HEALTH AND SPORT COMMITTEE

Wednesday 16 September 2009

Session 3

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HEALTH AND SPORT COMMITTEE
23rd Meeting 2009, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Helen Eadie (Dunfermline East) (Lab)
*Rhoda Grant (Highlands and Islands) (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:

Brian Beacom (Scottish Health Council)
Dr Frances Elliot (NHS Quality Improvement Scotland)
Dr Donny Lyons (Mental Welfare Commission for Scotland)
Fiona Mackenzie (NHS Forth Valley)
Richard Norris (Scottish Health Council)
Catriona Renfrew (NHS Greater Glasgow and Clyde)
Alison Smith (Scottish Independent Hospitals Association)
Sir Graham Teasdale (NHS Quality Improvement Scotland)
Dr Jean Turner (Scotland Patients Association)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Wednesday 16 September 2009

[THE CONVENER *opened the meeting at 10:03*]

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning. I welcome everyone to the 23rd meeting in 2009 of the Health and Sport Committee. I remind everyone in the room to switch off their mobile phones and other electronic equipment. I have received apologies from Michael Matheson and we will be joined later by his substitute, Joe FitzPatrick, who is on a train at the moment.

Item 1 on the agenda is to decide whether to take item 4, which is on our work programme, in private. Are we agreed?

Members *indicated agreement*.

Public Services Reform (Scotland) Bill: Stage 1

10:04

The Convener: Item 2 is an oral evidence session as part of our scrutiny of the Public Services Reform (Scotland) Bill. Last week, we took evidence from a panel of witnesses who looked predominantly at part 4 of the bill, which will establish social care and social work improvement Scotland. I refer members to paper HS/S3/09/23/1, which summarises some of the key issues that emerged from last week's evidence.

Today, we have three separate panels of witnesses who will give evidence on part 5 of the bill, which will establish healthcare improvement Scotland, or HIS, as I will refer to it. Although we will focus primarily on the establishment of HIS, I am aware that our witnesses may also wish to express some views on the establishment of social care and social work improvement Scotland, and that members may wish to ask questions on that part of the bill, further to last week's evidence. I intend to do what I did last week. If there are any outstanding points on part 4 of the bill that do not come up during questioning—I say this to witnesses as well as to committee members—I will take them at the end. We will keep to part 5 to start with, but that does not mean that people will be deprived of the opportunity to comment on part 4.

I welcome our first panel of witnesses. Dr Frances Elliot is chief executive of NHS Quality Improvement Scotland and Sir Graham Teasdale is the organisation's chair. Brian Beacom and Richard Norris are, respectively, chair and director of the Scottish health council. The committee has received written submissions from the witnesses, so I will move straight to questions.

Helen Eadie (Dunfermline East) (Lab): In the process of reading the papers for today's meeting, I noticed that on the first page of its submission, NHS QIS says:

> "Assessment and measurement/scrutiny is just one element of this cycle of quality improvement",

whereas the submission from Forth Valley NHS Board says:

> "There is no mention of scrutiny in the overall aims."

Would any of the witnesses like to comment on that?

The Convener: I should have said at the beginning that if any of you wish to answer, please just indicate to me and I will take each of you in order.

Sir Graham Teasdale (NHS Quality Improvement Scotland): As I think that we said at the start of our submission, the bill provides an opportunity to refresh the role of NHS QIS as it becomes healthcare improvement Scotland and to reflect how the situation has moved on since NHS QIS was formed six years ago. The mention that is made of a lack of a scrutiny role relates to the position when NHS QIS was set up back in 2002.

However, we now recognise that if we are to make progress on health care, we need an integration of different components, one of which is good information. Scrutiny is a way of providing good information, which can be used for different purposes. We get that information from all sorts of sources, but information about the existing situation is the starting point. The next element is guidance on how the situation might be improved. The third part is helping to make things better through implementation. The final part is further scrutiny to see what has changed. That integrated cycle, which we now view as the way to improve things, was not at the centre of the vision when NHS QIS was established. We regard scrutiny as being an integrated part of the whole process.

Brian Beacom (Scottish Health Council): As a board member of NHS QIS, I welcome the opportunity for clarity to be provided on the scrutiny role. We had many deliberations about whether NHS QIS was a scrutiny body. We are well aware that, as the organisation was set up, it did not have the capacity to carry out scrutiny to any great extent. Its role was about quality improvement. Now there is an opportunity to ensure that all of that happens together.

Helen Eadie: I have a further question about the core functions of SCSWIS, which NHS Forth Valley's submission says are

"regulation of care services and inspection of social services with little mention of improvement."

Given that improvement is an important element of the remit of NHS QIS, will you comment on that?

Dr Frances Elliot (NHS Quality Improvement Scotland): The Crerar report made a cogent point when it said that we must ensure that scrutiny is not about review for the sake of it but is about ensuring that review is used meaningfully to make improvements. In the discussions about the setting up of the two new scrutiny bodies, it is clearly understood that both will have an improvement function. There is certainly a great need for the two new bodies to work together, because much of the work that they do will be about joint inspection and services that are increasingly provided together in the community. The Scottish Commission for the Regulation of Care, the Social Work Inspection Agency and NHS QIS have some learning to do as they come together to form the two new bodies.

Ross Finnie (West of Scotland) (LD): You raise an issue about section 10E—I am referring to NHS QIS's extremely helpful submission. You seem to strike two slightly different positions. You open with a sentence that says that there is a potential risk of "scrutiny distorting, perhaps even dominating". You then refer to the requirement for there to be evidence in support of the relevant provisions of the Regulation of Care (Scotland) Act 2001 before they are commenced. However, it is not clear whether you retain that concern, or whether you believe that the requirement for evidence will address those concerns about scrutiny. Could you expand on that and on the implications for the way in which section 10E is drafted?

The Convener: I am sorry; I just want to clarify where we are in the bill. We are talking about part 5 of the bill, section 90, which will insert new section 10E into the National Health Service (Scotland) Act 1978.

Sir Graham Teasdale: I will start with the strategic view and then ask Dr Elliot to talk about the practicalities.

The risk of scrutiny distorting is partly conceptual and partly practical. One of the concerns is that there is a belief that scrutiny by itself is a good thing, when the reality is that it is only useful in the way in which it influences the things that happen afterwards. Simply producing information for the sake of it does not change things, and we have learned that scrutiny needs to be integrated with follow-up mechanisms. So one of our concerns is that, by itself, scrutiny has a limited role to play in improving public services.

We are also concerned about the amount of work that could be involved. We could be opening a Pandora's box by going from the existing independent hospitals into all aspects of private dentistry, cosmetic surgery, laser clinics and so on. That would mean an immense amount of work in addition to the work that we would be carrying out in mainstream health care.

Dr Elliot: As the submission points out, the Regulation of Care (Scotland) Act 2001 has not been fully commenced. The new body, HIS, will have little experience of the scrutiny and regulation function, so getting to grips with that will be quite a challenge. The concern is that, if all the provisions in the 2001 act are commenced at the point at which HIS is established, that will be a major challenge that might deflect organisational impetus around the improvement cycle: working with services to follow up the output from scrutiny to ensure that changes are made that benefit patients and other people who are using the services.

Ross Finnie: I wholly accept the philosophical distinction that Sir Graham draws between the two elements, but what does that really mean? We are looking at the principles of the bill and the practical implications of the sections as drafted, and whether the provisions that the Government is making for implementation are adequate. Over time, the 2001 act will have to be wholly commenced or the purpose of Parliament will have been defeated. Is there an issue with the way in which new section 10E is drafted, or is there an issue for you around whether the timing and, ultimately, the resource that will be made available to the new body is adequately reflected in the Government's financial memorandum?

Dr Elliot: I think that it is both. The issue of improvement should be in the bill, as well as the scrutiny function. That way, people will be clear that the two new bodies will have both functions.

The second point is about the implementation and enactment of the bill, and ensuring that the resources and the structure of the organisation are fit for purpose and able to undertake both functions of scrutiny and improvement.

Rhoda Grant (Highlands and Islands) (Lab): On the same theme, what are the current regulations? How is the independent sector governed at the moment? I am quite concerned that this provision is something new. Who is regulating the sector at the moment? How far does that regulation go across the independent sector? Earlier, Sir Graham mentioned laser clinics and things like that. There are a lot of places on the high street that people can just walk into, and it is a concern if they are not properly regulated at the moment.

10:15

Dr Elliot: We refer to that in the part of our submission that covers proposed new section 10F of the 1978 act. At present, the care commission is responsible for the regulation of care in the independent sector, but it looks only at independent hospitals and mental health functions. That is a relatively small, circumscribed number of bodies in Scotland. The 2001 act covers many other independent services that are provided by health care professionals, but those provisions have not been commenced. Our concern is that if all the remaining provisions are commenced at the same time as HIS is established it will create an immense workload. We are beginning some work to scope that with other bodies that have a much better feel for the scale of independent health care in Scotland. Until we have done that work, we will not be entirely sure of the position, but our colleagues on the later panels this morning might be able to answer your question.

Another issue is that the meaning or definition of the independent health care sector under the bill is not clear. Does it include every independent health care service on the high street or only specific services? It would be helpful to have clarity about that.

Sir Graham Teasdale: The other aspect is that we do not have the evidence to say what the standards should be. NHS QIS has a strong reputation for ensuring that everything that it does is heavily based on the distillation of evidence and experience so that, when things come up, people accept that the right thing is being done. That sort of evidence does not exist for the new areas, so there is work to be done to determine the standards against which people should be judged.

