HEALTH AND SPORT COMMITTEE

Wednesday 8 October 2008

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
24th Meeting 2008, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Jackie Baillie (Dumbarton) (Lab)
*Helen Eadie (Dunfermline East) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Frank McAveety (Glasgow Shettleston) (Lab)
Jamie McGrigor (Highlands and Islands) (Con)
Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Philippa Bonella (ASH Scotland)
Theresa Fyffe (Royal College of Nursing Scotland)
John Gallacher (Unison Scotland)
Dr Andrew Lamb (British Dental Association Scotland)
Shona Robison (Minister for Public Health)
John Williamson (Scottish Government Primary and Community Care Directorate)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

David Slater

LOCATION

Committee Room 3

Scottish Parliament

Health and Sport Committee

Wednesday 8 October 2008

[THE CONVENER *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning, everyone, and welcome to the 24th meeting in 2008 of the Health and Sport Committee. I remind all present to ensure that mobile phones and BlackBerrys are switched off—I should know.

No apologies have been received, but Richard Simpson and Michael Matheson are running late. That is understandable, given the issue that exists with the trains. Jackie Baillie will join us later, as she is currently giving evidence to the Local Government and Communities Committee. We will allow her to declare any interests at the first appropriate moment after she arrives.

In line with our usual practice for the consideration of a draft response and an approach to an inquiry, the committee is invited to take items 6 and 8 in private. Is that agreed?

Members *indicated agreement*.

Subordinate Legislation

Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008 (Draft)

10:01

The Convener: For our first main item of business, which is evidence taking on a draft set of regulations on cross-border transfer of mental health patients, I welcome Shona Robison, who is the Minister for Public Health. She is accompanied by John Williamson, policy officer in the Scottish Government's mental health division, and Joanna Keating, legal adviser in the legal directorate. Good morning to you all. I invite the minister to make some opening remarks, after which we will have questions from members.

The Minister for Public Health (Shona Robison): Good morning, convener.

The purpose of the regulations is to make provision, under section 289 of the Mental Health (Care and Treatment) (Scotland) Act 2003, that will enable the cross-border transfer of Scottish patients who are on community-based compulsory treatment orders or compulsion orders to England and Wales, and allow patients in England and Wales who are on the newly created supervised community treatment orders to transfer to Scotland.

The 2003 act made provision for a new system of community-based compulsory treatment orders and compulsion orders. Section 289 of the act gave Scottish ministers a power to make regulations to provide for the cross-border transfer of patients who are subject to a requirement other than detention—that includes patients who are subject to community-based CTOs and COs—to enable patients who are on such orders to transfer from Scotland to another country in the United Kingdom and be placed on a similar order, and to allow community patients in other UK jurisdictions to transfer to Scotland.

However, until now, there have been no orders comparable to the Scottish community-based orders in other UK countries to enable reciprocal arrangements to be made. That is in contrast to the position with detained patients, in relation to whom similar regulations were made at the time of the commencement of the 2003 act to enable their cross-border transfer within the UK.

That position is now set to change. The UK Government plans to implement the main provisions of the Mental Health Act 2007 on 3 November, which, together with accompanying

regulations, will bring into effect supervised community treatment orders in England and Wales. That means that there will be equivalent community-based mental health orders in England and Wales, to which Scottish community patients could transfer, and that community patients in England and Wales will be able to transfer their orders, thereby allowing them to be based in Scotland.

To tie in with the introduction of those provisions, we are introducing the regulations that are before the committee. At present, they will apply only to transfers to and from England and Wales; they will not apply to transfers to or from the other UK territories, which do not have similar orders under their legislation.

The regulations will allow community-based patients to request a transfer from Scotland to England and Wales, or vice versa, and have their order converted to an equivalent order under the mental health legislation in the other jurisdiction. In general, patients will seek to transfer to be closer to their families. The regulations will enable community-based patients to do that while still being subject to an appropriate mental health order. I will be happy to answer any questions that the committee might have.

The Convener: The regulations seem eminently sensible to me. One does not always say that on this committee. Do members have questions?

Ross Finnie (West of Scotland) (LD): I agree with the convener—the regulations are generally quite easily understandable and appear to be perfectly sensible. However, could you clarify something for me? I note that in regulation 6, on notification of a decision, there is a requirement to notify "the patient"—unsurprisingly—"the patient's named person" and, given the status of many such patients, "any guardian" and "any welfare attorney"; other persons are also listed, but my question refers only to the ones that I have mentioned. However, in regulation 28, which concerns the notification requirements post-assessment, paragraph (3) states that there is a requirement to notify "the patient" and "the patient's named person" but does not include a requirement to notify any guardian or welfare attorney. In my understanding—limited as it is—those offices might be discharged as part of the transfer process, so it is not clear why, given that such patients come within the mischief of the adults with incapacity regulations, there would not be a requirement to notify a patient's attorney or guardian.

Shona Robison: We will have to come back to you on that, as I am not sure why the two regulations are different in that regard. I am sure that there is a logical explanation, but it is a fair point.

Ross Finnie: I did not wish you to come all this way without having to answer a good question.

Shona Robison: Can we come back to you with that information? I do not think that it makes a difference to the provisions.

Ross Finnie: No, it does not—it just seems a bit odd.

Shona Robison: If there is an issue arising from that, I am sure that we can sort it out.

The Convener: We can move on to other questions while Joanna Keating and John Williamson examine that—perhaps a blinding light of explanation will come before the end.

Mary Scanlon (Highlands and Islands) (Con): I am pleased to hear about the joint working with Westminster and the other jurisdictions in the UK, which is eminently sensible. I think that it was Dr Richard Simpson who mentioned an agreement with the European Union at a previous meeting. In his absence, I wonder whether anything further has been done on that front.

Shona Robison: We have looked into that. There are at present no reciprocal arrangements that cover transfers between Scotland and anywhere other than England and Wales. The power in section 289 of the 2003 act is wide enough to enable further regulations to be made at a later date, to provide for community patients to be transferred to any other jurisdiction, including outwith the UK. According to the information that I have, we are talking about a very few cases, and I am sure that they could probably be dealt with at present through negotiation.

