Convener: The minister cannot complain. She has been asked questions that will take her from Burger King to public-private partnerships. All human life is here.

Susan Deacon: I wonder whether I should go into the issue of burger bars.

The point that Dorothy-Grace Elder began with is important: we are running a health service, not a burger bar. Although I am not the first person here to invoke the memory of Margaret Thatcher, perhaps I can be the second. As somebody who worked in the public sector throughout the 1980s and 1990s, I was quite appalled and offended by the way in which the Conservative Administration sought to monopolise the concepts of effectiveness, efficiency and good financial management in the public sector. I find it to be entirely consistent with the principles and philosophy of Bevan that we should aspire to sound financial management in a modern NHS. Those of us who believe in public services and public service values ought to be the strongest champions of that approach.

11:00

I will move on to the second point that Dorothy-Grace Elder made, which was about how we improve health and reduce the rates of cancer and coronary heart disease. For a long time—in health policy and wider socio-economic Government policy in Scotland—there was an explicit refusal to acknowledge the link between poverty and ill health. As the committee knows, that was one of the major shifts in policy direction that took place in 1997. That shift was encapsulated in "Towards a Healthier Scotland", which was published in 1999.

We will not achieve our health targets simply through health spending or through activity in the NHS alone. We will achieve the targets by reducing inequalities, tackling poverty, giving people better houses and jobs, and by building people's self-esteem and building our

communities. It is through that wider agenda, extending across the work of the Executive—

Dorothy-Grace Elder: Excuse me minister, but if only £1 million is set aside for cancer services—

Susan Deacon: I am making an important point. The initial question was about achieving health improvement targets for cancer and coronary heart disease. We will not achieve our health targets simply by doing more and more in the NHS to treat ill health; we will achieve those targets by tackling the root causes of ill health. That is why that approach is centre stage in our health policy and across the wider work of Government.

I know that Dorothy-Grace Elder is keen for me to comment on the specific amounts that are being spent in health. I will comment on three things. First, Arbuthnott is highly relevant because it recognises the particular needs of areas that have high levels of rurality and deprivation. As the committee knows well, that is reflected in the relatively higher allocations to those areas. Secondly, we go full circle and address the issue of accountability and performance management. Rather than measuring every pound, shilling and penny that a local system spends in its area, the heart of the performance management process will be a requirement that local systems explain and set out how they have sought to address health inequalities in their areas and how they have worked with other organisations—such as local authorities and the voluntary sector—to do that.

Thirdly—notwithstanding the need for local bodies to have the scope to act at a local level—we have identified health inequalities nationally through the health improvement fund. We have ring-fenced a substantial element of health spending and targeted it specifically towards work in that area.

It is a long haul and a big agenda. However, as we have agreed in the committee and the Parliament, it is the right agenda for us in Scotland.

Dorothy-Grace Elder: What about PFI, minister? How are you going to monitor that to ensure that the private financiers do not make the huge killings that they stand to make and to ensure that the health service really benefits?

Susan Deacon: Dorothy-Grace refers to PFI in health, but of course the use of PFI or PPPs, extends to other areas. I note that there are wider issues that fall outwith my ministerial remit.

Several changes have been made to the way in which PFI and PPP projects have been handled over recent years to ensure greater transparency and better protection for staff who are affected. Thorough processes are set down, not by the health department, but by others, on how value for money is assessed for each project. All projects are assessed individually on their merits. Half of our hospital building programme is being funded by PFI, while the other half is being funded traditionally. All those developments are delivering real improvements for patients. John Aldridge might want to comment on the financial details.

John Aldridge: We will, of course, undertake post-project monitoring of the PFI projects. That is built into the system. To date, the PFI-funded hospitals that have come on stream have come in on budget and on time. That suggests that if the original value-for-money assessment was carried out correctly—we have no reason to doubt that—they are currently on track to deliver value for money.

Dorothy-Grace Elder: When they are completed, will those hospitals belong to the public or to the financiers? They will belong to the financiers, will they not?

John Aldridge: That will depend on the contract in individual cases. It is intended that all new projects will be returned to the public sector. Most of the older projects include an option for the buildings to be returned to the public sector.

Dorothy-Grace Elder: Do you mean to be bought back? That would be double paying.

John Aldridge: It would not be double paying. Matters can vary in specific cases but, generally, the cost to the public sector of buying the establishment at the end of the contract would be the residual value. It would not be paying twice, but paying what had not been paid through the PFI payments over the year.

Margaret Jamieson: You said, minister, that you would assess each PFI on its merits. Obviously, I hope that you did not mean only its financial merit. You referred briefly to the impact on staff. We should never lose sight of the fact that we will not have a good health service if we do not have good staff to deliver it. I declare an interest, as a member of Unison.