Rhoda Grant: Are you saying that they are not regulated at the moment?

Dr Elliot: They are not, as far as we know.

The Convener: You said something about a scoping exercise and the practical difficulties that could arise when all the other regulations come into force and there is reorganisation. When will that exercise be concluded?

Dr Elliot: It is part of the work that is under way to scope what has to happen to bring the new bodies together by April 2011. A number of task groups are working and a number of questions have been asked about the information that we do not have yet. That is one of the key areas that were identified.

Some communication is already under way with colleagues in the independent health care organisations to find out what knowledge and understanding they have of the scale of independent health care services. We all know about the services that are provided by independent hospitals and the larger clinics, but there are also small, sometimes one-person services that are delivered in high streets and other areas. The challenge is to understand exactly where those services are so that they can be brought into the fold of regulated services in due course.

The Convener: I hear what you say. I know that the matter is complicated, but when you say "in due course", what time period are we looking at?

Dr Elliot: The work has to be done in this calendar year so that we understand what needs to be done to create the two new shadow bodies.

The Convener: That is helpful.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I have a main question, but first I want to follow up that point. I understand your concern that the new body will be overloaded, but the public want to be reassured that services such as laser

eye treatment meet the appropriate standards. Are you saying that there is at present no mechanism for checking whether all the groups that run laser treatment to alter vision are properly regulated, and that there is no evidence of what the standards should be, which would allow them to be regulated?

Dr Elliot: I am not in a position to give a definitive answer to that. I do not know whether there is any self-regulation of those services by a professional body, although I suspect that there might be. The Royal College of Ophthalmologists, which is the professional body, already has some standards to which it expects colleagues to work, so I expect that they are in place, but as far as I know there is no formal regulation or review of those services. The regulation that exists is self-regulation based on professional standards.

Dr Simpson: Thank you.

I want to continue the questions on scrutiny and inspection. Those are slightly different things. As Sir Graham said, scrutiny is part of a cycle of audit based on standards, which leads to improvement and keeps the circle going. It is important for NHS QIS to support that. However, on page 4 of your submission you say that, although reports will be

"transparent and accountable to the public"

—because, I assume, they will be published independently—

"this does not guarantee that the findings and recommendations of reports will be able to secure an adequate response by government".

Do you have any suggestions as to whether there should be any other reporting mechanism? For example, should reports be lodged with the Parliament or this committee? Obviously we have access to the reports, but at the moment there is no requirement for them to be lodged with us, although we can call you before us.

You talked about going beyond inspection and about the virtuous cycle, but enforcement does not seem to be addressed anywhere in your paper. If the Government is failing to support the health service in the enforcement of adequate standards, who is responsible for enforcing those standards?

Sir Graham Teasdale: The Government is accountable to the Parliament and the people of Scotland; it is not directly accountable to NHS QIS. Our upward escalation route is to make our findings well known to the health directorate, and any action that is to be taken on those findings is the responsibility of the health directorate and the minister who leads the health service. Our reports go to Parliament as well as being published. If you are starting to explore whether NHS QIS or HIS should be responsible to the Parliament, as opposed to the Scottish Ministers, that opens up an interesting area but I do not feel qualified to get involved in the debate.

Dr Elliot: The challenge is in the fact that NHS QIS has not been an enforcement agency up until now. During the passage of the bill it would be helpful to clarify how, in the future, the findings of reports should feed more clearly into performance management arrangements through the Scottish Government's health directorate. Some of the findings could clearly flow through to that. Given the fact that the health directorate will shortly launch its new quality strategy for consultation, there is an opportunity to feed issues and comments through that route. Sometimes, what the patient wants to experience can be different from the reality. There must be a mechanism for following that up and ensuring that the issues are addressed.

At the moment, however, we do not have an enforcement function. As Sir Graham has pointed out, that is a matter for the health directorate. There is a need to clarify how that will be followed through more clearly in the future.

Dr Simpson: On page 5 of your submission, in relation to new section 10N of the 1978 act, you talk about the examination of individual records. You seem to display a slight reservation about that, if I can put it that way. Would you like to amplify those comments?

Sir Graham Teasdale: Our inspections look at groups of patients—they do not go down to the level of the individual. If we started to do that with adults, that would begin to raise issues with human rights and data protection. We would be very cautious about any new arrangement that gave anyone the right to access personal health information without the person's consent. There may be circumstances in which that would be in the person's interests or in the public safety interest, but it would be controversial to put the power in statute. If that happened, as with children's services inspections, there would have to be a clearly established code of practice. The information would have to be health information only and it could be used in an identifiable way only with the person's consent. That is not clear in the bill as it is drafted.

Dr Simpson: That is very helpful. You do not see a great need—except in exceptional circumstances—for inspection to go down to the level of the individual patient. You are looking at outcomes in groups of patients.

Sir Graham Teasdale: Yes.

Dr Elliot: It would change the purpose of scrutiny. Individuals and communities would be very concerned if they thought that anybody on a team that was going in to review a service would have access to personal health information. The

matter raises real issues around confidentiality and the protection of the individual's rights. Moreover, it would not be necessary for the majority of reviews of services.

Dr Simpson: That is helpful. We can raise that issue with the minister.

The Convener: There is an important distinction to be made between looking at a class of patients and individual patients.

Dr Simpson: We have received lengthy evidence from the Law Society of Scotland, which, to summarise, indicates that the bill contains excessive powers for ministers, because they will be able to amend, abolish, restructure or do almost anything that they want to the new organisation. I wonder whether Sir Graham is comfortable that his organisation could be subject to further change or even abolition without recourse to further primary legislation.

Sir Graham Teasdale: I would be uncomfortable if it could be abolished without further legislation. Part of the life of leading a board is that you become accustomed to interactions with ministers on how the body's functions are best fulfilled. That is just part of life that you deal with. There is a balance to be struck. The changes are an opportunity to state even more clearly the independence that exists in NHS Quality Improvement Scotland, which is important. That independence is there, but the proposals give us a chance to state it much more strongly than in the past. The independence has been implicit, and we have never had to worry about what we said. Crerar's definition of independence is that it means not being constrained in what is said about findings. That has been the case for NHS QIS, but we have not made enough of that. If the legislation is used and put in practice in that way, there could be advantages.

Dr Simpson: There do not seem to be sufficient safeguards.

The Convener: Politically, it would be a pretty tough route for a Government of any hue to take to behave in such a cavalier fashion.

Dr Simpson: Why have the powers, then?

The Convener: The point has been raised.

Ian McKee (Lothians) (SNP): I would like to explore issues to do with the Scottish health council. The bill contains statements such as

"There is established a body to be known as Creative Scotland",

or

"There is established a body to be known as Social Care and Social Work Improvement Scotland",

or

"There is established a body to be known as Healthcare Improvement Scotland".

However, the bill also states:

"HIS may establish … a committee to be known as the Scottish Health Council."

I presume that if HIS "may" do that, it can choose not to do so, or it may establish the council and then disestablish it. That is a function of HIS, rather than a guarantee that the council will exist in future.

If we look to the future, we now have pilot elections to health boards in Fife and Dumfries and Galloway that will give the local public a big say in the running of the health service. If that system is expanded, that could affect the Scottish health council. In its submission, the council states that it is

"the only organisation in Scotland with a dedicated role and responsibility for championing patient and public involvement."

That is bound to change dramatically in the next few years if further direct elections to health boards go ahead. What is the future of the Scottish health council in the scenario that lies ahead, rather than the scenario of today?

Brian Beacom: You make an interesting point about the provision that HIS "may" establish the body. When I inquired about that, I was told that, in parliamentary parlance and the legal terms of a bill, "may" actually means "will". The bill does not say "will", it states "may". That can be read as meaning that HIS may not establish the body. There is an opportunity for deciding which way to look at that and whether it means that HIS may or, in fact, may not establish the body.

Direct elections to health boards will be another avenue for ensuring local input into them. However, the Scottish health council, in its present situation and moving into the future, has the role and responsibility of ensuring that boards can demonstrate that they have mechanisms in place to listen to and take cognisance of what patients and the public say. The patient focus and public involvement agenda is bigger than individual parts of a board sitting making decisions. We appreciate fully that boards, whether they have elected members or appointed non-executives, have a responsibility to make decisions, which are sometimes tremendously difficult, to improve health for everyone and to consider the big picture. Those decisions do not please everybody. However, boards are now able to demonstrate a much better patient focus and public involvement agenda than they have ever done previously. They now accept that as a duty that they must perform—they cannot choose not to do it. There is good evidence that we have made progress in that respect during the four years in which we have

been in place. We have some good examples of feedback. Boards may not have come up with everything that the public wanted, but they were able to demonstrate why they needed to do things slightly differently—something that they never really bothered to do before.

10:30

Another issue is option appraisal for services. Previously, there were options that, in truth, were not options—they were put on the table just to make it look as if a lot of opportunities were being provided. We now make it clear in our discussions with boards that option appraisal exercises must present genuine options that patients and the public can understand. Ultimately, the public and protest organisations will still be unhappy about decisions, but so far we have been able to demonstrate—and continue to do so—that boards have taken cognisance of and listened to what has been said. That is a vast improvement on the position five years ago.

The Convener: I can clarify that in legislation "may" is discretionary and "shall" is mandatory. As you said, there is the option of using the power. Dr McKee was making the point that much of the democratic input that you have achieved will be taken over well by the directly elected boards that are being piloted at the moment. Those were not in place to start with—the Scottish health council was trying to perform that role.

