HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 19 December 2001
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
32nd Meeting 2001, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*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)
*Nicola Sturgeon (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Malcolm Chisholm (Minister for Health and Community Care)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Elliott

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 19 December 2001

(*Morning*)

[THE CONVENER *opened the meeting at 09:32*]

Item in Private

The Convener (Mrs Margaret Smith): Good morning, everybody. Welcome to this morning's meeting of the Health and Community Care Committee. Does the committee agree to discuss item 4 in private, as it is a draft response to the Executive in connection with the hepatitis C report?

Members *indicated agreement*.

Subordinate Legislation

National Health Service (Charges for Drugs and Appliances) (Scotland) Regulations 2001 (SSI 2001/430)

The Convener: Agenda item 2 concerns statutory instruments that are subject to the negative procedure, the first of which is the National Health Service (Charges for Drugs and Appliances) (Scotland) Regulations 2001 (SSI 2001/430). No comments on the regulations have been received from members. The Subordinate Legislation Committee made several comments to the Executive regarding defective drafting of the regulations, which the Executive acknowledged. No motion to annul has been lodged and the recommendation is that the committee makes no recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

National Health Service (Superannuation Scheme, Injury Benefits and Compensation for Premature Retirement) (Scotland) Amendment Regulations 2001 (SSI 2001/437)

The Convener: No comments have been received from members. Again, the Subordinate Legislation Committee made several comments to the Executive regarding defective drafting of the regulations. The Subordinate Legislation Committee feels that the Executive's response is unsatisfactory and that the Executive failed to follow good drafting practice. That has been brought to the Executive's attention. No motion to annul has been lodged, so the recommendation is that the committee makes no recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Community Care (Direct Payments) (Scotland) Amendment Regulations 2001 (SSI 2001/447)

The Convener: No comments have been received from members. The Subordinate Legislation Committee considers that the explanatory note to the regulations is insufficiently informative and has brought that to the Executive's attention. No motion to annul has been lodged and the recommendation is that the committee does not make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Miscellaneous Food Additives (Amendment) (No 2) (Scotland) Regulations 2001 (SSI 2001/450)

The Convener: No comments have been received from members and the Subordinate Legislation Committee has no comments to make. No motion to annul has been lodged and the recommendation is that the committee does not make any recommendation in relation to the instrument. Is that agreed?

Members *indicated agreement*.

Community Care and Health (Scotland) Bill: Stage 2

Section 14—Scottish Ministers' power to require delegation etc. between local authorities and NHS bodies

The Convener: Agenda item 3 is stage 2 of the Community Care and Health (Scotland) Bill. I welcome the Minister for Health and Community Care and his team.

The Minister for Health and Community Care (Malcolm Chisholm): Good morning.

The Convener: We have reached section 14 of the bill. Amendment 11 is grouped with amendments 12, 13, 14, 15, 17 and 18. I invite the minister to move amendment 11 and speak to all the amendments in the group.

Malcolm Chisholm: Section 14 is important. Four of its subsections were dealt with last week. I want to deal with the fifth and most important subsection.

Section 14 provides specifically for intervention by the Executive where, in its judgment, joint working is failing. Obviously, we will consider the outcome for individuals in reaching a decision to intervene, but such a decision must be based on joint working being the cause of failure to deliver. Other causes such as lack of resources may be factors, but the intervention must centre on joint working.

I want to make some preliminary general remarks. The powers are broad and we will need to consider carefully how we use them, but that breadth is vital if we are to embrace the range of circumstances in which joint working might fail. I am sure that circumstances will vary considerably from case to case. We need to consider each case on its merits—that is the value of the powers that are before us.

The Executive's approach to joint working is that one size does not fit all and that different models suit different services and areas. I am pleased that the committee endorsed that general approach at stage 1. The flexible approach is embodied in sections 10 to 13 of the bill, which complement the ability of local bodies to work together under existing legislation. I take the opportunity to reiterate the Executive's intention to allow local partners to make use of those flexibilities and to exercise the power of direction that section 14 provides only as a matter of last resort.