I represented health service workers for a long time and was involved in some PFI projects. Is it not about time that we said how much we value our staff? Under a PFI or a PPP, certain individuals will manage a hospital building. I accept that there have been significant moves since 1997, but a safeguard needs to be applied, so that the staff will be employed within the NHS family. They must have continuity and their worth must be recognised. For too long, those ancillary service workers, to whom Mary Scanlon referred when she spoke about hospital-acquired infection, have been thrown to the private companies. Their terms and conditions have been eroded, yet their colleagues remain part of the NHS family, albeit

under restricted terms and conditions. Can you give us a commitment that you will work towards that end?

The Convener: We can safely say that Margaret Jamieson still represents health service workers.

Susan Deacon: I am happy to give a commitment that we will continue to ensure that all staff who contribute to the NHS are valued appropriately. I am pleased that Margaret Jamieson rightly made the distinction between the staff element of PFI projects and the wider building projects.

Very robust value-for-money arrangements are in place for building projects. Effective and successful developments are coming on stream. However, I share the view that it is important that we retain the NHS team within those developments. That can be done in various ways. Changes have been made in pension rights, for example. As Margaret Jamieson will know, we continue to work with Unison on the wider arrangements for the transfer of staff. However, I am happy to give a commitment that we will continue to move in that direction to ensure that all members of the NHS team, wherever they work, are protected and valued, as they deserve to be.

Gerry Marr: On a technical point, the new scheme—

The Convener: Before I let Gerry Marr go on to that technical point, I will let Margaret Jamieson in again, because I think that she has a specific question on another technical point.

Margaret Jamieson: The minister mentioned pension rights. Diligent as I am in reading trust board minutes—on a Saturday night, because I am a sad individual—I have found that we seem to have inherited a little difficulty. Pension fund provision has been insufficient, and the Government has now indicated that, for the next 14 years, we will have to supplement it. I do not see how that money has been allowed for. One trust in the Ayrshire and Arran Health Board area has said that staff employment costs will increase by 1.5 per cent, which will cost that trust £1.06 million per annum. If we multiply that to cover all Scotland, it comes to a significant amount of money. All that ties in with the previous question about what happens to individuals who have NHS pensions and who transfer. How will you ensure that their pensions are protected?

Susan Deacon: I never cease to be impressed by Margaret Jamieson's assiduous reading of the very small print of trust board minutes. I will ask John Aldridge to deal with some of the technical aspects.

John Aldridge: I can certainly deal with the point about employers' contributions to pensions. We are well aware of the situation. The Government carries out a reassessment every so often—I am sorry, but I do not know how many—

Margaret Jamieson: Fifteen.

John Aldridge: Every fifteen years. Contributions can go up and down as a result. After the most recent assessment, employers' contributions will go up. That will start to hit the trusts next year—2002-03. We have taken that into account in the total increases that the health system will receive. We reckon that the impact of that increase in contributions on the total provision to health boards will be between 0.5 per cent and 0.75 per cent. Therefore, the fact that the total minimum increases to health boards next year and the year after will be 1 per cent above the minimum that they get this year means that there will be more than enough to cover that impact.

Margaret Jamieson: You said that the effects would kick in in 2002-03. However, although there was a neutral effect in the budget year just passed, there will be a small increase during this budget year because effects kick in between January and March.

John Aldridge: I understand that this year—2001-02—trusts must make provision in their accounts to allow for that. The overall effect should be neutral.

Margaret Jamieson: The effect will be neutral for 2000-01, but not for 2001-02, because the pension year is different from the financial year.

The Convener: I have a point on PFI that I will put to the minister in writing, because I want to finish off with questions from Richard Simpson on the primary care sector.

Dr Simpson: I should declare that I am still a member of the Royal College of General Practitioners and the British Medical Association. I do so in light of certain things that those organisations are doing with which I do not agree.

The committee took evidence earlier this month from somebody who was in charge of a local health care co-operative. The first thing that he pointed out was that the LHCC had taken a hit last year and this year because of generic prescribing. He said that that was discouraging general practitioners, because people felt that there had not been a rescue package. I understood that there had been a rescue package; there was certainly one in England and Wales. I do not know whether we did the same up here and whether we acknowledged the increased pressures because of the generic cost rises.

11:15

That witness also said that the LHCC had been given only a 2.3 per cent increase last year and a 3.1 per cent increase this year. At the same time, staff costs rose by 3.7 per cent. That LHCC was therefore being squeezed. This perhaps relates to points that my colleagues Nicola Sturgeon and Shona Robison made earlier. We have evidence that—at the bottom level, once we have got through the health board to the LHCC—the supposedly dynamic new area of development and co-operation between general practitioners is being squeezed. Things are not being allowed to develop. Here we are again, hearing evidence for the second year in a row to the effect that the primary care sector is being heavily squeezed. How does that square with the fact that we have had 10 years of talking about a shift towards primary care?