Ian McKee: I fully accept that you are describing the current situation, in which non-executive members of health boards are appointees. Often those people are not known to the public and they do not have a democratic mandate. The Scottish health council is trying to carry out the difficult task of interpreting what the public in an area want, so that that information can be passed to the board and any excessive action by the board can be checked. Surely that will be the function of a directly elected health board, because members will be accountable to their constituents and will suffer later if they do something that is way out of line. That is what the democratic procedure means. I wonder what the Scottish health council's function will be in those circumstances.

Brian Beacom: I understand that not all board members will be elected—there will be a mixture of elected and non-elected members. If eventually all board members are elected and have constituents, they will be able to take on the local aspect of our work.

There is another difficult issue in that both elected and appointed board members must make decisions based on what they have in front of them. They must consider how they can best use that resource and what they need to do with it. A local aspect may be nice and desirable, but it is not always deliverable. Regardless of whether members are elected or appointed, they must make decisions for the benefit of all users, rather than particular local interests.

The Convener: I take that point. My experience of the Scottish health council in my area is that people misunderstood what it could do. You say that you look at processes, but many members of the public in the area thought that your role was to be on their side. When they saw local cottage hospitals closing, the perception was that you were on the board's side. I am not saying that that was the case, but it was people's view. You are nodding—do you agree with me?

Brian Beacom: One difficulty was the change from local health councils—I am a former convener of the Greater Glasgow health council—to the Scottish health council. Many people continued to see us as having a tick-box role that involved monitoring what was happening and responding to consultation documents, but we had no remit for that at all. Our role was purely to inform the minister about the processes that boards had in place.

The staff have grasped the nettle, I am delighted to say, but many former members of local health councils hark back to their old role and would like to deal with complaints and do all the things that they were ill-equipped to do in the first place. We have done a tremendous amount of work to try to make them realise that we are not there to say whether we think a decision is good or bad. We might have private views, but we must stick to the point and say, "Yes, the board followed a process that was robust and inclusive" or, "No, the process was neither robust nor inclusive." It is not about whether we think there has been a good or a bad outcome; it is about the process.

The Convener: I knew from experience that that was an issue.

Richard Norris (Scottish Health Council): Our role is to check whether boards adhere to the guidance on how they engage and consult. The guidance explicitly acknowledges that the fact that a decision is unpopular does not mean that the guidance was not followed.

On direct elections, I suppose that an analogy can be made with local authorities, which have directly elected members but are increasingly using consultation engagement structures, such as community planning partnerships, and are not simply relying on directly elected members to channel public views.

Since 2004, NHS boards have been under a legal duty to involve the public in decisions about services. There is no reason to think that that will change if the pilots are successful and all boards

get directly elected members. There is a distinction between having the right people on a board to make a judgment—or having the people who are seen to be the right people—and how a board has gone through the process of gathering and taking account of different views.

Dr Elliot: The new organisation will need governance arrangements to ensure that it involves the public in work that it carries out. Whether or not the governance committee is called the Scottish health council, it will have the role of reviewing what boards are doing, as Richard Norris described.

More important, in relation to the participation standard, a key role for healthcare improvement Scotland, working with health boards, will be to consider how national standards and national guidance are formulated. There will be a need to oversee that in some way. Whether the committee of the board is called the Scottish health council or not, it will have to take ownership of that responsibility.

Sir Graham Teasdale: I think that "may" is the right word. We agree that the Scottish health council's functions are vital and might well expand in various ways, perhaps to merge more closely with what healthcare improvement Scotland does on public focus. Things might change. We agree that for the time being the council's functions—and its identity, which is a vital asset to the organisation—must continue, but to set that in stone for ever would be unwise.

There might be an issue about the independence of the board of healthcare improvement Scotland. If the board is independent, it should be able to decide how the functions are best carried out and whether that should happen in a way that will achieve more integration and save resources, through the internal arrangements. A main driver for the bill is resource conservation as a result of the merging of organisations. Consideration should also be given to how well people can work together within the organisation. We agree that the organisation will continue, but "may" is a well-chosen word.

The Convener: We have a bit of a suck-it-and-see situation. Many proposals for the integration and tightening up of all activities in health provision in Scotland are good ideas on paper, but we will have to find out how some of that works out. The approach allows for flexibility.

I welcome Joe FitzPatrick, who is here as committee substitute for Michael Matheson, who could not attend due to an illness in his family.

Mary Scanlon (Highlands and Islands) (Con): You will be pleased to know, convener, that I now have only two questions rather than five, thanks to my colleagues.

The Convener: You have let everybody know that you had five questions—it was important to get that on the record.

Mary Scanlon: I ticked off the boxes as my colleagues spoke—that is why I was last to ask questions today.

I want to come back to the independent sector. The written submission from NHS QIS states that "the other functions" introduce

> "a responsibility in relation to independent healthcare services, the equivalent of which will not be applicable to NHS services, and presents a challenge in … ensuring a common approach. While the NHS is heavily performance managed it is not formally regulated".

I am aware that the witnesses may not all have this piece of information—Sir Graham Teasdale has obviously seen it—but the Mental Welfare Commission for Scotland has given us a helpful chart. In relation to the point that Sir Graham made, I find it interesting that the Mental Welfare Commission does not see consistency in the bill. The commission has helpfully listed in its table 11 functions for parts 4 and 5 of the bill. In my homework for today, I noted that 10 of the 11 boxes in the table for "Care service" and independent "Health care" are ticked, seven of the 11 "Social service" boxes are filled, and five of the "NHS" boxes are ticked. Obviously, I will ask Dr Lyons about that when he comes. However, in terms of your acknowledging that there is not a common approach and that independent health care services will be regulated but that the "equivalent" of that will not apply to the NHS, I think that we would want all patients in all services to be aware that inspection was consistent. I wonder whether Sir Graham can respond to that.

The Convener: Do panel members have a copy of the table to which Mary Scanlon referred?

Sir Graham Teasdale: Yes—the paper is in the evidence papers. The approach to inspection and examination of independent services and the NHS will come together in the bill. We might therefore pick up on, for example, things that the care commission looks at, which we do not look at. Currently, the independent health care sector is not included in consideration of the quality of care that is delivered in clinical terms. The independent sector relies on the quality of the individual practitioner. Regulation of that sector is about the basic standards of infrastructures, whereas ours is more about how services are organised and provided to the individual, so there is a fundamental distinction.

There is another distinction in that there are many independent services, which are often small and inevitably have a responsibility to their owners and shareholders, whereas the NHS is a very big public body that is staffed by people who are

committed to public service, and it is performance managed by Government. Those differences will never disappear. Moreover, the independent sector will be regulated by healthcare improvement Scotland rather than by SCSWIS. HIS will never have the power to close Edinburgh royal infirmary, for example—

The Convener: That is not to say that there is any plan to do that. Let us ensure that that is not tomorrow's headline.

Dr Elliot: The difference at the moment is that independent health care services are registered and regulated by the care commission. If they do not meet the standards that the commission sets, they can be deregistered and could go out of business, as Sir Graham Teasdale pointed out. I do not think that HIS would wish to carry on that function for the NHS. We must identify where things can be improved, and we must work with services to improve them. As we move into the new body, we clearly hope that many of the standards that apply to the NHS will apply equally in independent health care services to ensure that improvements can be made in the longer term.

Mary Scanlon: With respect, I have listened carefully to your answers and I appreciate and understand them. However, I was not talking about what happened previously. The Mental Welfare Commission paper clearly relates to functions in parts 4 and 5 of the bill and to what will happen once the bill goes through. The Mental Welfare Commission says—according to the tick-box table in the appendix to its submission—that once the bill is passed, the independent health care service will fulfil 10 out of 11 of the bill's proposals and the NHS will fulfil five of them. That is my concern. You seem to be saying that there will be more consistency in the new system, despite the inconsistencies that you have highlighted in your submission. Are you saying that the Mental Welfare Commission has got this wrong and that the NHS will perform all the functions that are set out in the bill? I simply seek an assurance that the NHS will, in its own way, fulfil patients' expectations.

10:45

Sir Graham Teasdale: The table in question is very helpful. The boxes for the "Review and evaluate effectiveness" and "Encourage improvement" functions, which have been ticked across the board, refer to the primary role of working with the service and finding out whether it is doing well. However, differences emerge when we come to the actions that will be taken. In the independent sector, for example, regulatory powers are enforced though the serving of improvement notices. HIS will not be able to issue such notices for the NHS; instead, the system will rely on HIS sending information to the health directorate, which will then exercise its influence on health service providers to carry out the recommendations. Similarly, HIS will not be able to issue a condition notice and, although it will certainly recommend improvements, it will not do so explicitly on paper. Those functions will be different because of the different system.

Mary Scanlon: I appreciate that. I was concerned by the Mental Welfare Commission's comment that it is unclear whether the NHS will have certain functions, when it is clear that other elements of health care systems will.

Sir Graham Teasdale: That point is valid.

Dr Elliot: Having joined QIS from a mainland health board, I have to say that, with regard to the investigating incidents and events function, boards are already very clear about their patient safety and clinical governance roles. Incidents and events must be clearly investigated and root-cause analyses must be undertaken to ensure that boards learn from the reasons why something has happened. The functions on registration, improvement notices and condition notices will not progress through the bill. On the complaints function, I point out that the NHS already has a complaints system with recourse to an independent principal adjudicator. As a result, mechanisms are already in place to deal with the areas that Dr Lyons and the Mental Welfare Commission have said are unclear. The key differences centre on the improvement notice, the condition notice and registration functions.