In the bill as it stands, directions under section 14 can require local partners to enter into joint working arrangements only in relation to section 12 powers—that is, in respect of delegation of

functions, transfer of funds and pooling of budgets. However, that is only the tip of the joint working iceberg. The Executive wants to be able to deal with joint working deficiencies more generally. For example, as they stand, the provisions could be used for a pooled budget but not for an aligned budget. More significantly, the provisions do not extend to the vast majority of joint working activities, such as assessment, joint commissioning and planning.

I said that, in the stage 1 report, the committee endorsed the Executive's flexible approach to joint working and took the view that different models are appropriate in different cases. The amendments are in line with that view. They would not water down the power of direction that section 14 provides. They recognise that, although the existing section 14 powers are flexible, that flexibility is confined to the section 12 powers. The section 12 powers do not always provide the best model. The amendments would allow directions to be given that require more appropriate joint working arrangements—for example, ministers could spell out what particular piece of joint working was needed and invite agencies to draw up a plan with outcomes and time scales for its delivery. When directing on aligned budgets, for example, ministers could set out which categories of resources should be included, what joint management arrangements were needed and what reports should be provided on the effectiveness of the course of action.

I turn to the amendments in more detail. Amendments 14 and 15 are at the heart of the Executive's proposed changes to section 14. They would allow greater flexibility in the directions that are provided for under section 14 so that different joint working models can be required if those are more appropriate. In the spirit of the Executive's one-size-does-not-fit-all approach, the amendments would enable the Executive to prescribe, for example, that agencies should adopt an aligned budget—rather than a pooled budget—under section 12, or that they should deliver on single shared assessment, for which there is no explicit legislative requirement.

The need for amendments 11, 12 and 13, which extend the range of functions, is consequential on the Executive's overall intention to extend the range of joint working arrangements that ministers may direct under section 14. That means allowing for directions for joint working arrangements other than those that come under section 12. There may be functions that are not suitable for delegation under section 12 but that are suitable for other joint working arrangements. Amendments 11, 12 and 13 allow for those to be prescribed under section 14(1).

Amendments 17 and 18 would require that arrangements that are made following a direction comply with the direction. In the case of arrangements that are made under section 12, they must also comply with the regulations made under section 12(4). The requirements of directions in relation to such arrangements are additional to the regulations.

The drafting of this group of amendments is a little complex, but the amendment's purpose and intention should be clear. Given the concerns that the committee expressed about joint working in previous meetings, I hope that members will support the comprehensive approach.

I move amendment 11.

Mary Scanlon (Highlands and Islands) (Con): I appreciate that your purpose and intention are clear, but it is not yet clear to me when there would be ministerial intervention. Intervention would take place "in cases of failure", to use the words of paragraph 66 of the policy memorandum, or where joint working is not working. The submissions that we have received suggest that joint working is not working well throughout Scotland.

You say that the cause of an intervention must be a matter concerning joint working. What criteria will you use to judge whether joint working is not working? Three thousand beds are blocked now. If that number were to rise to 5,000, would that be used as a criterion? Will you have a measure of unmet need? If a sum of local authority money is diverted away from care of the elderly and the mentally ill to other budgets, for example, would that be considered to stem from a lack of joint working?

You say that it is not a matter of resources. However, we are talking about "cases of failure". How is failure measured? You have said that the judgment is based on outcomes, but I do not think that it is yet clear when ministers will intervene. A lot of people could suffer while they wait for you to measure whether a case is definitely a case of failure.

Malcolm Chisholm: Judgments on failure will be linked to the achievement of appropriate outcomes for service users and whether joint working could improve those outcomes. I know that there are also a lot of resource issues. Delayed discharge is at the front of my mind in that regard. Further action is needed in that area. The issue relates partly to joint working and I hope that the new arrangements in April will help. Some of it relates also to resources.

Mary Scanlon's other point about resources concerned the diversion of money. That concern has been well aired by members and by me, not least in the care development group's report. I do not think that we can expect the powers in the bill

to solve all the problems. The question is whether failures of outcome are related to failures of joint working. We cannot simply draw a hard and fast objective line about that.

We would always consult local authorities or national health service boards before using any of the powers. The principle remains that we must always base our judgments on outcomes for service users. Failures of outcomes would relate to failures in joint working.