Susan Deacon: I will take in turn the three main points that Richard Simpson made. If I picked him up correctly, the first point is one that we corresponded on and discussed in various forums last year, and is to do with additional payments on the drugs budget. That was some time ago and, from memory, a different approach was adopted in England, but that reflected a different approach in the initial setting of the budgets. We are all aware that the drugs bill represents a significant element of expenditure, not only in primary care, but throughout the NHS. That is why we continue to work with the UK Government to put in place measures that secure improvements in prices.

Richard Simpson's second point concerned the budget of a particular local health care co-operative. That situation will have been the result of local decisions, so I cannot answer the point in detail. That takes us back to issues of accountability and the unified NHS boards. We have said clearly that we expect the NHS boards to adopt a proper whole-system approach that ensures that services are provided in the right places at the right time for the local population, and that that system should ensure that services do not get locked up in turf wars between different parts of the system. We have seen that often in the past. In our health plan, we say clearly that LHCCs have a key role to play. One of the things that the unified NHS boards will be asked about, and held to account for, is how effectively they work with LHCCs in their areas, to allow the people who are closest to communities to do their jobs.

The third point leads on from that. It concerns the wider issue of the shift to primary care. I have touched on some issues that I hope will lead to improvements in that area. I stress that I do not think that the stated aim should be to make the shift to primary care: the issue is to ensure that services are provided close to people. It so happens that that means that certain things are best done within primary care. It is important that that is recognised and resourced accordingly.

I have had several meetings with various primary care interests over recent weeks and months to consider how we can further improve that area. I have spoken to representatives from the Scottish general practitioners committee of the British Medical Association and to representatives of professionals who are allied to medicine, such as nursing interests, pharmacists and others. Several pieces of work on LHCCs are coming to fruition at present, including work by Audit Scotland and by a best-practice group that I set up in the Executive. We are in the process of drawing together all the strands of that work to ensure that we can make policy and, where appropriate, financial interventions that will achieve those aims.

Dr Simpson: The witnesses raised a supplementary point. They said that they are unable to get information from the prescribing division and that there is still a massive delay, which makes it difficult for them to manage their funds. Through the National Institute for Clinical Excellence and the Health Technology Board for Scotland, we are now releasing new drugs. For example, there is a new circular on drugs for dementia. How is that taken into account in the budget? How can health boards manage the information so that the drive to increase funding will mean that there are supplementary funds? When you announce new initiatives on drugs, is there new money or do health boards have to meet those demands from within their existing budgets?

Susan Deacon: Health technology assessment is a huge area for health care systems around the world, as they consider how new drugs and treatments should be introduced into the system in a way that is both cost-effective and clinically effective. In the UK, we have recently established mechanisms for looking at developments in that area, through the National Institute for Clinical Excellence in England and the Health Technology Board for Scotland here. We are also developing various other consortium arrangements to ensure the best possible co-operation and sharing of advice and information throughout the system.

I acknowledge that the area is developing and evolving all the time. As science advances and new drugs and health technologies regularly come on stream, the issue will remain challenging for clinicians, health care systems and Governments alike. Some of the decision-making processes that Richard Simpson referred to are in their infancy, so that the way in which they are rolled out into the NHS, in Scotland or elsewhere in the UK, is relatively new terrain. We do not have enough

historical examples to say exactly how that will be managed, not just in resourcing terms but more widely. However, we continue to be actively engaged with the issue.

What was the other question?

Dr Simpson: I cannot remember, either.

John Aldridge: It was about delays.

Susan Deacon: Of course. Do you want to comment on that, John?

John Aldridge: Dr Simpson is right to say that there have been quite serious delays in the provision of information from the prescribing directorate at the Common Services Agency because of technology problems. The problems have now been resolved. The agency can now process one month's prescriptions within a month, which is its target. However, there is a backlog, which it is now in the process of recovering.

Dr Simpson: That is good.

My final budget question is this: is the department holding back some funding against the known programme of the HTBS? When the HTBS announces that it has assessed a new drug for ovarian cancer or for Alzheimer's disease, and considers that it can now be prescribed, or that beta interferon can now be prescribed more widely, will you have the reserve funds to apply those decisions, or will you expect the service to absorb those pressures?