The other important point is that if someone wanted to go to another jurisdiction and the equivalent community treatment order was not in place, they would not be allowed to go, on the basis that, as was the case in England and Wales until recently, there would be no equivalent mental health order in that jurisdiction to cover the patient. The authorities would have to be satisfied that equivalent arrangements were in place for a level of supervision that would ensure public safety and, of course, the safety of the person concerned. Those things would have to be considered on a case-by-case basis. Similarly, in the case of someone returning to Scotland, a jurisdiction with an order in place similar to the community treatment order would presumably discuss with the authorities here the transfer of that person on to the community treatment equivalent.

Mary Scanlon: That was very helpful—thank you.

Helen Eadie (Dunfermline East) (Lab): That was the exact question that I was going to ask. You alluded to the fact that there might be other negotiations further down the line with regard to

Northern Ireland. Would you like to comment further on that?

Shona Robison: Yes. My understanding is that there are no equivalent community treatment orders in Northern Ireland. Do we know whether there are plans to legislate for such orders there?

John Williamson (Scottish Government Primary and Community Care Directorate): We have had notification that they are working on legislation in Northern Ireland, but we have no timescales.

Shona Robison: In that case, once that legislation is in place and there is a commencement order in Northern Ireland, we will probably come back to the committee with similar regulations to ensure that there is a clear process.

Helen Eadie: Thank you for that.

Ian McKee (Lothians) (SNP): At what stage in the process can a person coming to Scotland register with a general practitioner? Would it be on discharge from hospital? Or would they be registered with a GP where they had come from in the first place? Is there any mechanism for registering with a GP?

Shona Robison: Once a person comes under Scottish jurisdiction, they will be assigned an appropriate medical officer, who will be a psychiatrist. The appointment of a responsible medical officer is dealt with in regulation 18. As part of the person's settlement into Scottish jurisdiction and the health system here, I presume that the services of a GP will be required, too. I suppose that the priority will be to ensure that the mental health services are in place, but the services of a GP will have to be established, too.

Ian McKee: But you do not regard it as necessary to put that into the legislation.

Shona Robison: The position will be the same as for anyone else who moves here. The community treatment order and its supervision are a responsibility of the responsible medical officer, so it will be for the psychiatrist to ensure that they are compliant and that the CTO and all its requirements are being progressed.

On the person's general health, they will be supported and encouraged to register with a GP, but that will not be a requirement under the legislation.

The Convener: My attention may have just drifted a bit, but could the minister tell me whether guidance will follow the regulations—or would that be overegging the pudding?

Shona Robison: There will be guidance. It will be good practice to ensure that matters such as registering with a GP are considered when the person is settling under the CTO.

The Convener: Could I just clarify something? Issues have been raised that may or may not mean that change will be required in the regulations, particularly with regard to the issue that Ross Finnie raised. Am I correct to think that change may be required?

Shona Robison: I do not think that the issues that were raised are material to the issue of cross-border transfers of patients who are subject to CTOs or the equivalent in England and Wales. They are more issues surrounding the legislation, and I am sure that they could be dealt with in guidance. I am happy to report back to the committee on the substance of Ross Finnie's question.

The Convener: I am trying to be helpful because I know from the committee clerk that the deadline for considering the regulations is 27 October. Given that the recess begins on 11 October, the committee will be unable to consider the regulations further, whether we want to or not. Therefore, I think that the committee wants not only to be reassured that the regulations are robust but to know what the procedure would be if the particular regulation to which Ross Finnie referred had to be amended or revised.

Ross Finnie: I have a supplementary point on that. I take the minister's point that it might just be a slight awkwardness that, according to regulation 28, a person's welfare attorney or other party might not be notified. However, the minister might find that there is no good reason why reference to those people was omitted from regulation 28 and that it ought to be there. I would be happy if the minister stated on the record that, until she has had an opportunity to amend the law, she will instruct the relevant authorities to ensure that those persons are notified under the provisions of regulation 28. I am not saying that the minister will have to do that. There may be a logical explanation for the current provision in regulation 28, but we do not know what it is.

10:15

Shona Robison: If there has been an omission, we could deal with that in guidance.

The Convener: Indeed.

Shona Robison: However, there may be another reason for the persons to whom Ross Finnie referred not being included under regulation 28. For today's purposes, I am happy to give an assurance that any issues that have been raised that require clarification, whether Ian McKee's or Ross Finnie's point, can be dealt with in guidance, if it is found appropriate to do that in the light of further discussions.

Ross Finnie: That is fine.

The Convener: We are content with that. Some important issues have been raised but, given the deadline, and given that they will be dealt with in an appropriate forum, we are content. I do not think that any member wishes to debate the regulations.

Motion moved,

That the Health and Sport Committee recommends that the draft Mental Health (England and Wales Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008 be approved.—*[Shona Robison.]*

Motion agreed to.

National Health Service (Recognition of Health Service Bodies) (Scotland) Order 2008 (SSI 2008/315)

Mental Health (Certificates for Medical Treatment) (Scotland) Amendment Regulations 2008 (SSI 2008/316)

The Convener: We move to consideration of two negative Scottish statutory instruments. The first is SSI 2008/315, which will allow the payment of allowances and remuneration to the members of the Dentists Vocational Training Appeal Body—I did not know that they had one, but there we are. The second is SSI 2008/316, which specifies the contents of forms used to issue certificates under sections 235, 236, 238, 239 and 241 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

No comments have been received from members and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendation in relation to the instruments?

Members *indicated agreement*.

The Convener: That concludes the first section of formal business in public. We now move into private session for consideration of item 6.

10:17

Meeting continued in private.

11:03

Meeting continued in public.

Budget Process 2009-10

The Convener: Agenda item 7 is the budget process at stage 2. I welcome Philippa Bonella, who is ASH Scotland's director of information and communications; Theresa Fyffe, who is the Royal College of Nursing Scotland's director; John Gallacher, who is a regional organiser for Unison Scotland; and Andrew Lamb, who is the British Dental Association Scotland's national director. Thank you for attending the meeting.

Helen Eadie: One issue in our papers that attracted my concern was the budget line for the workforce. You may or may not know that the draft budget suggests reducing that. What does Unison think about that? The Royal College of Nursing will be pleased, because the budget for nursing is to increase, but I am concerned that reducing the general workforce budget might have an impact on a wide range of non-nurses.