Mary Scanlon: I appreciate that.

My final question has not yet been raised. On page 6 of the QIS submission, you recommend:

"If regulation of independent healthcare is to be extended beyond the existing arrangements, it is essential that provision is made for full cost recovery."

I remember that way back in the first session of the Parliament we expected the care commission to be self-funding. However, I think I am right in saying that its fees cover only a third of its costs. Will you expand on that?

The Convener: Can you tell us to which page you are referring?

Mary Scanlon: I quoted page 6 of the QIS submission, under the heading "10Z Registration fees".

Sir Graham Teasdale: I will pass that question to Frances Elliot. [*Laughter.*]

The Convener: That was a very successful piece of buck-passing. I will really need to learn how to do that; when I try, the thing usually lands in my lap.

Sir Graham Teasdale: Dr Elliot knows about strategic business operations.

Dr Elliot: I am chief executive of QIS, but there is no guarantee that I will be the chief executive of HIS. However, an important principle is that if additional work is not going to be funded through the new body's allocation there must be a mechanism for recovering costs. We will need to have a debate about the guidance and the information that will be provided when the new body is established, because at the moment the function is not carried out either by the care commission or by QIS. Although some economies will be made by bringing processes together, we still have to find out how that particular function will be created. As I say, that work is not funded at present.

Mary Scanlon: You are recommending that the independent sector should, as far as registration is concerned, be self-funding. However, that same ambition for the care commission in the first session of Parliament was simply not realised.

Dr Elliot: That was my understanding of the provisions in the original Regulation of Care (Scotland) Act 2001. The issue needs to be debated and clarified further in the consideration of this bill.

The Convener: Some of us, including the Association of Directors of Social Work, have been concerned about the self-funding aspects of the care commission, because of the perception of a conflict of interest. I stress, though, that it is only a perception. Do you wish to pick up that point, Sir Graham?

Sir Graham Teasdale: I hope that you do not mind, but my point is actually on the financial aspect. There are hidden on-going extra costs in the new legislation, because it will confer several extra functions on HIS that NHS QIS does not currently carry out. Those functions are substantial, and we need to recognise that the changes could mean that more is done rather than less.

Under the legislation, HIS has a duty to "disseminate … information" to promote health;

"a duty to provide information to the public about the availability and quality of services";

and a duty to "provide … advice" to ministers and to anyone who asks. NHS QIS does not currently undertake any of those duties.

Proposed new section 10B(2) of the 1978 act states that HIS has a duty to protect the

"safety and wellbeing of all persons"

who are receiving health care. There are around one million people a year in hospital, which—as Dr Simpson and Dr McKee can tell us—is only the tip of the iceberg. That duty sits alongside proposed new section 10D of the 1978 act that says that HIS will be "liable" for negligence.

There are many hidden elements in the new legislation for which NHS QIS currently does not have responsibility, and they could be very expensive.

The Convener: Something like £640,000—I cannot remember the exact figure—is projected as being the saving over a period of years. We should perhaps view the proposal more in terms of delivering a better service for the professionals and the patients in the system, rather than in terms of costs. If there are savings, that will be well and good because they can go to the front line, but the driver would be that changes will result in better services. Would that be an appropriate way to view the situation, with regard to the additional costs that you are rightly trailing before us?

Sir Graham Teasdale: That would be received with great acclaim at this end of the table.

Dr Elliot: The aspiration is to work with both the NHS and the independent sector because we can share good practice with, and learn from, each of those sectors and work together to improve delivery of care.

Brian Beacom: I am pleased that that question has come up, because there are definitely concerns around resource and finances, with regard to whether the proposed changes will result in savings. HIS would be a different organisation: the most important thing is that it should represent value for money, give a better service to patients and be far more engaging and encompassing than it is in its current form. To come up with a figure for a saving, however, would at this stage involve being a hostage to fortune. It would be slightly difficult.

The Convener: Bearing in mind the time, do any of the witnesses want to raise any issues in relation to part 4 of the bill, which the committee dealt with at its last meeting? It is not obligatory but discretionary; a "may" rather than a "shall".

Dr Elliot: NHS QIS welcomes the duty of co-operation, and the anticipation that there will be further joint inspections and joint work across the care sector. Health and social care are increasingly provided together, and we welcome those aspects as an essential part of the bill.

Richard Norris: I echo that view from the Scottish health council perspective. We are aware that there is an issue about how well organisations can co-operate in engaging with the public, so the duty of co-operation is welcome in that area.

The Convener: I am being reminded—it is a dangerous place to be—that I have omitted Helen Eadie. I hope that she will not take revenge.

Helen Eadie: I would not seek any revenge on you, convener, so you are all right.

The Convener: Not yet.

Helen Eadie: I will probe Graham Teasdale's point on independence and independent assurance.

The committee has received evidence from NHS Forth Valley, which states, with regard to independent assurance, that

"the establishment of HIS as a health body and not an NDPB as is the case with SCSWIS"

—there is a lot of jargon there—

"may, from a particular perspective, reduce the ability for truly independent assurance and assessment."

It goes on to state that the Government "may" at some stage

"move to a single external scrutiny body but not at this stage."

Why not at this stage?

Sir Graham Teasdale: I suggest that there are two issues. The first is the independence of NHS QIS and healthcare improvement Scotland and the Scottish health council. The second is whether the scrutiny of health and social care should be combined into one body.

On the second issue, there are currently so many differences between the two areas that to move to a single body in one step would be a jump too far. That is due to the different nature of the services, the different existing performance management systems and so on.

On the first issue, the Crerar review states that the key point is that the external scrutiny body

"must be independent and must not be constrained by any party in reaching its conclusions and publishing its findings."

That key point is fulfilled by NHS Quality Improvement Scotland. We have never been asked to change what we say in our findings and I am sure that that will continue to be the case under healthcare improvement Scotland.

The independence of scrutiny bodies can also be judged by a number of other criteria, which are suggested in work that was carried out by Consumer Focus Scotland. Without wishing to bore the committee, I will just mention them briefly. Is the body established by legislation? Yes, healthcare improvement Scotland will be so established. Does the body have a governance system and an independent board? Yes, healthcare improvement Scotland will have those. Can the body publish its findings? Yes, we currently publish our findings, and HIS will do so. Will the body promote public discussion? We currently do that, and HIS will do that. Will the body have a user focus? Yes, we have a user focus, and HIS will increasingly have such a focus.

The perception of independence might be an issue due to the location of HIS, but that perception might be challenged by putting across the reality. If there has been an issue with our independence in how we deal with matters, that has been because we are accountable to ministers, who manage the health service. That point could be addressed only by setting up bodies such as ours in a radically different way. The same issue would apply to any of the scrutiny bodies whose members are ministerially appointed. Unless the members of all scrutiny bodies are appointed by Parliament or the Crown or whatever, that will always be an issue. Careful analysis shows that the new body will be independent. Certainly, it clearly ticks five of the six boxes.

The Convener: Mary Scanlon may ask a quick final question.

Mary Scanlon: It will be very quick indeed.

I appreciate that proposals on the Mental Welfare Commission are currently out for consultation, but I want to follow up Richard Simpson's question about consent for access to health records. Dr Elliott quite rightly said that we could not have anyone and everyone looking at health records. Does she acknowledge that that would not apply to the role of the Mental Welfare Commission, which very much focuses on the individual's health care? Is its specific role of the protection of the individual—Miss X or whomever—very different from the way in which HIS would work in general?

Dr Elliot: It was clearly enshrined in how the Mental Welfare Commission for Scotland was set up that it should provide individual protection for vulnerable adults who are unable to speak up for themselves. If the Mental Welfare Commission at any point became a part of healthcare improvement Scotland, that role would absolutely need to be protected by being enshrined in legislation.

The Convener: I am grateful to have that important point put on the record.

I thank the witnesses for their evidence in what has been a very gentle session—I am sure that we will continue in that vein. I will suspend the meeting for five minutes.

10:58

Meeting suspended.

11:04

On resuming—

The Convener: On our second panel of witnesses, we have Alison Smith, the chair of the Scottish Independent Hospitals Association; Dr Jean Turner, a familiar former colleague and chief executive of the Scotland Patients Association; Fiona Mackenzie, the chief executive of NHS Forth Valley; and Catriona Renfrew, the director of corporate planning and policy in NHS Greater Glasgow and Clyde.

I note that the members of our second panel sat through the previous question-and-answer session, for which I thank them; that is helpful.

Rhoda Grant: Following on from my question to the first panel about the independent sector, including organisations that are on the high street and are not facing scrutiny and regulation, what is in place to ensure that the consumer—the patient or the client—is protected?

Alison Smith (Scottish Independent Hospitals Association): At present, the high street is unregulated. That has been a source of great concern to the regulated independent providers, and we have been flagging it up for a considerable time.

Some progress has been made on the issue in England, where the same concerns have emerged. The model that England is looking towards involves sharing responsibility for regulation between the General Medical Council, the General Dental Council and the Nursing and Midwifery Council. We have alerted the Scottish Government to that. Sally Taber, who is present in the room today, is on the secretariat of the SIHA and has met Audrey Cowie and Andrew Macleod to make them cognisant of the discussion and the changes that are being proposed in England.

The Convener: For the benefit of the *Official Report*, could you say who those two people are?