Susan Deacon: We retain a reserve at the centre to cope with eventualities and needs that can arise. As you say, some things can also be planned and predicted. However, we obviously want to limit what we hold in reserve at the centre, not least because we believe that the resources should be out in the system. As we have said in other contexts, it is important that local systems have control over their resources as far as possible.

Rather than speculating about what might happen, I will give an example of the approach that we have taken to releasing additional resources. Zyban and nicotine replacement therapies have both been made available on prescription. We have not released resources into the system specifically for the direct costs of prescribing NRT or Zyban. However, we have identified smoking cessation as a key priority, in policy terms and through the health improvement fund's targeted resources. I am not saying that that is the ideal arrangement for the longer term. We are continually learning and evolving the way in which we work with local systems. However, those treatments offer a good practical example of how we have struck the right balance. Not every national decision has to have a specific pot of money allocated from the centre, but we can try to align those sorts of decisions with wider resource and priority decisions.

Dr Simpson: Presumably the LHCCs can come back to you, to the health board or to their MSPs if they do not get the money from that health promotion pot to meet those aims and they are being called on to squeeze their budgets to provide Zyban and NRT.

Susan Deacon: I hope that they would not have to come back to us or to you. We want far more of those things to be fixed at local level. Although we are setting up unified boards and are therefore drawing together different strands of decision making into one strategic board, that process of integration and rationalisation has to be matched by a devolving of decision making and service delivery to the front line. As Richard Simpson knows better than most of us, we are in the realm of a big change in culture as well as in the flow of resources. We are certainly trying to put in place a national system that allows for far more to be pushed down to the front line, so that resource-allocation decisions can be taken as close as possible to where people are.

The Convener: We shall come back to you in writing with any further questions. I am aware that we have taken up a good deal of your time and that you are not feeling all that well. Even if you came to the committee feeling well, you would probably not be by the time you had finished. Could you tell us briefly when the review of LHCCs is likely to be published? I have questions about some of the detail behind that, but I will not indulge myself at this point. When can we expect the review?

Susan Deacon: There is not one specific review exercise. There will be a series of different pieces of work. We are having a conference in June, at which I fully expect much of that work to be drawn together. Further developments will be taken forward around the time of that conference, which is specifically about LHCCs and will involve a wide range of primary care interests.

The Convener: We probably have other questions about primary care, but we shall put those to you in writing. I appreciate that we have run on a little, but it was important that we covered all those issues. I thank the minister, Gerry Marr and John Aldridge for attending.

11:28

Meeting adjourned.

11:35

On resuming—

Regulation of Care (Scotland) Bill: Stage 2

The Convener: I welcome Malcolm Chisholm and the Regulation of Care (Scotland) Bill team back to the committee. Today is the final day of committee scrutiny of the bill before the stage 3 debate.

There are no amendments to sections 42 to 45.

Sections 42 to 45 agreed to.

Section 46—Inquiries

The Convener: Amendment 244 is in a group on its own.

Janis Hughes: Amendment 244 was lodged to address concerns raised by witnesses at stage 1. We have all heard stories of unacceptable treatment in various care settings. Several witnesses, including representatives of the National Care Standards Committee, Help the Aged and Community Care Providers Scotland, felt that there should be no barrier to making a complaint in such cases. What has become known as whistleblowing should be positively encouraged. Amendment 244 would protect staff in the care sector who wished to complain and it would offer encouragement by way of ensuring that their position was not compromised.

I move amendment 244.

The Deputy Minister for Health and Community Care (Malcolm Chisholm): Section 46(1) enables Scottish ministers to act on concerns over the exercise of functions by the commission or council—or, in the commission's case, concerns over the provision of a care service—by setting up an inquiry. Subsection (2) allows the commission to set up an inquiry on the exercise of its functions or over the provision of a care service. Subsection (3) allows the council to set up an inquiry on the exercise of its functions.

I fully support Janis Hughes's intention that care workers who through their participation in such inquiries blow the whistle on wrongdoing should be protected from detriment under the terms of the Employment Rights Act 1996. I am, however, unable to accept amendment 244.

First, the terms of the amendment are outwith the legislative competence of the Scottish Parliament, as the matter to which it relates—the Employment Rights Act 1996—is reserved under section H1 of schedule 5 to the Scotland Act 1998, and the matter comes within neither the specific exception in section H1 nor the general exception in paragraph 3 of schedule 4 to that act.

Secondly, as drafted, the amendment would not achieve the necessary effect of including the commission and council as prescribed bodies under the terms of the Employment Rights Act 1996. That is done by making an order under section 43F of the Employment Rights Act 1996. My officials have been in contact with the Department of Trade and Industry, which is responsible for the Employment Rights Act 1996, about adding the commission and council to the list of prescribed bodies, and will be submitting a formal case for their inclusion. That is a matter for DTI ministers and I cannot speculate on the timing of their decision. I am hopeful that they will look favourably on what I consider to be a strong case for the inclusion of the Scottish care regulators under the act.