John Gallacher (Unison Scotland): The question is simple but the answer is complex. Unison is a big nursing union as well as a representative of all occupations in the health service. It is right that the question focuses attention on health boards' budgets. As members know, 70 per cent of boards' budgets is for the workforce. Boards are under extreme pressures to meet efficiencies and to deal with rising cost pressures for utilities, which we all know about.

The 2009 pay rise is only provisionally settled at 2.4 per cent; Unison and other staff-side organisations have triggered the reopener clause in the three-year pay deal. Even an increase of 0.5 of a percentage point beyond 2.4 per cent for 2009 would have significant implications. For example, in Greater Glasgow and Clyde, that would mean finding another £7 million in a health board system that seeks to make revenue savings of £42 million.

Workforce pressures are considerable. The agenda for change is not a done deal. It still involves financial pressures in relation to incremental progression and funding for the KSF.

The Convener: What is the KSF?

John Gallacher: It is the knowledge and skills framework. That system has been introduced to ensure proper investment in training and development for all occupations in the health service. It needs to be funded and the concern is felt that that funding might come under pressure because of core service delivery issues.

We are increasingly concerned that the workforce will bear the brunt of any tight budget

settlement. In the past few years, significant progress has been made in achieving efficiency savings in procurement—the national procurement strategy in Scotland has been a great success—and in drugs budgets. However, this year and in the next couple of years, we fear that the workforce will bear the brunt. Issues will arise about jobs, vacancies and developing services that are in the pipeline but for which we need the right number of trained staff to extend roles for nursing staff or other occupations.

The question is good. The committee is right to focus on workforce issues in the near term.

Theresa Fyffe (Royal College of Nursing Scotland): Workforce projections are influenced by financial constraints. We are concerned about the projected 0 per cent growth in the workforce budget from boards, which relates to financial affordability. As boards go through service redesign, we are concerned that how the 2 per cent efficiencies that must be made are put back into the service is transparent and that how they support workforce growth is clear.

Helen Eadie: Where could savings be made in our health budget? When I read the papers the other night, my attention was attracted by the distinction awards. Is the health service's entire workforce eligible for those awards? They cost about £26 million. Could we make savings there, which could be reinvested elsewhere in the health service?

John Gallacher: If only the bonus scheme applied to all workers in the health service—I fear that it is the domain of doctors and consultants. I leave it to the British Medical Association to speak on their behalf. The scheme is based on agreements that are in place. I do not know the details of those agreements, but I am sure that other associations could speak about them.

Theresa Fyffe: We have made it clear that it is interesting that £28 million is being provided for the distinction awards, which will increase by £2 million in the following year, when we are not sure whether, if a pay negotiation took place, any money would be found to support a pay change for others. If that scheme were complementary for one professional group when it was not clear that we could pay for the wider workforce, that would be a major concern. I will not go into whether the arrangement is appropriate or right. The question is more about the balance of funding.

Helen Eadie: I have a general question about whether you have suggestions—

The Convener: Ian McKee has a supplementary question on the narrow point.

Ian McKee: I had a supplementary question, but I see that Mr Lamb wishes to speak. I note that distinction awards are for dentists, too.

Dr Andrew Lamb (British Dental Association Scotland): They are, of course, and they are there to recognise excellence within the health service. If that budget were to be reduced, there would be a risk of consultants' moving more into the private sector.

The Convener: Thank you. That is helpful.

Helen Eadie: My point is the general one that, as politicians, we are constantly reminded that if we are going to increase one aspect of the budget, we must also suggest where savings can be made. Where do you suggest that savings can be made so that money can be redeployed?

Theresa Fyffe: One of the areas that might be looked at—I do not have enough data to go further—is drug efficiency and the use of prescriptions. Although work continues on that, I believe that more efficiencies and savings could be made in that area.

The Convener: Can you expand on that, please?

Theresa Fyffe: Work is being done on what drugs are used and to improve prescription practice. There is a definite change in practice for all professionals, not just in nursing, in being clear about what we prescribe. The issue is probably more about the allocation to the boards, but I believe that, if the directive came, they could do more to make savings in that area.

John Gallacher: I agree with Theresa Fyffe. Obviously, we would prefer non-workforce issues to be considered first. As I said before, the procurement strategy for supplies and so on has realised millions of pounds of savings in the past few years and will continue to do so. That is a particularly Scottish strategy that is delivering.

The drugs budget is huge. There has been a reduction in the prescription of antibiotics because of MRSA issues, but I do not think that that has fed through to the GP service. There are also targets to reduce the prescription of antidepressants, which will have an impact.

The Convener: Mr Gallacher, when you say that you do not know whether that has fed through to GP practices, you do not know the effect that that has on our two medical practitioners. There are some mild explosions going off.

John Gallacher: I am sure that they will keep taking the medication. [*Laughter.*]

The negotiation of drugs contracts and the move towards generic drugs is a huge issue. I do not know the detail of that, but the drug companies are keen to promote their wares and we should ensure that we get a good deal from them in negotiating the contracts.

Mary Scanlon: I am quite disappointed that, out of 10 sets of witnesses who were invited to give

evidence, only four were brave enough to turn up. I am disappointed that the others did not turn up because I would like to ask the British Medical Association and others why the distinction awards are going up by £2 million every year.

The Convener: I should say that some of the organisations that we invited to give evidence have not been able to do so for practical reasons.

Mary Scanlon: Nevertheless, I would like to know the Scottish Association for Mental Health's response to the fact that its budget is standing still, and I would like to ask Capability Scotland and Carers Scotland about the wheelchair strategy. I simply put on record the fact that I am disappointed that six out of 10 of those organisations are giving written evidence and are unable to turn up, for whatever reason.

My questions are for Andrew Lamb, on general dental services. In cash terms, your budget will stay the same—£355 million over three years—but in real terms it will fall by £10 million next year and the following year. I have worked out that that is an annual change of almost 9.8 per cent—although that does not quite make sense. To what extent is the budget related to outcomes? To what extent is it related to an increase in access to dental services on the NHS? How will dental services be affected by the reduction in funding?