Mary Scanlon: I still think that the approach is too vague. If the NHS, social work departments and the great public do not know what is being measured, how can the Executive say whether those involved have passed or failed? Which outcomes will be measured and how will they be measured?

09:45

Malcolm Chisholm: I quote from the consultation paper, "Better Care for all our futures", which was published earlier this year. Paragraph 2.1.4 on page 7 states:

"Decisions on the use of this power need to be taken objectively with a common understanding of the grounds for action. This might rest on a combination of expected standards of service delivery, where these are available, and other measures in the shape of monitoring/performance material derived from existing sources such as Audit Scotland, the SWSI Annual Report, Best Value and SHAS"

—the Scottish Health Advisory Service. It continues:

"A further important indicator will be the extent to which the agencies concerned have made progress with the recommendations of the Joint Future Group."

Performance measures for community care are still being developed. I have indicated some of the factors that will be considered and some of the bodies whose monitoring will be relevant in this area.

Mary Scanlon: I feel strongly about this matter. I have talked about the vagueness of what is proposed and have indicated that I am looking for criteria that are measurable. You said that decisions on the use of the power

"might rest on a combination of expected standards of service delivery, where these are available, and other measures".

We all know that Audit Scotland, SHAS and others produce excellent, first-class reports, but they often appear about two years after the event. I am worried that there is no way of measuring cases of failure and that people will continue to suffer because the bill is so vague on that point. The Executive's purpose and intention are not clear. Situations could run on because no measurable criteria have been specified. I acknowledge the minister's intention, but I do not think that it is workable. There is no mechanism that would allow him to introduce the single-budget, single-management structure that he proposes. The minister has not provided me with any measurable criteria for failure.

Malcolm Chisholm: Mary Scanlon is making an important point, but I do not think that it is an argument against either section 14 or the amendments that the Executive has lodged. We need constantly to develop better performance indicators. I have referred to some of the bodies that are involved in that process.

I remind Mary Scanlon that a lot of the new money that the Executive is providing for community care is being handed out on the basis of outcome agreements. Certain outcomes must be delivered in return for new money. Outcome agreements are fairly concrete: for a long time, the Convention of Scottish Local Authorities complained that they were too concrete. Members will recall that one of the outcomes from the money that was announced in October 2000 was 22,000 extra weeks of respite care—what might be more appropriately called short breaks. The notion that money should be dispensed on the basis of outcome agreements was endorsed by the care development group, which went further and said that all money for older people's services should be handed out in that way. This is new territory, as this is the first year in which the system has been in operation.

Mary Scanlon has raised some important issues, but work is being done to enable us to start measuring outcomes in community care. I am not saying that we do not have some way to go, but we have acknowledged the importance of such measures, which will form the basis for decisions in this area.

Shona Robison (North-East Scotland) (SNP): Mary Scanlon has made a good point. The bill is vague about when intervention will happen. Will the Executive intervene when there is failure on one, two or half a dozen outcomes? The minister seems to be saying that he will take a subjective view of when failure occurs, rather than an objective view. Can he confirm that? I am not saying that it is wrong to take such an approach, but it does not appear to me as if there will be a tick box for failure at joint working. Rather, the minister will take a subjective view on whether there is an appearance of willingness to move forward on the basis of joint working. Does the minister agree with that assessment?

Malcolm Chisholm: There is a great deal of space between subjectivity and a ticked box. That is the space that we are occupying. I do not think that Shona Robison is arguing against section 14 and the amendments to it, any more than Mary

Scanlon is. She may want to consider lodging an amendment at stage 3 that would make the bill's provisions in this area hard and fast and objective, but I am not sure whether that would meet our purposes. This is an evolving area and there might be problems if we adopted a tick-box approach.

Section 14 and the amendments to it would provide the Executive with a general power of intervention. Ultimately, it is for the Parliament to ensure that important policies are implemented. Some people may think that that is going too far and that local autonomy could be threatened, but on the basis of what the committee and the Parliament have said, I think that we want to ensure that progress is made on joint working. None of the members of the committee would disagree with that. Section 14 and the amendments to it would enable us to ensure that such progress is made. Regulations will follow and, if members so wish, those may be more precise than the provisions in the bill. There are good reasons for keeping section 14 fairly open and flexible. If we do not do that, there is a danger that we will hit the wrong target.