Finally, the amendment erroneously implies that disclosures by care staff to ministers, or to officials or those carrying out inquiries established by Scottish ministers, are covered under the terms of whistleblowing legislation. That is not the case, although whistleblowing to ministers or civil servants by staff of non-departmental public bodies, such as the commission and council, is protected under the Employment Rights Act 1996, regardless of whether the bodies are listed as prescribed regulators.

I share Janis Hughes's desire to protect care workers as far as possible under the terms of whistleblowing legislation and I can assure her that I am pursuing all available measures to achieve that end. Amendment 244, although well intentioned, deals with a matter that is not within the powers of this Parliament and in any case would not achieve the desired effect. I apologise for the rather complicated explanation but, in view of it, I hope that Janis Hughes will withdraw amendment 244.

Margaret Jamieson: On a point of clarification, minister, you are indicating that the amendment does not fall within the competence of the Parliament, which leads me to ask the clerks why they deemed the amendment to be competent. I had a similar discussion last week on an amendment that I had lodged, which was deemed to be incompetent and was therefore not published. I know that the clerks undertake such scrutiny before an amendment is included in the marshalled list.

The Convener: Apparently legal advice was taken from within the clerking service, rather than from the parliamentary legal team.

Margaret Jamieson: In which case, why was legal advice sought in respect of one amendment

and not another?

The Convener: Are you saying that legal advice was sought on your amendment?

Margaret Jamieson: The amendment was not on the marshalled list.

The Convener: Could you clarify which amendment you are referring to?

Margaret Jamieson: I have forgotten which one it was. I am trying to ensure that amendments are checked for legal competence before they are included in the marshalled list.

The Convener: The view of the clerks, on advice from other clerks in the legislation team, was that the amendment was competent. Obviously, the Executive takes the view that the amendment is not competent. At this stage, I cannot say anything other than it is the committee's decision whether we agree to the amendment, given that I have to ask Janis Hughes whether she wishes to withdraw it. Are there any other comments on that point?

Mr McAllion: First, could amendment 244 be interpreted as the view of the Scottish Parliament as expressed in the bill, and therefore be deemed competent? There may not be the power to make that view law, but we can certainly express the view of the Parliament that the issue should be included within the argument. Secondly, could the minister make available a copy of his formal submission to the DTI not only to the committee, but to the whole Parliament, by placing the submission in the Scottish Parliament information centre?

Malcolm Chisholm: I have no problem with making that information available and I will do so.

I made two arguments against amendment 244. I believe that the amendment is not competent because it relates to a reserved matter. However, irrespective of that point, the wording does not achieve the intention behind the amendment. The amendment says that a qualifying disclosure

"is to be treated as a protected disclosure".

That is necessarily the case under the legislation because qualification and protection are two sides of the same coin. The amendment does not achieve the intended effect. We need to ensure that the commission and the council are inserted into the list of prescribed bodies and the procedure for that is to make an order, which is a regulation-making power of Westminster. The problem is not just that the amendment relates to reserved powers, but that the wording does not achieve the intended effect.

The Convener: We want to deliver something in relation to whistleblowing, but we have a legal question mark about whether amendment 244 is competent, or, even if it is competent, whether it would achieve what all the committee members clearly want. We could revisit this issue during the stage 3 debate, should the Presiding Officer be minded to allow us to do so. In the interim, we could take legal advice in order to find out whether it would be competent for us to exercise the committee's intention in relation to the amendment.

11:45

Janis Hughes: The advice that we take from clerks when we lodge amendments is that our amendments are acceptable—if they were not, they would not be included in the marshalled list. I am therefore concerned to learn that the committee clerks accepted an amendment that is deemed legally incompetent because it refers to a reserved matter. We must investigate that situation further.

I accept the minister's argument on the legal competency of amendment 244, although it puts us in a difficult situation. He suggested making representations to the DTI, but that will not happen overnight, given the situation at the Westminster Parliament. I am concerned about being caught between two stools. However, given that we still have the option to revisit the issue at stage 3, the most sensible thing for me to do would be to seek the committee's agreement to withdraw amendment 244 at this stage. We should then seek further, robust legal advice and, should that legal advice be that the proposals in amendment 244 are legally competent, we could revisit the issue at stage 3.

The Convener: We will bring it to the attention of the Presiding Officer that that is the committee's wish. I hope that we will then be able to debate the issue again, and vote on it, at stage 3.

Amendment 244, by agreement, withdrawn.

Section 46 agreed to.