Dr Lamb: You are probably aware that, in our response in 2003 to "Modernising NHS Dental Services in Scotland", we felt that the GDS budget should be somewhere in the region of £521 million. In our manifesto for the 2007 election, we revised that figure to £571 million, and in next year's terms it is something of the order of £600 million. Therefore, the budget of £355.5 million is not in itself sufficient to deliver the access that many members of the public and MSPs wish.

11:15

We would be happy to provide some written evidence on how we arrive at the figure of £600 million for next year's budget. It is based on the funding that the NHS already gives salaried dental practitioners to provide general dental services through the boards. We know that the budgets in some of the boards are based on something like £160 an hour to provide dental services. The provision of dental services is affected by factors that reduce access and output, although not outcome, such as health and safety legislation, decontamination requirements and the space that is required for decontamination.

If the Scottish Government is serious about delivering NHS dental services for all, it must examine the funding that is required. Although we are looking for a substantial increase in funding, it must be realistic. If that level of funding is not provided, dentists will continue to support their practices by providing some care through a private contract. I have said on many occasions that dentists do not ditch their vulnerable patients; they see the majority of their children and the majority of their exempt patients on the NHS. However, dental practices are businesses and it is important that the level of funding that is provided through the NHS is sufficient to keep those businesses operational.

We are looking for a level playing field. We hope that, if the NHS is prepared to support the salaried general dental service at the current level, the non-salaried service will be supported in the same way. It is not that the salaried service is overfunded, but that the non-salaried service should be brought up to the same level of funding. If it was, more dentists would be prepared to see their adult patients on the NHS and would be happy to do so. Although there has been substantial investment in dentistry over the past three years, it is not sufficient and access will worsen because of the pressures from health and safety legislation and the impact of decontamination requirements on premises.

Mary Scanlon: Could we get some written information about what could be provided for £600 million and why the British Dental Association thinks that that amount is necessary? In Moray, for example, 15 per cent of adults are registered with an NHS dentist, so the fact that we have received evidence that the situation is getting worse instead of better and that dentists are funded for 55 per cent of their activity is a serious matter.

The Convener: Yes, and it was a comprehensive response.

Dr Lamb: We would be happy to supply the evidence for which Mary Scanlon asks.

The Convener: If you send it to me as convener, it will be sent to the rest of the committee.

Ross Finnie: The British Dental Association is comparing a plan from more than a year ago with the £355 million plan for the current year and has worked out that £600 million is necessary. How much does the association believe is being funded this year?

Dr Lamb: We have been asking the Scottish Government for those figures for some time. We have been looking for its spend on the salaried and on the non-salaried GDS, but we have not yet had the figures.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): We are aware that the way in which the budget is presented means that the budget lines for GDS, general medical services and, I think, pharmaceutical services are flatlined because the

negotiations have not been completed. What disappoints me is that there is no distinction between whatever negotiations go on and the need to increase dental services. Those two aspects of the budget should have been separated and we should be careful not to conflate the two issues. The budget for such services is always presented as a Flat line. The only exception this year is the general ophthalmic services, because a three-year settlement has been negotiated and, therefore, we know the outcome. The question that Mary Scanlon asked and which was suggested by my colleague Ross Finnie, is what increase have you been expecting in the budgets for the totality of services, as opposed to your negotiations for individual contracts?

Dr Lamb: The reason for the flatline funding is that the Scottish Government health directorate waits until the outcome of the Review Body on Doctors' and Dentists' Remuneration. We are looking for the inflationary rise that the review body gives to doctors and dentists. We would like an increase in the fees, on which we hope we will be able to have a dialogue with the Scottish Government. There has been investment in infrastructure support, which we are pleased about. However, the real negotiations are not those that go on between the British Dental Association Scotland and the Scottish Government health directorate, but our representations to the doctors and dentists review body. I am afraid that those representations bear little resemblance to our belief that we require a substantial increase in funding. Those discussions have to go on in Scotland.

Dr Simpson: To be clear, are you saying that the only way in which we can increase our dental services is to increase the fees? Should we not put more money into salaried dentists and community services to pull back the effective privatisation of dental services that went on for so long?

Dr Lamb: The British Dental Association represents dentists whether they are high street dentists or independent contractors and non-salaried dentists or salaried general dental practitioners in the health service funded by health boards. There is not always a like-for-like comparison. The evidence from the workforce review shows that the salaried dental service sees only about 40 per cent of the patients that are seen by high street dentists. That is not because the salaried dental practitioners are not efficient, but because they see a different cohort of patients. The most effective way in which to provide NHS dental services for the people who require them on the high street, close to where they live, is through independent contractors. We are looking for an increase in the level of funding for those dentists to the same level that is provided for the salaried service.

Mary Scanlon: Andrew Lamb has not answered my question about how spending is linked to outcomes. I seek clarification on that.

Dr Lamb: People are interested in outcomes and outcome targets. There is no doubt that the childsmile initiative in Scotland has delivered an improvement in the oral health of some children. The problem is that the bulk of tooth decay in children is restricted to those who live in more deprived areas. Most tooth decay is in the Scottish index of multiple deprivation's six and seven group. We must attract those patients to attend dentists regularly. The childsmile programme is beginning to make inroads into that. When children are introduced to oral health in nursery or primary school, the parents are encouraged to take them to see an NHS dentist. That seems to be working to an extent. The level of tooth decay is improving for children in more affluent families, but not in those from more deprived areas.

The health improvement, efficiency, access and treatment—HEAT—target of having 80 per cent of three to five-year-olds in Scotland registered with an NHS dentist, which is the only HEAT target on dentistry, is a little conservative. Last year we had already reached 77 per cent, so in three years we should make the 80 per cent. I am disappointed that the Scottish Government has not set itself a harder target.

The Convener: I am sure that it is listening. Under which budget line is the childsmile programme funded?

Dr Lamb: It comes out of the £355 million for general dental services.

The Convener: If there are no more questions for Dr Lamb, we can move on to other issues.

Dr Simpson: I ask the panel to comment on the tobacco control budget.

The Convener: I am glad that you asked that, because Ms Bonella has not yet had a chance to comment.