Alison Smith: They work in the Scottish Government's health department.

The approach that has been adopted in England is a good way forward as there are, for example, a lot of mobile nurse practitioners who are providing an aesthetic or cosmetic function in rural areas, and many laser clinics and so on. As Dr Elliot said earlier, such practitioners are bound by professional codes of conduct as opposed to being overseen by a professional regulatory body that deals with the way in which services are delivered in the industry.

Rhoda Grant: Would it be possible for such arrangements to be delivered under the bill, or would we need to approach the issue differently?

Alison Smith: I reflect the caution that Dr Elliot and Sir Graham Teasdale highlighted. The situation that is developing represents a welcome change in the independent sector. There is a huge remit. As the committee has identified, a lot of areas remain to be fleshed out before we can understand what the way forward will be. I do not think that creating that sort of structure would be one of the primary decisions that would have to be made at first. I think that there would be a willingness to see such a development, but I do not think that it would be in the primary tranche of regulation and inspection.

Rhoda Grant: Is there anything that we would need to add to, or take away from, the bill to allow that development to happen in the future?

Alison Smith: No. The bill is structured in such a way that such services could be incorporated when the people who were implementing the bill judged it to be the right time to do so.

Mary Scanlon: I have vague memories that the independent care sector was included in the Regulation of Care (Scotland) Act 2001. Is my memory deceiving me, or have those provisions simply not kicked in yet?

Alison Smith: At that point, it was known that the sector was there, but it has not yet been formally regulated.

Mary Scanlon: Am I right in saying that the sector was included in the 2001 act with a view to its being regulated?

Alison Smith: Yes.

Mary Scanlon: Why has that not happened?

Alison Smith: I do not think that I can fully answer that. The care commission could, though. It has rolled out its inspections as and when it has felt that it would be able to robustly inspect each area that it made a commitment to cover. We are regulated by the care commission, but I cannot tell you why the care commission has not fulfilled that function to date.

Mary Scanlon: That is an important point. In 2001, many of us assumed that the independent health care sector would be regulated because it was included in an act of this Parliament. I had assumed that that had come to pass, but it does not seem to have.

The Convener: We could clarify that with the minister.

Mary Scanlon: Yes. That would be helpful.

The Convener: The regulations may have been introduced incrementally.

Alison Smith: Over nine years, the environment and what is available in the high street have changed very quickly.

The Convener: Yes. We did not use to have all the laser adverts; I have not fallen foul of them yet—I still wear contact lenses because I am scared.

Dr Jean Turner (Scotland Patients Association): In general, the public are naive and think that the services are regulated. However, even psychologists may not be regulated as the public think that they should be. Dentists and denturists were not regulated, and an awful lot of people fell foul of that. The registration of health care professionals is an important issue that needs to be addressed.

Ian McKee: I want to follow up a question that I asked the previous panel about the Scottish health council; I am sure that you heard my question, as you were in the room at the time.

There is a new scenario ahead of us whereby there will most likely be directly elected health boards and the people who are directly elected will have a function of representing the patients in their areas. Another point, which I did not put to the previous panel, is that there will be an expansion and development of community health and care partnerships with much more local authority involvement in the provision of what we have traditionally regarded as health care. There seems to be a bit of a blurring between the function of the Scottish health council and some body that will oversee what the local authorities—which are directly elected—do in that field. How do you see the future developing in that context? Are we going to have another unnecessary body in the Scottish health council, or does it have a vital function?

Catriona Renfrew (NHS Greater Glasgow and Clyde): I have two or three points to make in response. We were surprised that the Scottish health council still appears as an entity in the bill—albeit as a "may", not a "shall"—instead of its functions appearing as a set of functions for HIS. That takes us to the heart of the way in which the legislation has played out from Crerar. In a sense, it is trying to apply the Crerar principles to the current bodies instead of starting from the Crerar principles and creating a system of regulation that delivers on those principles. It is looking at what already exists and reshaping that in order to move forward.

From our point of view, there is an issue about the Scottish health council still being a distinct part of a new body. However, if the Scottish health council's functions were to become a part of the new body, that would be a different matter, as it would then be for that body to take a view on how it discharged those functions.

I will not enter into the debate about the role of elected health boards, as I am not sure that that would be helpful, but your point about CHCPs is correct. We have 10 CHCPs, involving a total of 45 elected councillors, in the direct control of community health services, primary care and a whole raft of local services. We feel that CHCPs are an important step forward in engaging people who have a democratic mandate—not all of our non-executives do—and engaging the public through the public partnership forums that each of our CHCPs hosts.

Fiona Mackenzie (NHS Forth Valley): I broadly agree with Catriona Renfrew's comments. Brian Beacom talked about the parallel with local authorities and the need for further ways of engaging people. Given the expertise that the Scottish health council has built up and the importance of its function, it is valid for it still to exist as a distinct role within the new improvement body. However, I agree with Catriona's comments about the mechanics of how that is put in place.

Ian McKee: Do you know of any body to which local authorities, which are directly elected, are accountable for their work? You say that it is valuable to have a body outside the health service that feeds in information. Does any equivalent body exist for local authorities?

Fiona Mackenzie: I am not aware of any parallel arrangement.

Ian McKee: Why do you think that such a body is necessary for the health service?

Fiona Mackenzie: My point was not so much that it is necessary in its present guise. As Catriona Renfrew said, the expertise that the Scottish health council has built up could be valuable and fulfil a function as HIS takes on its new role.

11:15

The Convener: I was just observing that councils are elected and are therefore accountable to their electorate when they stand for—

Ian McKee: That is the point that I was trying to make, convener.

The Convener: I am sorry; I am so slow. I forget that I have a high-IQ team on the committee—I defer to them.

Catriona Renfrew: If one of the key purposes of the Crerar review and the legislation that followed it was to be proportionate and to reduce the levels of scrutiny and bureaucracy, a hard look needs to be taken at what is required by the external bodies and at the fundamental duty of each organisation. Scrutiny can be undertaken in other ways by the members, non-executives or councillors who are involved in those organisations. That question needs to be addressed as the detail of the arrangements—they are pretty high level at the moment—is developed.

Dr Simpson: My first question follows on from the last comment and concerns the relationship between self-evaluation and self-assessment, and

the need to ensure that the necessary improvements are enforced and driven forward. Will Ms Renfrew expand on that? I refer in particular to the second, fifth and sixth paragraphs on page 2 of the NHS Greater Glasgow and Clyde submission.

Secondly, the NHS Forth Valley submission refers to

"the establishment of HIS as a health body and not an NDPB".

Does that fit in? An NDPB would be more independent, rather than simply acting as a health body.

Fiona Mackenzie: My point was about the perception, rather than the reality. In earlier evidence, Sir Graham Teasdale covered very well the issues surrounding dependence. The concern that I was highlighting is that there could be a perception or assumption on the part of people looking at the way in which the organisations are set up that an NHS body will not be independent enough. The proof of the pudding will be in how the organisation actually works. In that respect, the enabling framework is an important issue in the policy memorandum—the basic point is about how the framework sets out how both bodies will work. We need to guard against the possibility of people not being comforted enough about HIS's independence.

Catriona Renfrew: The devil will be in the detail. Three potential elements of the system are competing to scrutinise, to assess, to evaluate and to improve. There is the health board, with elected and unelected non-executives, who have a role in the scrutiny of the board's performance in clinical governance, audit and financial performance; the new bodies that are to be established; and the Scottish Government's role in relation to the health service. We have highlighted in our evidence the potential for continuing or increasing overlap and duplication across those three functions, unless there is clarity as the new organisations develop.

There is a fourth dimension to that, too. One of the core issues is that many health and social care services are now managed in single structures, or in a joint or closely related way. Although there are lots of messages about jointness and ensuring that scrutiny from the two bodies is coherent, that will continue to be a challenge. It is interesting that the decision was not taken to go down the route of having a single scrutiny body. I think that the Convention of Scottish Local Authorities highlighted that to you in its evidence, as did the Association of Directors of Social Work.

Dr Simpson: There is also the question of how Audit Scotland's role might be altered. I think that you mentioned that in your written submission. Those various bodies are all to be slotted in.

I take it that, in your view, it would have been better to consider having a new body and investing it with certain functions, rather than trying to slot all the existing organisations into some amalgamated or integrated structure—which is what everyone is talking about.

Catriona Renfrew: There was a choice there. Because of the way in which the Crerar report was taken forward, without a process of consultation, as has been highlighted in evidence, that choice was not fully explored with all the stakeholders. The answer might still have been the answer that is being proposed now, to move in an incremental way, but the choice was not explored with all the stakeholders and bodies that are to be scrutinised.

Dr Simpson: That is an important point.

The Convener: You used the word "incremental". That might mean political with a small p—I am thinking about the parties involved, and about personnel.

Ross Finnie: One difficulty with such complex bills is that committee members and witnesses understandably tend to read their policy memorandums and try to establish in their minds what the direction of travel is. That is perfectly proper, but the difficulty for the committee is that, in trying to establish whether we agree with the general principles involved, we do not address the general principles of the policy memorandum; rather, we address the general principles enunciated in the bill.

I am not picking on NHS Forth Valley, but its written submission tends to refer to the bill's policy memorandum. Is NHS Forth Valley satisfied that the bill as drafted, particularly part 5, adequately articulates the requirements of the policy memorandum? Does it want to direct the committee's attention to drafting in the bill that is either wholly supportable or which supports its contention that elements in the policy memorandum require further buttressing?