Sections 47 to 51 agreed to.

After section 51

The Convener: Amendment 242 is in a group on its own.

Margaret Jamieson: The proposal in amendment 242 was suggested to me by the British Agencies for Adoption and Fostering, which is seeking to introduce a common age throughout all legislative provisions that relate to young people.

I move amendment 242.

Malcolm Chisholm: I understand the concern that prompted Margaret Jamieson to lodge amendment 242. Amendment 242 would align the

age limit for the discretionary allowance that is paid to carers who look after a child, where the carer is a relative or friend, with that for fostering allowances.

In the interests of fairness, I am prepared to accept the proposal in amendment 242, although I cannot accept the amendment as drafted. Therefore, I undertake to lodge an amendment at stage 3 to effect the change proposed by amendment 242. In so doing, I recognise that extending a discretionary scheme in such a way increases expectations and therefore financial pressures on authorities. We will keep under review the use made of the extra discretion and take account of any pressures that may arise in the next spending review.

Margaret Jamieson: I am happy with the minister's comments.

Amendment 242, by agreement, withdrawn.

Sections 52 and 53 agreed to.

Section 54—Panels for curators *ad litem*, reporting officers and safeguarders

The Convener: Amendment 241 was also lodged by Margaret Jamieson.

Margaret Jamieson: I move amendment 241, which is a technical amendment.

Malcolm Chisholm: I will argue that amendment 241 is a bit more than a technical amendment.

The purpose of section 54 is to improve support for the training of safeguarders. Safeguarders play a key role in looking after the interests of children who are involved in children's hearings, and that training will help to ensure that they are properly prepared to perform that role. We consulted on the provision when we were preparing the bill and it received strong support.

Amendment 241 would extend the provisions of section 54 to curators ad litem and reporting officers. I do not believe that that is necessary or appropriate. Although there are clear similarities between safeguarders and curators ad litem and reporting officers, there are important and fundamental differences.

Safeguarders work exclusively within the children's hearings system. Their primary role is to provide an independent opinion on the child's circumstances and to recommend what they consider is in the best interests of the child. They are appointed by local authorities, after appropriate consultation. They receive a fixed fee per appointment—currently, the fee is just under £100—which is determined by the Convention of Scottish Local Authorities.

By contrast, curators ad litem and reporting officers have a wider remit than that of safeguarders. They play an important role in adoption and parental responsibility order procedures and deal with all sorts of family and mental health matters. It is crucial to note that they are appointed by the courts and are paid a professional fee, which can range from £500 to £5,000, reflecting the fact that the vast majority are qualified solicitors and are expected to offer a professional service.

Amendment 241 would place a duty on local authorities to provide training for curators ad litem and reporting officers. I am not convinced that it is either right or proper for local authorities to have such a duty in respect of people who are appointed by the courts. There might also be questions about why those individuals, given their professional status and income, should benefit from training provided at the expense of local authorities.

I am content that section 54 is appropriate. It will provide valuable additional support for safeguarders. The section does not need to be extended in the way proposed by amendment 241 to cover curators ad litem and reporting officers and I urge Margaret Jamieson to withdraw the amendment.

Margaret Jamieson: Thank you for that explanation, minister—I am not going to argue with you. The proposal in amendment 241 was certainly not portrayed to me in that way. Given those comments, I seek the committee's agreement to withdraw the amendment.

Amendment 241, by agreement, withdrawn.

Section 54 agreed to.

After section 54

The Convener: Amendment 188 is in the name of the minister.

Malcolm Chisholm: Amendment 188 inserts a new section into part 4. It deals with training for the members of children's panel advisory committees. Amendment 188 will amend the Children (Scotland) Act 1995 by placing a duty on local authorities to train members of those committees and their sub-committees and by giving Scottish ministers the power to assist with that training.

The members of children's panel advisory committees play a key role at the heart of the children's hearings system. They lead annual recruitment campaigns, interview applicants, make recommendations to Scottish ministers for the appointment of children's panel members, oversee local needs for panel members' training and development, monitor panel members and provide

feedback. In short, they are a key support to the success of Scotland's system of child welfare and justice. Most local authorities already offer training to committee members. Placing a duty on them to provide that training makes good sense.

We propose a partnership approach in amendment 188. Through its regional network of children's panel training organisers, the Executive will meet the full cost of organising training. Local authorities will be required to meet the cost of training materials and events. The financial impact on local authorities is likely to be minimal, given that they already support some training events for advisory committee members.

Last year, we consulted the Convention of Scottish Local Authorities, the Association of Directors of Social Work and individual local authorities on the proposed new duty. No particular concerns were expressed about the funding of the proposed new arrangements. As I said, local authorities already support this type of training; amendment 188 would simply give them a formal duty to continue doing so.