Dr Simpson: I thought the same thing.

The Convener: Dr Simpson is being charming and a gentleman, as usual.

Philippa Bonella (ASH Scotland): The first thing to say about the tobacco control budget is that it is flatlined over three years. Although £13.8 million is the most that we have had on tobacco control—on a three-year basis, it is the most money that tobacco control has ever had—we are concerned that, moving into year 2 and looking forward to year 3, there will be an impact on services. According to NHS Health Scotland, tobacco costs the economy £837 million every

year, but we are spending only £13.8 million. There seems to be a bit of an imbalance between cost and spending.

This year, in addition to the tobacco control budget line, an extra £3 million is going through the pharmacy scheme into local pharmacy smoking cessation projects—that is new money. Of the £13.8 million, £11 million is for smoking cessation work in local boards and the remainder is attached to the smoking prevention action plan—that money was announced fairly recently, so it is just starting to flow through to boards and local authorities.

We are in a new situation with the budget. We are able to see smoking cessation services sustained over three years, although the budget is flatlined. We have new money for smoking prevention among young people and for the pharmacy scheme.

ASH Scotland is concerned that smoking cessation services are not getting real-terms increases year on year. We hope that services will become more sustainable and that staff will start to get permanent contracts, so that they can plan ahead, but it is not at all clear how that will happen in practice. We know of a number of health boards where staff are still on temporary contracts, which means that they are unable to think ahead. That is a real issue for the effectiveness of smoking cessation services.

The pharmacy scheme is welcome; it means that there is new money in communities for smoking cessation work. However, that scheme appeared speedily and it is yet to be seen how well the new services will link in with what is already going on in health boards or how well the people involved in the scheme will monitor and report on what they are doing. We will have to wait and see what difference the money will make.

The Convener: What will the pharmacy scheme do?

Philippa Bonella: Community pharmacists will give smoking cessation advice to people in the pharmacy.

The Convener: Over the counter.

Philippa Bonella: Yes.

Dr Lamb: We are also disappointed by the lack of increase in funding for tobacco control. Oral cancer is a big issue in Scotland; I am afraid that Scotland suffers a disproportionate number of the United Kingdom's oral cancer cases. There is no doubt that the main risk factors are heavy consumption of alcohol and tobacco, so we are pleased to see the increase in the budget for alcohol misuse, but we are disappointed by the real-terms decrease in the tobacco control budget. BDA members see the effects of tobacco at first hand in gum disease and oral cancer. In December, ASH Scotland, NHS Health Scotland, the BDA and the Scottish Government are holding a conference for dentists and members of the dental team to see how they can link into the smoking cessation schemes. Given that initiative, we are disappointed that there is a decrease in funding for tobacco control.

The Convener: That is helpful, because I do not think that many people would make the connection between the role of dentists and smoking and alcohol.

Ian McKee: I understand that, as well as the £13.8 million for tobacco control, £3 million is going into the community pharmacy scheme. How much is going into work with young people?

Philippa Bonella: There is £2.8 million for work with young people, but it is included in the £13.8 million.

Ian McKee: But there is an extra £3 million on top of the £13.8 million.

Philippa Bonella: Yes.

Ian McKee: So, the money spent on tobacco control is not going down. It is going up; it is just under different headings. Is that right?

Philippa Bonella: Yes, to a degree. A new scheme has been set up for pharmacies that is not connected with the existing smoking cessation services.

Ian McKee: I understand that, but Andrew Lamb's concern at the amount of money that the Government is spending on helping people to stop smoking might well not be justified, given what you said, because more money is going to help people stop smoking; it is just going under two headings instead of one. Is that correct?

11:30

Philippa Bonella: That is correct, but we think that more money could be spent on smoking cessation. It is also a matter of making the services sustainable in the long term. Health board services that have been up and running for a few years have flatline budgets and additional money is going to pharmacies under a different scheme. The issue is sustainability.

Ian McKee: But the total amount of money that is being made available is going up.

Philippa Bonella: Yes.

Ross Finnie: For guidance, what is the general profile of the number of persons who smoke? What is the movement in that respect? I am sorry; I should have looked that up before I came to the meeting.

Philippa Bonella: The numbers are dropping, and there are targets in the Government's national outcomes and indicators to reduce the numbers even further. The situation is changing over time, but we think that it could change much more quickly if more money were invested in prevention and cessation work. Around a quarter of all adults smoke now, but the numbers have reduced significantly over time.

Ross Finnie: So the amount that is being spent per smoker has gone up.

Philippa Bonella: That is probably true.

Between £40 million and £50 million is going into the health inequalities budget, and we would expect a significant part of that budget to go towards tackling tobacco use, because it is obvious that there are strong links between deprivation and smoking. However, no announcement has been made about how that money will be spent in local areas. That is something to watch.

The Convener: So you are telling us that we cannot look at only one budget line; rather, we must look at many other lines to find out what is happening. At the moment, even you do not know what will come out of the other pots.

Philippa Bonella: No.

Dr Simpson: That is an important point. We are not clear about what the smoking cessation budgets are. We need and should have clarity on that. We are talking about what is still the most important public health challenge in Scotland, and we need clarity. The message that I take from the discussion is that the new money is welcome, but we will not be taking the matter as seriously as we should be unless there are sustainable services that respect staff and programmes.

Helen Eadie: The papers in front of us—

The Convener: Helen Eadie has jumped the queue. I am losing track. Mary Scanlon was going to ask a question, but I will let Helen Eadie come in.

Helen Eadie: On that point—

The Convener: Ms Baillie can see that I rule with a very light touch and that things are done by consent.

Helen Eadie: In real terms, the money for pharmaceutical services is minus £4.2 million, and there is minus £9.8 million for general dental services. It is a bit like smoke and mirrors. We are saying that there is new money, but the bottom line is minus around £14 million. In fact, in real terms, the money in the overall health budget is minus £16 million, the bulk of which seems to be coming out of pharmaceutical services and general dental services at a time when there are major problems in dental services throughout Scotland.

The Convener: I hear what you are saying. In fairness, we must let Ms Fyffe say something. She has been very patient.

Theresa Fyffe: We entirely agree with ASH Scotland on the sustainability of services. Roles have been developed to deliver that, and they should continue.