Mr John McAllion (Dundee East) (Lab): You have made it clear that the broad power of intervention that section 14 gives to ministers would be used only as a last resort. I accept that we do not want hard-and-fast criteria, but we could do with having greater clarity about the circumstances in which the power could be invoked.

How will the power of intervention be used? Will the minister simply make a judgment call, or will service users or carers who believe that the failure of joint working in their area is depriving them of the best service be able to appeal to the minister to intervene? Will there be an appeals mechanism for service users and carers?

Malcolm Chisholm: Absolutely. There are such mechanisms both in the Executive and in the Parliament. In the past couple of years, both the Parliament and the Executive have shown a willingness to involve service users and carers in the development of policy. That work is continuing in areas such as care standards. It is entirely desirable that service users and carers should be able to appeal to the minister. At the end of the day, failure must be defined as failure to deliver the best possible service to the people who receive it. The bill does not provide for a formal appeals mechanism, but I am very keen that the views of service users and carers should be one of the criteria for judging outcomes.

Mr McAllion: Are you saying that, under section 14, a carer or service user can appeal to the minister to intervene if they believe that their local health board and local authority are not doing enough to promote joint working?

Malcolm Chisholm: Section 14 does not say that.

Mr McAllion: But you are saying that.

Malcolm Chisholm: Such a provision would be consistent with our approach not just to community care policy but to health and community care policy. Last week we published a paper about patient focus and public involvement, which was lost in the midst of other health stories. We have committed ourselves to giving individual patients and service users, as well as the community more generally, a much greater role. We are keen to have feedback from service users and patients about services in the health service. That is one of our central commitments in health and community care.

Mr McAllion: Are there likely to be implications? If a large number of carers or service users begin to appeal for you to intervene under section 14, will that not necessitate civil servants being allocated to that task to ensure that all the complaints are dealt with properly?

Malcolm Chisholm: You make a good point. I suppose that that would be a good dynamic for the power. We do not want to use the power lightly. If a lot of people were to express dissatisfaction with the way that a service was operating, that would be a highly relevant factor. However, your general point is also true to some extent. The amount of work that a particular area of the Executive has is obviously related to the number of people there.

Mr McAllion: Even if a large number of people from one area appeal to you, whether to use the power will remain your judgment call.

Malcolm Chisholm: Many decisions in Government rely on the judgment call of ministers. The good thing about the Scottish Parliament—I have not changed my mind—is that members keep a much closer watch on and have more power over ministers than they do in certain other Parliaments.

Mr McAllion: I say amen to that.

The Convener: Do you want to make any closing comments, minister?

Malcolm Chisholm: We have thrown the matter around a lot. I am repeating myself, but I point out that the powers of direction are for use in the case of failure of a local health and social care system to use joint working or joint budgeting to improve the delivery of the health-related functions of a local authority. Ministers will use the powers only as a last resort and after consultation with the NHS bodies and the local authorities concerned.

The circumstances that trigger use of the powers will not be the same in all cases. Each situation will need to be considered closely on its

merits to justify the use of the powers. As I have said, judgments on failure will be linked to the achievement of appropriate outcomes for service users and whether joint working would improve those outcomes.

The amendments in the group would mean that we can intervene far more flexibly. The bill, as drafted, only allows us to direct local authorities or NHS boards towards pooled budgets. The powers in the amendments could clearly have reference to a much wider range of issues, such as the single shared assessment, to which I know that everyone is committed.

Amendment 11 agreed to.

Amendments 12 to 15 moved—[Malcolm Chisholm]—and agreed to.

The Convener: Amendment 16 is in a group of its own.

Malcolm Chisholm: In explaining the previous group of amendments, I said that the Executive's approach to joint working is based on the principle that one size does not fit all and that different models suit different services and areas. I am grateful to the committee for approving amendments 11 to 15, which support that approach by allowing greater flexibility in directions under section 14 so that different joint models can be required where they are more appropriate. Amendments 17 and 18 also support that approach.