I move amendment 188 and commend it to the committee.

Amendment 188 agreed to.

Section 55—Interpretation

Amendment 86 moved—[Malcolm Chisholm]—and agreed to.

Amendment 125 moved—[Margaret Jamieson].

Malcolm Chisholm: Amendment 125 would extend the definition of "child" in section 55 to include, for some services, persons up to 18 years. The bill currently defines a child as

"a person under the age of sixteen years".

One effect of amendment 125 would be to extend the regulation of day care services for children aged up to 18, which is not our intention. Any day care services for 16 to 18-year-olds—who may have a disability, for example—would be covered by the definition of support service that is already in the bill.

However, I can see why the amendment was lodged and as the bill now covers adoption and fostering services that extend up to 18 years, it is appropriate that we revise the definition. We have had the matter under review and intend to lodge an amendment at stage 3 to ensure that the definition of a child reflects the age limit of particular services: 16 for day care and 18—with appropriate qualifications, as at present—for adoption, fostering and secure accommodation.

On that basis, I ask Margaret Jamieson to withdraw the amendment.

Amendment 125, by agreement, withdrawn.

Amendments 87 and 88 moved—[Malcolm Chisholm]—and agreed to.

Amendment 126 not moved.

Amendment 127 moved—[Margaret Jamieson]—and agreed to.

Amendment 128 not moved.

Amendment 26 moved—[Malcolm Chisholm]—and agreed to.

The Convener: Amendment 189 is in the name of Malcolm Chisholm.

Malcolm Chisholm: Amendment 189 is a minor technical amendment that clarifies the definition of an independent medical agency in section 55 by inserting the full reference to the National Health Service (Scotland) Act 1978. It makes no substantive change to any provisions in the bill and I trust that the committee will accept it.

I move amendment 189.

Amendment 189 agreed to.

Amendments 89 and 27 moved—[Malcolm Chisholm]—and agreed to.

The Convener: Amendment 90 is in the name of Malcolm Chisholm.

Malcolm Chisholm: Amendment 90 would extend the definition of social worker to include all qualified social workers.

The bill currently defines a social worker as a person who

"engages in social work which is required in connection with any care service, or health".

That definition would exclude people who work as field social workers for local authorities or the voluntary sector or in criminal justice settings. As members know, field social workers carry out a range of duties. For example, they assess care needs, manage the provision of services, support families, engage in child protection work and support people with addictions.

Amendment 90 would ensure that, for the purposes of the bill, all social workers would be covered by the definition in section 55. Anyone with professional qualifications acceptable to the council would qualify as a social worker. The amendment strengthens the bill and I ask the committee to accept it.

I move amendment 90.

Amendment 90 agreed to.

Amendment 28 moved—[Malcolm Chisholm]—and agreed to.

The Convener: Amendment 91 is in the name

of Malcolm Chisholm.

Malcolm Chisholm: Amendment 91 is a technical amendment, which is linked to the amendments on adoption and fostering to which the committee has already agreed. The bill provides that the Scottish commission for the regulation of care will regulate adoption and fostering services that are provided by local authorities and voluntary organisations. As drafted, the bill does not define what constitutes a voluntary organisation. The amendment provides such a definition.

I move amendment 91.

Amendment 91 agreed to.

Section 55, as amended, agreed to.

Section 56—Orders and regulations

12:00

The Convener: Amendment 92 is grouped with amendments 29 and 93.

Malcolm Chisholm: Amendments 92, 29 and 93 relate to the making of secondary legislation and respond to the recommendations of the Subordinate Legislation Committee in its stage 1 report.

The Subordinate Legislation Committee recommended that the first set of regulations made under the powers in sections 23(1)(a) and 39(a) should be subject to the affirmative procedure, as they give ministers wide-ranging powers to confer new functions on the commission and the council. We have accepted that suggestion; amendments 92 and 93 make the necessary provision and, indeed, go further than that. All regulations under those sections will be subject to the affirmative procedure. The amendments also provide that orders made under section 58(2) should be subject to the affirmative procedure. The Subordinate Legislation Committee considered that that procedure was appropriate, as the power allows primary legislation to be changed by secondary legislation. We have accepted the committee's views and the amendments will effect the necessary change.

Amendment 29 will bring the bill into line with normal practice by excluding commencement orders made under section 59(2) from any parliamentary procedure, although such orders will still be scrutinised by the Subordinate Legislation Committee. In the bill as drafted, such orders would be subject to negative procedure. Again, the change is in line with the view of the Subordinate Legislation Committee. I am sure that the committee will recognise that we have responded appropriately to the concerns of the Subordinate Legislation Committee by lodging the amendments.