I want to introduce a different anomaly. We welcome the lines for alcohol misuse and tobacco control, but we could not see a line for drug misuse. Perhaps we missed something—perhaps it is covered in other budgets—but we were concerned that there did not seem to be clarity on that.

The Convener: Thank you. We shall carefully consider that matter.

Mary Scanlon has also been patient.

Mary Scanlon: My questions are more general; they are not about drugs, alcohol or tobacco.

Dr Simpson: I suggest that we find out whether the witnesses have any other general comments on the section on drugs, alcohol and tobacco. We can then move on to deal with other matters. I am sorry, convener; that is simply a suggestion.

The Convener: That is all right. Forbearance is my watchword today.

Philippa Bonella: On a point of information, both the alcohol and drugs lines are in the justice budget.

The Convener: Thank you. That is helpful.

Mary Scanlon's time has come.

Mary Scanlon: I have three questions.

First, the HEAT target for the NHS absence rate is down to 4 per cent for next year. Do the witnesses representing Unison Scotland and the Royal College of Nursing Scotland think that we are on course to achieve that target? Do they have any concerns about that, as it is obviously a budget issue?

I would also like to ask John Gallacher—

The Convener: Before you go on Mary, it would be helpful if you could tell us what page you are referring to.

Mary Scanlon: It is the HEAT target.

The Convener: No, I meant what page in the draft budget.

Mary Scanlon: Do you mean the NHS absence rate?

The Convener: Yes.

Mary Scanlon: It is the Government's HEAT target in "Better Health, Better Care".

The Convener: I beg your pardon.

Jackie Baillie (Dumbarton) (Lab): It is on page 26 of the briefing paper.

Mary Scanlon: That was my first question. The second one is about single outcome agreements. I am concerned that they are difficult to monitor. Does Unison have any concerns or advice about how we should monitor local authority health spending?

The Convener: Mary, I do not want to stop you asking questions, but can we deal with the first one first, and then the second? The first question is about NHS boards achieving a sickness absence rate of 4 per cent from 31 March. Can the witnesses address that first, so that we do not get confused?

John Gallacher: The 4 per cent attendance target is relatively arbitrary, and the unions do not agree with how it was conceived. The situation is being monitored through the annual accountability reviews. Several health boards are struggling to meet the target within the timescale, but a lot of work is going on with local trade unions to put in place schemes to address health issues among the workforce. Obviously, the workforce is huge and some of the issues that we mentioned earlier, to do with drugs, alcohol and tobacco for example, apply equally to the workforce. We need to make sure that services are available to the workers.

Good partnership work is being done to deliver fast-track occupational health and counselling services to staff to address long-term sickness. We have to recognise that the nursing workforce is ageing. In the past, staff might not have remained at work when they got chronic problems with lifting, handling and so on, but we are now facing the issue of ageing workers who have chronic illnesses.

The target is complex. A lot of good work is being done, which we support. Obviously, we get concerned when the absence management regime becomes dogmatic or oppresses staff and threatens their security of employment. We have not had huge difficulties with that to date, but we remain vigilant to make sure that employers do not abuse people who are on long-term sickness absence from their jobs.

The target is challenging and good work is being done. I do not think that the target will be universally achieved, but the direction of travel is okay so far.

Theresa Fyffe: I agree with much of what John Gallacher said, so I will not go over that issue again.

On the ageing workforce, we are gathering evidence about the impact of nurses who continue to work in clinical roles but who are presenting to occupational health with knackered knees and backs, and who are concerned about how they will be able to continue to work. They have a huge amount of clinical expertise to offer, and they are immensely valuable, but they are concerned about how their attendance might be picked up. The physical labour of nursing is a challenge for those people, which is why the ageing workforce and ageing nurses have become an RCN theme for this year. We want to retain that valuable expertise in the workplace—our students and younger nurses are saying that they do not want to lose it. How can we enable people with that expertise to stay in such a physical job? Work has been done on that for surgeons, and we have tried to look at the issue in relation to nursing, but we have not done enough around it. Those people risk becoming victims of attendance management.

I agree with John that we are doing excellent partnership working on absence management. A number of us have just done the annual health board reviews, and we can see that partnership working, which was very helpful, but we are being vigilant about how the target is being used.

The Convener: That was very helpful.

Mary Scanlon: Can Unison help with my question about single outcome agreements?

John Gallacher: Not in two minutes, no. The question is complex. The joint future agenda was about encouraging health boards and local authority social work departments to pool their resources and money and to have common objectives and service outcomes. That is still at an embryonic stage—the approach does not exist yet.

Services such as those in the community for addiction and mental health are increasingly being delivered jointly, but we are still talking about the two very different worlds of health boards and social work departments and how they operate in terms of local democracy, staff roles and the information systems that they use.

There is a long way to go before there is a ready fix to the problem of delivering common budget heads—and targets and outcomes. We do not want a cottage industry to develop to monitor that. However, a lot of good joint work is being done at the coalface. That work is delivering good outcomes for patients and clients and it is increasing in capacity. The trend is in the right direction.

Theresa Fyffe: We welcome local authorities' growing responsibility for health care, which is in line with the shifting the balance of care work stream. However, we have a concern. The

committee should consider how a monitoring plan can be established. The outcome agreements can be measured, but we are concerned about the other pots of money that are involved. How are they understood, and how will they be monitored to assess whether they are delivering? We need to be vigilant about that.

The Convener: What are those other pots of money?

Theresa Fyffe: An example is the fairer Scotland fund, which was launched in 2008. Under that fund, £145 million will be provided each year until 2010-11. We want to see how that ring-fenced pot of money makes a difference and what it will mean when it is rolled up.

Mary Scanlon: I have a supplementary question for John Gallacher. I appreciate what he said and I agree that the matter is complicated. We are in a new position, of course, because the abolition of ring fencing has taken us into a different era. When will the committee be in a position to consider the single outcome agreements and monitor local authorities' health spending and the outcomes? Do you have a date for that?

John Gallacher: How long is a piece of string? I am sorry, but I do not have the expertise to gaze into a crystal ball on that.