Amendment 16 would extend that approach. It would allow ministers to require a payment by a local authority to an NHS board or vice versa under section 10 or 11 of the bill. The power could be used to require the movement of resources in connection with models of joint working where delegation of functions under section 12 is not present. An example of that might be the reluctance of an agency to play its part in the facilitation of hospital discharge through rapid response services and intensive home care or, in preventive services, to minimise inappropriate hospital admission.

Ministers could direct agencies to agree a joint plan within a set time and demonstrate achievement of agreed outcomes according to the plan. Alternatively, they could direct agencies to take specific action such as setting up a rapid response service. That might include identifying an appropriate budget and agreeing outcomes and staffing implications. Amendment 16 would complete the range of powers of direction under section 14. It is consistent with the Executive's overall approach that different joint working models suit different cases. We must cover all models.

I move amendment 16.

10:00

The Convener: As members have no comments, I assume that the minister does not wish to wind up.

Amendment 16 agreed to.

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

Section 14, as amended, agreed to.

Section 15—Services lists and supplementary lists

The Convener: Amendment 21 is grouped with amendments 25, 29, 38 and 39.

Malcolm Chisholm: The amendments are technical. Amendments 21 and 25 link to amendments 22, 23 and 26, which are substantive and will be discussed in the next grouping.

I turn to amendment 29. At present, the only listing arrangement for general practitioners under the National Health Service (Scotland) Act 1978 relates to the medical list for GMS—general medical services—GPs, who contract with NHS Scotland under the national GP contract. The introduction of services lists and supplementary lists will mean that there are three lists. In the light of that fact, the two references to lists in the 1978 act require updating, to make it clear that they are references to the medical list. Amendment 29 would provide that updating and is entirely technical.

Amendments 38 and 39 are also technical. They are intended to ensure that the terms that are needed for the provisions on NHS board lists are defined in section 108 of the 1978 act, which is the interpretation section.

I move amendment 21.

Amendment 21 agreed to.

The Convener: Amendment 22 is grouped with amendments 23 and 26.

Malcolm Chisholm: The committee's stage 1 report recommended that the Executive hold discussions with the Royal College of General Practitioners and the British Medical Association about points that they raised with the committee. Officials wrote to the bodies about their concerns. The RCGP indicated orally that it is content with the clarification that my officials gave them. The BMA and the Scottish general practitioners committee asked for a meeting, which was held on 4 December. At the meeting, the BMA and the SGPC were largely content with the clarification that was provided on the points that they had made to the Health and Community Care Committee. However, they mentioned concerns about the bureaucracy that would arise from the

fact that the bill, as originally drafted, would require GPs, depending on work patterns, to apply for more than one list in a single NHS board area.

Amendments 22, 23 and 26 address that point and will achieve the following. First, a GMS GP principal will be able to work in any capacity as a GP in their NHS board area without joining either the board's services list or its supplementary list. To be a GMS principal, a GP must be on the board's medical list and go through an application process that is equivalent to that involved in joining the other lists. Secondly, a GMS GP who is on the supplementary list in a board's area will be able to work in personal medical services in the area. Thirdly, a personal medical services GP who is on the services list in a board's area will be able to assist with the provision of GMS in the area.

As we have indicated previously, the need to apply for entry to different lists is to ensure that the disciplinary rules that relate to the NHS tribunal can apply to all GPs. We intend to lodge an amendment on the NHS tribunal at stage 3 as a result of these changes. The Council on Tribunals has an interest in matters relating to all statutory tribunals. My officials are consulting the council on the amendment that we intend to lodge at stage 3.

We have considered carefully whether we can go further to simplify the process for GPs who want to be available to work in the area of more than one board. That is especially relevant to locums, whose work patterns may take them to every part of the country. The amendments that we have lodged will help, as they mean that a locum will be required to apply for only one list per board. However, we have concluded that it is not practicable to lodge amendments to simplify the process further. It is important that lists are board-specific to ensure that they attract the current disciplinary rules to GPs on the supplementary and service lists.