I move amendment 92.

Amendment 92 agreed to.

Amendments 29 and 93 moved—[Malcolm Chisholm]—and agreed to.

Section 56, as amended, agreed to.

Section 57 agreed to.

Schedule 3

MINOR AND CONSEQUENTIAL AMENDMENTS

The Convener: Amendment 222 is grouped with amendments 223 to 227, 135, 228, 190 to 192, 229, 194, 136, 195, 196, 213, 197, 198, 231, 199, 200, 95, 232 and 30.

Malcolm Chisholm: This large group of Executive amendments makes minor and consequential changes to existing legislation to take account of the changes that will be made by the bill. Members will be pleased to hear that I do not propose to talk in detail about individual amendments, but I am happy to offer more information on particular amendments if members have any questions or concerns. Many of the amendments simply update terminology by, for example, removing references to nursing homes and residential care homes and replacing them with references to care home services, as defined in the bill. All the changes introduced by the amendments will be needed once the bill is enacted and I ask the committee to support them.

I move amendment 222.

Amendment 222 agreed to.

Amendments 223 to 227, 135, 228, 190 to 192, 229, 194, 136, 195, 196, 213, 197, 198, 231, 199, 200, 95, 232 and 30 moved—[Malcolm Chisholm]—and agreed to.

Mary Scanlon: As adoption was not covered by the bill at stage 1, we agreed that we would like some time at stage 3 to reflect on the substantive amendments, in case any organisations wish to make points to us. We reserve that right.

The Convener: We will no doubt return to that at stage 3.

Schedule 3, as amended, agreed to.

Section 58 agreed to.

Schedule 4

REPEALS

The Convener: Amendment 233 is grouped with amendments 201, 234 to 238, 137, 202, 97, 203, 243, 204 to 206, 240 and 98.

Malcolm Chisholm: Like the amendments in

the previous group, the Executive amendments in this group make changes to existing legislation. They repeal some provisions to take account of the changes that the bill will make. I see little point in talking about the amendments in detail, but I will expand on any of them if members would like further clarification.

Many of the amendments repeal legislation that provides for the registration of care services and which will be superseded by the bill. Examples include provisions in the Nursing Homes Registration (Scotland) Act 1938, the Social Work (Scotland) Act 1968 and the Children Act 1989.

As with the previous group of consequential amendments, each repeal that the amendments propose will be needed once the bill is enacted. I ask the committee to support the amendments.

I move amendment 233.

Amendment 233 agreed to.

Amendments 201, 234 to 238, 137, 202, 97, 203, 243, 204 to 206, 240 and 98 moved—[Malcolm Chisholm]—and agreed to.

Schedule 4, as amended, agreed to.

Section 59—Short title and commencement

The Convener: Amendment 31 is grouped with amendment 32.

Malcolm Chisholm: Amendments 31 and 32 make changes to the list of sections that will come into force 14 days after royal assent.

Amendment 31 adds sections 40 and 44 to the list of those that will come into force after 14 days. Section 40 gives the council the power to make rules about registration under part 2. The council needs to have the power to start making rules as soon as it is legally established. Section 44 requires the commission and the council to consult each other on matters that are of interest to them both. The section also requires commencement shortly after royal assent, to allow the council and the commission to begin a dialogue at the earliest opportunity. I am sure that the committee will appreciate that it is important that sections 40 and 44 come into force at the earliest opportunity.

Amendment 32 removes sections 51 and 52 from the list of sections that will come into force when 14 days have expired following royal assent. Section 51 amends the definition of community care services in the Social Work (Scotland) Act 1968 to allow direct payments to be made to children for the services that they require. We are consulting further on the role of direct payments as part of our work on the long-term care bill. It is sensible to delay commencement of section 51 until that consultation is complete.

Section 52 amends sections 13A and 59(1) of the Social Work (Scotland) Act 1968 to allow local authorities to provide and maintain residential accommodation where nursing care is provided. That will allow local authorities to provide nursing care in their homes and supply a seamless package of care. The provision forms part of our plans for single care homes. Section 52 will not be required until the new arrangements for care home regulation start in April 2002 so we need not commence the section straight away.

I commend amendments 31 and 32 to the committee.

I move amendment 31.

Amendment 31 agreed to.

Amendment 32 moved—[Malcolm Chisholm]—and agreed to.

Section 59, as amended, agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the Regulation of Care (Scotland) Bill. I thank the minister and the bill team for all their assistance in the past few weeks. I also thank colleagues on the committee for their assiduous work on the bill, which is the first that we have dealt with as a lead committee. Thank you all for your hard work.

Meeting closed at 12:11.

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