Mary Scanlon: That is helpful. My final little—

The Convener: Mary—

Mary Scanlon: I asked—

The Convener: Well, no one else has indicated that they want to ask a supplementary question, so you can go ahead. [*Interruption.*] Now that I have said that, Richard Simpson and Helen Eadie want to come in. Whenever I say, "That concludes the evidence for today", I see the hands go up.

Mary Scanlon: My final question is a small one for Andrew Lamb. You said that the target for 80 per cent of three to five-year-olds to be registered with an NHS dentist by 2010-11 is not ambitious enough. What would be an appropriately ambitious target for dental provision in Scotland?

Dr Lamb: An ambitious target would be 100 per cent, of course, but that is unlikely to be achieved. I would think that somewhere between 85 and 90 per cent—

Mary Scanlon: I meant for the whole population, not just for three to five-year-olds.

Dr Lamb: For the whole population, a reasonable target would be 75 to 80 per cent.

Mary Scanlon: That is for registration with an NHS dentist.

Dr Lamb: Yes. That would be an ambitious target for the Government. However, if it set such a target, it would have to provide the funding to deliver on it. That is the issue—if the Government is going to set targets, it must take them seriously and provide appropriate funding so that they can be met.

Dr Simpson: The funding that was transferred from health boards to local authorities no longer appears in the budget. I think that Mary Scanlon was trying to get at how we monitor that spend. We have to accept that the Government made the decision not to ring fence the money, but how do we monitor the spend? For example, I completed a freedom of information request on the choose life budgets for the suicide programme, which were previously ring fenced, and four of the 23 responses showed a reduction in those budgets. What method should we propose to the Government so that we can continue to monitor the funds that have been lost to the health service's control—albeit that they are not completely lost?

John Gallacher: That is a difficult question. We need a system that will hold the deliverers to account for the outcomes, based on the general money that has been allocated to them. Ring fencing money from the centre to pump-prime services is a good thing, but the real pressures arise in sustaining local services. Although the health budget will increase by 1.4 per cent, health boards will receive only 0.5 per cent per annum, so in order to meet their base spending requirements and sustain services they will need to make efficiencies from other initiatives.

Local authorities are in exactly the same position. Both groups face huge increases in costs, because of sector-specific inflation, utility costs—which have gone up hugely—and pay pressures. We have a view on pay pressures, given that offered settlements this year and next year are way below the retail price index. There are huge pressures, and services will suffer.

11:45

The development of services is as important as the maintenance of existing services. Health boards have squirrelled away money to develop new services. For example, by the end of this year NHS Lanarkshire will have £14 million in reserves, but that money is allocated to funding the opening of new services such as the Airdrie health centre. If it is used to fund core services and budgets, and if savings are squeezed in, progress in developing services will be arrested. That applies to both health boards and local authorities. It is difficult to get to the bottom of the issue unless you hold health boards and local authorities to account. You need to get them to speak for themselves.

The Convener: Do you concede that the difficulties that we face with regard to budget lines are a result of the new way of interworking and that we will be able to determine whether it has worked only a year or two down the road?

John Gallacher: Absolutely. Joined-up allocation of budgets and joined-up monitoring of how they are used are needed. The committee process is helpful in making the budget-setting process transparent and open to representations. In health boards, there is a good system for monitoring how budgets are spent, because we get regular reports and input through area partnership forums. There are different systems in local authorities, but at the coalface we are able to monitor how moneys are being spent. When setting budgets, you must ensure that everything joins up.

Philippa Bonella: I can give a small example of how money is moving from health to local government. The budget line for enforcing the smoke-free law now sits in the local government general grant. Recently we analysed all the single outcome agreements, focusing on tobacco. We were surprised to find that only one local authority mentioned in its single outcome agreement environmental health officers enforcing the smoke-free law, despite the fact that they have funding as part of the block to continue to do that. In addition, very few local authorities mentioned youth smoking prevention, despite the fact that they have just received new money for that.

Local authorities cannot include everything in their single outcome agreements, so the fact that some measures are not there does not mean that they are not being implemented, but it makes it extremely hard for us to track what is happening. Besides looking at national outcomes and indicators when they become available in a couple of years, we have no way of monitoring whether enforcement of the smoke-free law is happening or whether youth smoking prevention work will be done as a result of the funding that has been allocated to local government for those purposes. It would be really helpful if the committee would consider doing some work with local government in a year or so to find out where it is spending that money and whether authorities think that they are on track. Their single outcome agreements will not help us to do that, because they do not mention the issues that I have raised.

The Convener: It is fair to say that they do not all put things down in the same way. We must assume that even local authorities that do not mention enforcement of the smoke-free law have charged environmental health officers with doing that. However, I take your point.

Theresa Fyffe: The shifting the balance of care delivery group may give you some answers. The group is trying to find a model for joined-up working and resource shift. As a member of the group, I know that the framework that it is using to assess what will happen in community planning may provide some answers. We are trying to understand how we will get a true picture of health provision when we start to make the change. We welcome that change, but we need to know what action will be delivered and where.

Dr Simpson: You have dealt with the supplementary that I planned to ask. Your comments have been extremely helpful and have clarified a number of key issues and principles that the committee may want to address in its report.

My substantive question relates to workforce planning and, specifically, to health visitors. The model proposed by the review of nursing in the community is being piloted. We have "Health for All Children 4", which is an excellent report. A number of boards are going off in different directions: Lanarkshire NHS Board is doubling the number of school nurses; and Greater Glasgow and Clyde NHS Board apparently wanted to put health visitors under social work, as far as I can judge, although I am not clear what that is about.

I understand that the average age of health visitors is even older than the average age of our nursing group as a whole, who are already older than one would like. They are very experienced and excellent—

The Convener: He has to say that.

Dr Simpson: Nevertheless, the situation is worrying. On the workforce planning part of the budget, although the nursing budget is increasing, have we got the numbers right? Have we got the funding right for new people coming through? Are we investing in health visitors, which we do not appear to have done for a number of years, or is there a planning blight in that area? What is happening in that area and is the budget addressing it?

Theresa Fyffe: Data sets on the community nursing workforce are being built. The information is not substantial, and the workforce projections are therefore based on the data that we have, which tend to be based on hospitals and other services. I would not say that the projections that are based on workforce data will necessarily meet community planning needs. We have raised that issue on a number of levels in the past week or so.