Fiona Mackenzie: I am glad that you are not picking on me if that is an easy question.

Ross Finnie: I am only warming up.

Fiona Mackenzie: I would be happy to provide the committee with more detailed consideration of the drafting of the bill. My main issue with the structuring of the bill is that it seems to deal with the move from the existing bodies rather than our need to set up two entirely new bodies with new powers. I understand the reasons for that, which are obvious. There is probably more of a focus on improvement on one side of the house and on scrutiny on the other side. We need to ensure that things are equally well set out. That is an important principle from a drafting point of view. I am happy to elaborate on the details that you are

asking for after a bit more reflection, but that is a general point.

The Convener: If you do not wish to provide us with details now, you could provide us with a further written submission, if doing so would be more helpful.

Fiona Mackenzie: I would be happy to do that.

Ross Finnie: I would certainly welcome that. We understand the difficulty. People are trying to square a number of principles. As a committee member, my difficulty is that I am following the evidence, as I did last week, when a number of helpful suggestions about possible improvements were made, but in the final analysis, I must participate with my committee colleagues in reaching a decision on the general principles of the bill. Reaching that decision involves judging whether the parliamentary draftsman has adequately reflected the minister's intentions in the bill. That is the tricky bit. I understand why you have addressed the matter via the policy memorandum.

Perhaps the other panel members can answer my question now or later.

Dr Turner: I am concerned about two issues. The organisations need to share a lot of information to work well. The definition of "sharing information" therefore needs to be somewhere in the bill. If patient information is required, the sharing process must be secure. Rules and regulations must be set for how the various people can share information and what they can do with it once they have it. Currently, patients who get their records have difficulties. What a medical or health record is should be defined in the bill, because even when patients get information, they sometimes do not recognise themselves in certain areas or find other people's information in their record. Sometimes the acute health care summaries that are passed on are different from what was expected—they can contain inaccuracies.

Work needs to be done on how information is gathered currently and how things can be changed, because there are difficulties. That needs to be clarified. Information would have to be passed around all the organisations, so there must be rules and regulations in the bill for that, and for patient information and power of attorney. It is sometimes difficult even at present for somebody with power of attorney to be given consideration in a hospital.

The Convener: I am getting a bit confused. I thought that, although we are talking about sharing information, it is not information about individuals, with the exception of the Mental Welfare Commission's particular point.

Dr Turner: I agree that the mental health side is about dealing with individuals. However, with Crerar, patients expect to be safe and in partnership. It is not clear to me, from reading parts 4 and 5 of the bill, where individuals would be able to have an input. A business, for example, would want service users, rather than just focus groups, to be able to make an input. If someone was in hospital, for example, and was having difficulty with being given their drugs on time, but nobody seemed to be taking account of them, there would be no point in their making a full, formal complaint, because they would want to be able to find an appropriate mechanism. If they could not find that in the hospital at the time, there could be a helpline to one of the organisations, in particular HIS, which might be able to step in—that is what is missing from the proposals for HIS. It seems that it would not be able to go into a ward and examine it as the care commission can examine private places.

The Convener: Does somebody want to pick up on that issue of looking at the state of a ward if there are concerns about it? Will such examination be part of the bill?

Catriona Renfrew: What the issue highlights is the different language that is used for what the two different bodies will do, and the lack of clarity about why they have different purposes and what the logical basis for that is; despite that, the two bodies are to co-operate on joint investigations and inspections. Certainly, SWIA and the care commission use client records as a fundamental part of their current inspection functions for child protection or services in homes or care settings. There is a problem in that regard, because it seems that HIS will take a population-based approach to its functions, yet it is to co-operate with a set of bodies that will take an individual-client approach, not in the way that the Mental Welfare Commission does but by using individual client records to test and inspect services. It is not clear to me how that circle can be squared; it comes back to the differential language that is used in the bill about the functions of two bodies that, at one level, appear to be intended to have somewhat similar purposes.

The Convener: Can I just clarify something? You said that the care commission looks at individual clients. Is that anonymised unless the client or somebody representing them gives permission or a mandate authorising otherwise?

Catriona Renfrew: I cannot answer that specific question. Certainly, SWIA's inspections are not client consented. When we had the first joint children's services inspections, it was a particular issue for debate that the SWIA inspectors did not have the power to access individual patient health records but had the power to access social work

records. Information is only one example of that issue. I think that the committee has had comprehensive submissions from the Scottish Information Commissioner and others on information issues. That highlights the fact that, if different bodies are supposed to co-operate in inspecting the same services, there is immediately difficulty and confusion about how that will operate.

On the point about the drafting of the bill's policy memorandum, we would be happy, like NHS Forth Valley, to make a further submission on that, if that would be helpful.

Alison Smith: Catriona Renfrew is correct in saying that, as the care commission and SWIA stand at present, they have different cultures. As the general manager of an independent hospital, I have experienced a number of care commission inspections. When the care commission enters the building, it states that it has a right to access any information that it wishes. That can consist of a number of case notes, or personnel files for the staff or consultants, which would be checked for personnel governance and so on. Before the care commission attends for an inspection—if I am telling the committee something that it already knows, please stop me—it sends out posters, which we display to alert the public who are in the hospital on that day that the care commission inspectors will be present. The inspectors can enter patients' rooms and ask whether they would be willing to have a dialogue with them so that they can get real-time, face-to-face—

11:30

The Convener: But that is consensual. I was concerned about situations in which there is no consent. Is there a time when the care commission can do that without consent?

Alison Smith: Yes. The care commission can go on to the ward and lift patients' records without being asked to gain the consent of the patient.

The Convener: That is interesting.

Alison Smith: There is a fundamental difference. When I read the submissions—

The Convener: I understand that we are being advised about the independent sector, but I am very naive and did not appreciate that.

Alison Smith: When I read the submissions before this meeting, I noted that there is a distinct difference between an NHS QIS inspection and the care commission.

The Convener: That is very helpful in showing some of the practical problems that will be thrown up by this integration.

I have lost the thread now.

Mary Scanlon: I want to go back to a general point. In the same way as Ross Finnie and others, I am looking for a justification for the bill, and obviously I want to see progress on simplification and consistency, rather than the Government just ticking a box and saying that this is a bonfire of quangos.

It is obvious that there will not be many cost savings, and I am worried that we are creating a bigger bureaucracy. All the witnesses have been very polite, including the Scottish Independent Hospitals Association, which welcomed the bill with great enthusiasm; that is good, but it means that I have had to resort to Dr Donny Lyons, who is sitting in the gallery behind the witnesses.

I would like to ask about some of the issues that were raised by the Mental Welfare Commission for Scotland. On inspection, it says that

"there are massive discrepancies in standards across the care spectrum. It is difficult to see how the Bill will improve this".

It goes on to say:

"There appears to be no provision in this Bill for investigation of incidents and adverse events"

and, on registration, improvements and requirement, it says

"There is no clarity over the arrangements for the NHS."

Finally, it says:

"There continue to be discrepancies in complaint handling across health and social care."

The Convener: Which page are you reading from?

Mary Scanlon: It is page 3 of the Mental Welfare Commission for Scotland's written evidence.

I am eagerly looking for, but am struggling to find, something to show that the bill will improve patient care and patient assurance, that it will not cost the taxpayer huge amounts of money, and that it will not become a massive bureaucracy. Will you comment on some of the points that were aptly raised by the Mental Welfare Commission?

Catriona Renfrew: The bill is intended to set up a structure that will enable those things to happen, but it does not contain enough detail about the points that the Mental Welfare Commission raised regarding how those functions will operate to allow you to test whether it will level up standards or create consistency or whatever. In a sense, the bill is an enabling process that will create the new bodies with a brief to do those things, so it is difficult to apply your tests to the bill at this stage.

Mary Scanlon: You are saying that, as a member of the Health and Sport Committee, I do not have the evidence that the bill ticks the boxes

of simplification, consistency, better regulation, better patient care, and better assurance. I am really signing a black box and, looking at the evidence I have, I do not know whether the bill will lead to improvements.

Catriona Renfrew: There will certainly be a simplification in terms of the number of bodies and the construct of what they do, which was one of the primary recommendations in Crerar.

Mary Scanlon: But will that be better in terms of the functions? That is what I am struggling to find out.

Catriona Renfrew: At this stage, there is not the level of detail about the actual application of how the new bodies will operate that would enable you to answer the questions posed by the Mental Welfare Commission.

Mary Scanlon: Thank you for that. I now realise why I am struggling to find the information.

Fiona Mackenzie: That might be one of the arguments for incrementalism. When I first looked at the bill, it seemed very attractive to make one huge leap forward, disband everything and go to one system. We seem to be struggling with the fact that things are being operated slightly differently at the moment: the ethos, culture, approaches, inspection regimes, the gradings that are applied and the ways in which things are moved forward.

In some ways, that might be an argument for taking the step, in a staged process, of rationalising broadly round a health-oriented group and a social care group and then considering how to proceed. A lot of work must be done to get to that interim stage and to get the two bodies working effectively together, so that the progress that we have begun to make on joint inspection can continue. For those reasons, I am more persuaded that we need an incremental approach, rather than a single move.

The Convener: Is it fair to say that the Government is going down the route in the bill partly because of the change in demographics and partly because of the change in care? We have shifted away from hospital care to care that is much more mixed—for example, for the elderly or people with long-term debilitating illnesses, who are surviving longer. Local authority social work services have stepped in to provide more care, but we have not changed our structures. Is that why the structure has to change?