As we have said before, the procedures will be made as simple as possible. Once a locum has gone through the hoops to join a list in one board area, a fast-track procedure will exist for entry to a list for all other boards. It will be necessary only for the board to be satisfied that the GP has gone through the full process elsewhere. I hope that the committee agrees that the amendments go a long way to addressing concerns that the profession and others have raised about the bureaucracy underpinning the listing arrangement.

I will take the opportunity to record that we propose to include GP registrars—doctors in training as GPs—in the listing arrangements. The policy memorandum lists, at paragraph 69 and 70, the categories of GP that we envisage being brought within the arrangements. GP registrars were not included in that list. That was largely because they are not eligible for independent practice. As doctors in training they are subject to supervision by GP trainers.

We have considered the matter further and have concluded that GP registrars should be included in the listing arrangements. First, although GP registrars are subject to supervision, they see patients on their own. Secondly, within the hospital system, pre-registration house officers are answerable to hospital discipline procedures, as are doctors at senior house officer level. Doctors go through that stage before they become GP registrars. It would be anomalous to exclude GP registrars from the listing arrangements that would bring them within the disciplinary regime that applies to GPs. That change does not require an amendment to the bill.

I move amendment 22.

The Convener: We welcome the fact that the minister has picked up the point that the committee made about the matter in its stage 1 report. We note his comments about locums and GP registrars. It is excellent that he has had extra discussion with GPs on these issues.

I take it that the minister does not want to wind up, as members have not made any points on these amendments.

Malcolm Chisholm: I have said more than enough on the subject.

Amendment 22 agreed to.

Amendment 23 moved—[Malcolm Chisholm]—and agreed to.

The Convener: I call amendment 24, which is grouped with amendment 27.

Malcolm Chisholm: As paragraph 75 of the policy memorandum makes clear, in introducing NHS board services and supplementary lists we are operating on the principle that the entry and control arrangements for those lists should, as far as is practicable, contain the same requirements on individuals as for the medical lists. Those amendments are necessary to meet that principle. For applicants for the services and supplementary lists respectively, the amendments apply rules on knowledge of English that are similar to those that apply to persons who seek entry to the medical lists. They give a power to make regulations to prescribe what is suitable experience for GPs, similar to those that are applicable to applicants to the medical list.

I move amendment 24.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): If English is not the first language of someone who wants to enter the list, what facilities will be available for them to get up to speed with it?

Malcolm Chisholm: With reference to GPs, I do not know. I am unaware of any specific arrangements. Margaret Jamieson raises an important point. I will have to investigate it and write to her about it.

Margaret Jamieson: If you do that, you will save me from writing to you. I have a constituent who is finding it difficult to practise in the NHS, because English is not their first language.

Malcolm Chisholm: The point is important and could apply to other people.

Nicola Sturgeon (Glasgow) (SNP): I will ask about the definition of satisfactory knowledge of English. The amendments contain a definition of suitable experience, but no similar definition is provided for satisfactory knowledge of English. What does that mean? Against what standards will that be judged? We all understand the pragmatism behind the amendments, but we must take care that they are not open to misuse.

Malcolm Chisholm: That is another important point. The 1978 act refers to the requirement, so all that the amendments do is extend the wording of the 1978 act, which applies to the medical list, to the services list and the supplementary list. I do not say that you did not ask an important question; all I say is that nothing in the amendments or the bill changes the definition.

I undertake to examine the 1978 act. Nicola Sturgeon may have raised an interesting point about the definition in that act, which I think is general. If that causes problems, it will have to be examined. I am not aware that it is causing problems, but the point is interesting. The amendments do not change any definition, although I accept that the wording is general. We merely extend the definition. Nicola Sturgeon raises an important point that bears further scrutiny. I will look into it and write to her.

The Convener: With those two caveats about further information for the committee, we will move on.

Amendment 24 agreed to.

Amendments 25 to 27 moved—[Malcolm Chisholm]—and agreed to.

Section 15, as amended, agreed to.

Sections 16 to 18 agreed to.

The Convener: That is as far as we will go with the bill this morning. I thank the minister and his team for attending.

That is the end of our public business. As agreed, we will proceed to agenda item 4. That is consideration of a draft report, which is why we will not discuss it in public.

10:13

Meeting continued in private until 10:37.

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