You are right that community nurses in general, and health visitors in particular, are among the groups with the highest average age. That is a matter of concern.

I have just come from a meeting at which we were planning how we can develop solutions, because we have to. We are working on a set of

principles to enable health boards, in situations in which we believe that they need to look at the work that they are doing, to get the right type of community nurse planning to deliver what is an incredible raft of exciting plans. If we do not get the planning right, the workforce will find those plans draining. We are concerned about that, and we are keen to bring the matter to the Government's attention.

John Gallacher: Unison subsumed the Scottish Health Visitors Association when we were formed. We have expressed huge concerns about the review of nursing in the community. Richard Simpson mentioned some of our concerns, such as the lack of uniformity across Scotland and the fact that health boards are going in different directions. We are concerned that occupations and disciplines such as those of the health visitor, the school nurse and the community nurse will be diluted and lost as a result of the review. We will continue to express our reservations.

Richard Simpson referred to NHS Lanarkshire having doubled the number of school nurses, but, technically, it has not done that. It has increased the number of posts involved in public health in schools and in the community, but the role of school nurse has been changed.

We have concerns about health visitors. A huge issue is that there is a planning blight, a training blight and a recruitment blight because of people waiting to see the new direction of travel that results from the review of nursing in the community. Given that the early years are viewed as being so important in respect of health and education, it seems perverse to experiment with young families in the community and young children in the early years of nursery and school by tinkering with services that have been of great benefit historically. Health visitors have a set of skills to bring to bear; I am not saying that they will fossilise and not keep up with developments, but we think that there are fundamental problems with trying to apply expertise generally.

Dr Simpson: That was helpful.

The Convener: I have been told that, because of the change in demographics in NHS Borders, there is an imbalance between the requirement for district nurses and the requirement for health visitors. Is that part of the issue? I agree that those staff have different expertise and skills, but sometimes they fit the requirements of the community. That is what was suggested to me in my area.

Theresa Fyffe: There is a difference. The principles that we are working on are that local boards will have to find a model or a template that works for them, but that there must be a core component. We do not have a set view about what that is, but we want something so that people can say, "That is the core." An important consideration is what we need to do differently because of demographic changes or needs assessment. Similar comments to those that have been made to you in the Borders are being made in other areas. I have been going around Scotland talking to people a lot in the past few months and I can see that such changes can be radical for them.

We need to ensure that nursing staff are able to move. For example, someone who works in Inverness should be able to take up a post in the Borders. Similarly, someone who works in the Borders should be able to take up a post in England or elsewhere. The lack of a currency is a problem in that model, and it would not help areas such as Borders that do not enjoy the same levels of recruitment as the cities. That is a concern.

The Convener: Helen Eadie has one more question. Is this your final question?

Helen Eadie: I have two questions.

The Convener: If you were Alex Neil, you would have said, "I have one question, but it is in two parts."

John Gallacher: This feels like "Who Wants to be a Millionaire?"

Helen Eadie: Do you want to phone a friend?

When the Finance Committee took evidence from John Swinney, he committed the Government to delivering 2 per cent cash-releasing efficiencies each year, which will allow £1.6 billion to be redirected over the next three years. Under the historic concordat—

The Convener: I swoon.

Helen Eadie: Under the concordat that was signed on 14 November 2007, local authorities will for the first time be allowed to retain all their efficiency savings for redeployment to meet on-going or new pressures. What are the panel's thoughts about efficiencies in the health service? Should the health service be allowed to keep its efficiency savings?

John Gallacher: My understanding is that health boards are now able to retain their efficiencies for spending locally. However, as I mentioned earlier, central efficiencies targets combined with the need for local efficiencies to balance budgets can put huge pressures on the budgets of health boards, which are the deliverers. For example, the director of finance of Greater Glasgow and Clyde NHS Board said recently that efficiencies have gone so far that it will be difficult to squeeze out more without impacting seriously on workforce issues. Obviously, impacts on the workforce have an impact on services. We are fast reaching the point at which it will become difficult

to squeeze out efficiency savings from budget heads other than those for direct services and staff. The next two to three years could be very difficult, both for health boards and local authorities.

The Convener: You pointed out earlier that one would seek efficiencies from the pharmacy side—from prescriptions, for example—and from commissioning.

Helen Eadie: Convener, my question is in two parts so—

The Convener: I hope that this is the second part, not a second question in two parts.

Helen Eadie: Do not confuse me.

The Finance Committee asked us to address a variety of issues, but I want to ask about one point that particularly chimes with me. How has the equality impact assessment process influenced the spending decisions that are made in the draft budget? That is a tough question, for which you might need notice. You could come back to us on that.

The Convener: You might want to write to us with a response.

Theresa Fyffe: That would be fine.

John Gallacher: I will make a couple of brief points. There is a hugely important new duty that no public sector employer has taken seriously enough in service design and employment issues. The duty raises issues particularly for health board and local authority sub-contractors. I will not stray into the whole equal pay debate, but there is a huge financial elephant in the corner. Some might think that the issue is not as huge north of the border because of historic concordats, but the equalities duty is hugely important in service planning, procurement and workforce issues. More attention needs to be given to it.

Theresa Fyffe: I have nothing to add to that.

Helen Eadie: Feel free to write to us about the issue.

Theresa Fyffe: We will.

The Convener: I thank our witnesses and, as usual, I thank committee members.

Interests

The Convener: Before we move on to our final item of business, I am at last able to welcome Jackie Baillie—who has been restrained beyond belief, apart from telling me which page I should be on—as a new member of the committee. Does she have any interests to declare?

Jackie Baillie: I will make one comment—in two parts. First, I apologise that I was delayed this morning—I had to give evidence to the Local Government and Communities Committee on my Disabled Persons' Parking Places (Scotland) Bill. Secondly, I do not believe that I have anything to declare, but I refer members to my entry in the register of members' interests, which is available on the Parliament's website.

The Convener: Thank you. I am sure that you will be another determined committee member. That will make matters even more interesting for me as chair. That concludes today's public business.

12:00

Meeting continued in private until 12:17.

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