Fiona Mackenzie: In part. That is also one reason why, when considering the inspection regimes, we must first agree what the model of care is in its broadest sense. That needs to be articulated. If it is articulated and the inspection regimes are designed on the back of that, the reason for the changes will be more explicit.

The Convener: I am thinking about how ordinary people will understand the reason for the changes. People understand the issues when they are in the middle of the system and they suddenly move from a health service to a local authority social work service; they have to deal with lots of different people. I am thinking from the point of view of the person who counts—not just the professional but the patient or user.

Alison Smith: We welcome the proposals. The independent sector is inspected by the care commission, which inspects hospitals twice a year with an announced and an unannounced inspection, but we also have key inspections by NHS QIS, which to date have been on anaesthetic services and blood transfusion. We in the independent sector have enjoyed them, because they have involved peer review and been a different experience from that of being inspected by the care commission.

I believe that both bodies have great strengths. If they are brought together, the whole can be greater than the sum of the parts. We must be cautious and identify the great strengths of both organisations. We can bring them together to deliver the greatest possible patient care in both sectors, and the bill presents an opportunity to do that.

When the care commission was set up, the independent sector was invited to sit at the table to consider standards and the inspection methodology. We would value the opportunity to be involved at the grass roots in the set-up of the new organisation. The sector has a lot to contribute to the way forward with HIS, and we would welcome the opportunity to do that.

Dr Turner: Patients look for uniformity, wherever they are. They move from the private sector to the NHS and back again—they go home for a bit, but they might need to go to hospital, for renal dialysis for example. It is extremely difficult to co-ordinate all that patients need in the community, but they look for uniformity. From reading the bill, it does not seem that the two new bodies will be uniform as the complaints systems will be different—although the bill is confusing if you try to read it from a patient's point of view.

If I were a patient sitting here today, I would be dead scared. The Government is bringing about a huge change. The present organisations have not existed for long and are just getting the hang of what they do. Obviously, we hope that any new organisation will pull together the best practice, but the bodies will have to amalgamate, as well as integrate and work with each other and with other organisations, including the police, the ombudsman and the NHS.

Patients who go through the NHS complaints system would probably rather not go through it—rather than make a formal complaint, they would prefer to speak to a body that might put something right. The present complaints system does not serve the public as well as it should, and nor does the ombudsman because of its remit. It is terrifying that we are going to change the system.

I agree that the idea is good. Wherever a patient receives care, they want to feel safe and be sure that their treatment is as good within the NHS as it is in the private sector. Sometimes, patients do not know that they are going into the private sector—say, in a care home—and the implications of that. However, I have reservations about the whole proposal. I do not feel confident that it has been thought out enough to be sure that the safeguards are in place for the patient. More service user involvement is expected. I will have to read the bill again more carefully—I have read it two or three times, but I am still confused.

Catriona Renfrew: Fiona Mackenzie highlighted the suggestion of an incremental approach. There is a choice: the incremental approach provides more certainty of direction and more safety, but it does not enable us to resolve all the overlaps and inconsistencies.

I will give one example, on which others may wish to comment. Under the bill, a continuing care patient in the NHS would not benefit from the same level of scrutiny as a nursing home patient regulated by SCSWIS would. A continuing care patient in the NHS would have the benefit of the involvement of the Mental Welfare Commission for Scotland if they had a mental disorder but not if they were just frail and elderly. Therefore, even in one potential group of clients—frail, elderly people; frail, elderly people with mental illness; and people in nursing homes—there are different sets of regulation bodies and securities for patients under the new arrangements. That is because the approach is incremental. One could argue that those arrangements would be less varied than the current ones, but the bill does not arrive at a consistent and joined-up system for health, social care and different kinds of client.

The Convener: That is helpful.

Helen Eadie: I have two questions, and the first one is—

The Convener: You always tell me in advance, just in case. I hope that it is not in several parts. Are they two distinct questions, not one with three parts and so on? I am just testing.

Helen Eadie: Fiona Mackenzie's submission says:

"The cultural changes required within the current organisations of NHS QIS and the Care Commission should not be underestimated."

You have all already mentioned that, but I ask Fiona Mackenzie to expand on the point.

Fiona Mackenzie: We touched on that in our discussion of incrementalism versus the big bang approach, if I can put it that way. It perhaps goes back to the difficult question about the details of the drafting. People have dealt with the bodies that already exist and considered how we add functions on, whereas we need to get into our minds the fact that we are moving to two different bodies that come from a certain historical background but need to move in a fundamentally different way.

The worry on HIS is that a strong, dominant culture from the bigger organisation might persist and take in a little bolt-on from the care commission. That perhaps ties in with Alison Smith's point. My point is that we need to think of HIS and SCSWIS as new bodies and think through properly how we implement the mergers, bringing strengths from the predecessor organisations into the new bodies.

I will link that with the question whether it should be one change or two steps. That argument allows us to iron out some of the issues to which Catriona Renfrew refers and to get to a single inspectorate in due course with all the bases covered. My slight worry about the bigger step is that the situation is highly complex and, although it is attractive to move to one inspectorate, we begin to drop important points in the process.

My primary argument is that we need to regard SCSWIS and HIS as two new bodies. We need to draw on and build up the existing strengths as a stepping stone to a future single agency.

The Convener: That is clear.

11:45

Helen Eadie: My second question takes us back to last week's discussion. Jean Turner has mentioned this issue, but I welcome views from any of the witnesses. In the context of patient focus and the need for a patient-centred approach, the complaints system is one of the biggest issues for all patients in the NHS. If the bill is passed in its current form, a conflict of interests will be inevitable, because the body that an individual complains about will investigate and respond to the complaint. Do panel members agree that that is a problem? What might be done about it?

Alison Smith: In the independent sector we have a robust complaints process, and we described its three stages in our submission. We hope that complaints are resolved during stages 1 or 2, in the company, but patients can also access the independent principal adjudicator.

A patient in the independent sector has the right to go straight to the care commission. We worked on the process with the care commission over the years. If the care commission receives a complaint, it comes to the hospital first to find out whether we have received the complaint and if so how we are managing it. If the care commission is comfortable with our process, it relays back to the complainant that it has investigated the complaint and is comfortable with the evidence that was presented to it. If the issue is not resolved, the complainant is given the information that will enable them to decide whether to pursue the process.

Under the new arrangements I would want the independent sector to retain internal governance in relation to complaints, because our system is robust. I value the approach whereby the care commission comes back to us with a complaint so that we can understand and address the issue, perhaps by providing an explanation that gives the complainant a better understanding of the situation, which means that the problem does not escalate.

As the committee knows, the independent sector has worked in partnership with the NHS for a number of years. If a complaint arises in relation to an NHS patient in the independent sector, the complainant can complain to the referring NHS board and to the independent sector. To date, we have had only one such complaint. I found it easy to work with the NHS complaints department. There was a free flow of information and a common aim to resolve the issue happily.

I hope that the new body can integrate our current complaints policies and give robust reassurance to the public that their voices will be heard and their complaints investigated fully, so that people can have a degree of satisfaction or comfort about the response that they receive.

The Convener: It is probably the experience of most MSPs that a complaint must go through an agency's internal procedures before it is taken further—although in extremis, if a complaint was about the whole agency, someone might not bother with that process.

Dr Turner: Patients raise many issues, and the problem is that sometimes they are not listened to. At all levels, many complaints arise from poor communication. Many problems can be resolved before a formal complaint is made, but I am not sure that the bill offers any way of improving the culture to allow that to happen.

This week, the Scotland Patients Association was contacted by someone who said that a relative was going into hospital and that they were worried about infection. They wanted us to ask whether there was any infection on the ward and whether they could take in wipes. They had the feeling that, if they asked such questions themselves, they would be treated as though they were in a different category. That does not happen throughout the system—many good people work in the NHS, or it would not be where it is today—but people are not always listened to. That includes staff at the coal face, who are not listened to by management.

I know of two or three patients who had to phone the head office to get someone in the ward to come and listen to them. That is dreadful. Those patients knew how to use the system, but most people do not have the capacity to do that—they are not feeling well and they are vulnerable. I would like something in the bill to give patients and staff more confidence that they will be listened to. No one wants a blame culture; we want everyone to work together, and the point of bringing the organisations together is to ensure that everyone is working for the patient's betterment. However, that does not seem to be written into the bill.

The Convener: We are nearing the end of this part of the meeting. Do the witnesses want to comment on part 4? Commenting is not mandatory.

Dr Turner: On confidentiality, the use of records, complaints and so on, part 4 should match part 5.

Fiona Mackenzie: I also want to make the point that parts 4 and 5 should mirror each other. Part 4 focuses very much on scrutiny and rather less on improvement.

Catriona Renfrew: A range of services will require a joint and coherent approach from the two new bodies. That is a key point. If the bodies are not similar in construction and purpose, such an approach will be difficult to achieve. The issue will be critical for people who are on the receiving end of what the bodies do. It is important for patients and clients that the bodies consider the whole spectrum of care, not just parts that are labelled "health" or "social care".

The Convener: All the witnesses have made that point clearly from their various perspectives.

The witnesses might want to submit additional evidence. I remind everyone that the Health and Sport Committee is a secondary committee and will not deal with the bill at stage 2. It will be open to members to desert this wonderful committee and sit in on the Finance Committee's consideration at stage 2—we have a representative of that committee here in Joe FitzPatrick. Members can lodge amendments, which will be considered by the Finance Committee. The Health and Sport Committee is rarely a secondary committee, so I thought that I should remind members about that.

11:52

Meeting suspended.

11:56

On resuming—

The Convener: I welcome our final panel of witnesses, who are from the Mental Welfare Commission for Scotland—Donald Lyons is the director and Alison McRae is the head of corporate services. Thank you very much for your patience—you have sat through a lot of evidence—and for your submission. We will move straight to questions.

Mary Scanlon: I will ask you the question that I asked the previous panel. Few savings are expected to be made as a result of the bill. We are looking for improvements in patient care. Rather than a huge bureaucracy, we want greater simplification and consistency. However, in your submission, you say that it is difficult to see how the bill will improve inspection and that it appears to make no provision for the investigation of incidents and events. You also say:

"There is no clarity over the arrangements for the NHS."

On complaints, you say:

"There continue to be discrepancies in complaint handling across health and social care."

I am trying to find some justification for the bill, but I do not see it in your submission.

I appreciate that a consultation on the Mental Welfare Commission is under way.

Dr Donny Lyons (Mental Welfare Commission for Scotland): It is true that those points formed a significant part of our submission. I will tell you where we are coming from. If we go into a long-stay or continuing care unit in hospital we see people—say, people with dementia—being housed in accommodation that the care commission would have closed yesterday if it had been a care home. It is clear, therefore, that the same standards are not being applied across the care spectrum for people who have very similar needs. We are looking for some way of providing a uniform minimum acceptable standard of care, treatment and accommodation that applies to every individual who has a particular health or social care need, regardless of whether they are in the health care sector or the social care sector.

It would be fair to say that we hope that the bill is a step in that direction. I agree with Fiona Mackenzie and Catriona Renfrew that it lacks the clarity that would allow us to say that it will get us there. That concerns us a bit. We would like the bill to provide greater clarity and to bring about a situation in which the recommendations that we make about a person's care—we focus very much on the individual—result in service improvements and in attention to standards that apply across the care spectrum.

Mary Scanlon: But you are not convinced by what you have seen to date.

Dr Lyons: We are not convinced by what is in the bill as it stands. A lot will depend on secondary legislation and regulations, especially in relation to health care. A lot of what I have said relates to inspection in the NHS, because that is left vague in the bill. I understand why it has been left vague—that goes back to what other witnesses have said. There are historical issues that affect what is in the bill. I am all for the adoption of an incremental approach; I just worry about how long it might take for such an approach to get us there.

12:00

Mary Scanlon: Can I ask you a question, convener? Given that—

The Convener: I do not think that answering questions is my job.

Mary Scanlon: It is important to know when we will see the regulations. Will it be before or after stage 1? Our witnesses this morning have told us that they are not convinced by what they see in the bill but that they might be persuaded by the regulations. It would help me and my party to decide whether we support the bill if we knew when we will have the regulations.

The Convener: First, I cannot answer that now, but it is a good question and we will find out. Secondly, the consultation ends on 25 September. We cannot pre-empt what the Government will do—or what anybody else will do, because other members can lodge amendments—but I think that some of your concerns will be addressed at stage 2, either by members or by the Government.

Dr Lyons: I am aware that something might be introduced at stage 2 to address the complaints issue. I have certainly seen that suggestion.

I am conscious of Dr Turner's evidence on complaints handling. There is a significant disparity between the internal resolution of complaints and the various organisations that might be involved at either a second stage or, in some cases, even the primary stage. That must be quite confusing for people and it would be helpful to have more consistency.

We used to have a complaints function in relation to mental health services. It is quite right that that was removed for simplification purposes, although that created a bit of a problem because people still think that they can complain to the Mental Welfare Commission. Of course, they can raise their concerns about services with us and, as

Dr Turner suggested, we will look into them. If we think that they are justified, we will make recommendations to put the matter right, albeit that we can do so only within a narrow remit. However, that is only for people with mental health problems and learning disabilities, who are the least likely to be able to speak up for themselves and safeguard their own interests. That is why our role is important.

The Convener: I am mindful that we will hear from the minister next week, so issues about regulations can be raised then.

Mary Scanlon: Yes.

I did not understand the point about primary and secondary complaints. I ask Dr Lyons to make the point clearer, or perhaps to give an example.

Dr Lyons: If I wanted to complain about my NHS treatment, I would complain to the health board's complaints department. My complaint would be answered, and if I was not happy, there would be a second stage of resolution within the health board. If that still did not satisfy me, I would make a complaint to the ombudsman. If my complaint was about a registered care service, I could complain to the organisation and directly to the care commission, which might take up the complaint. I am not sure, but I think that the ombudsman is able to carry out a third-stage investigation. If I do not understand the system, how can the poor patient in the NHS or recipient of a care service understand it?

Mary Scanlon: Thank you.

The Convener: I am just checking the timescales, for the committee's information. I am mindful of the fact that we are a secondary committee for the bill. I am looking at Joe FitzPatrick, who is a member of the Finance Committee, which is the lead committee. I think that the stage 1 debate will be held round about Christmas time.

Joe FitzPatrick (Dundee West) (SNP): I think so.

The Convener: We will not hold you to that. Stage 2 will probably begin at the end of January or the beginning of February, so members who have raised concerns should bear in mind that we have a reasonable lead-in time.

Dr Simpson: I have two questions. First, the Law Society has said that the MWC should be removed from schedules 3, 13 and 14. Do you agree? Under the bill, the minister has a delegated power to order you to carry out joint investigations and the right to amend your function in almost any way they wish. The Law Society appears to be extremely unhappy about that prospect because your prime function is the protection of vulnerable individuals.

Dr Lyons: That relates to part 2 of the bill. We have submitted comments on part 2 to the Finance Committee, in which we raise concerns that the powers could be exercised by a future Government in quite a draconian way. We share the Law Commission's anxieties, although we defer to its greater legal and constitutional knowledge on such matters. We know of its concerns and have raised the same concerns ourselves.

Dr Simpson: My other question is a question of principle. During the meeting, we have heard that there was not extensive consultation before decisions were made about the form of the bill and the proposals for the new organisations that are to be created. You have made it clear that the Mental Welfare Commission does not deal with individual complaints, but it can deal with people who are concerned about their care. You can take up such matters, and you have published a lot of material that show the general principles that are not being followed, based on the individual cases that you have examined. To whom do patients who do not have a learning disability, problems with capacity or a mental health problem go to get their concerns dealt with at present? To whom will they go under the new legislation?

Dr Lyons: I hope that, under the new legislation, that would be a function of healthcare improvement Scotland. I welcome the fact that the duties that are written into the bill mean that HIS can give advice. I heard Professor Teasdale say that that would be a new, potentially quite difficult and perhaps costly function for HIS, but nevertheless it is an important one. The MWC gives advice to people who have a mental health problem. You are right that, if the new body does not do that, it will be hard for the patient, who might not have anywhere to turn to. I hope that they will be able to get some help and support.

Independent advocacy is the other potential source of help and advice. It can help people to make their voice heard, which is an important part of mental health care. We hope that patient councils, the independent advocacy movement and so on will be able to help patients to put across their views about their care and treatment and help to make their voice heard so that matters will improve.

Dr Simpson: I am concerned because I have a number of individual cases relating to the overall standard of care received from a particular service—a stroke unit. Those cases do not fall within the MWC's ambit, and people are using the individual complaints procedure to try to deal with their concerns. However, that results in individual reports on particular cases; it does not put the thing together and conclude that the service is inappropriate and is not meeting adequate

standards overall. Have we missed a trick in the bill? Should we be saying to the MWC that your function should be extended to include all people, not just mental health cases or people who are specifically designated as having reduced capacity?

Dr Lyons: I will repeat what I said in response to Mary Scanlon's question. People with mental health problems and learning disability are uniquely vulnerable and are less likely to be able to speak up for themselves. That is why they are more in need of an independent safeguarding organisation, which is our specific remit. You are right that we use case studies and individual interventions to build up a picture of how a service is operating and to provide lessons for that service and similar services that will help them to improve. We agree that that model should be replicated. It would be useful to see something a bit more specific about that in the bill to give a steer that that will be a significant part of healthcare improvement Scotland's role.

Dr Simpson: Are you happy about having a duty to co-operate? For example, the capacity of someone who has had a stroke may be temporarily impaired, so by the time that they complain to you they may no longer have that impairment. Would you work with some other group—I presume that it would be HIS in such cases—to look at a service that was causing problems?

Dr Lyons: It is more basic than that. It has more to do with how our work on individual cases will dovetail with the service inspection and improvement functions of the two new organisations. You will be aware that we have completed a major piece of work, along with the care commission, on people with dementia. We are about to embark on an important piece of work with NHS Quality Improvement Scotland on the care of people in intensive psychiatric care units. We are happy to have the duty to co-operate; we co-operate already. We would like to be able to co-operate without requiring ministerial approval because we can, on a proportionate basis, just go ahead and do things, without making the process too bureaucratic.

The Convener: That makes sense.

Dr Simpson: I hope that you will help us to draft amendments, if we get to that point.

The Convener: Richard Simpson makes the important point that capacity is not always fixed—it is possible to have capacity at some times and not at others. That must always be remembered in the provision of services.

Helen Eadie: I, too, noted and read with concern that, although the MWC

> "had been involved in some discussions leading up to the Bill's publication, this Bill had not been subject to the same pre-legislative scrutiny as other pieces of legislation"

in which it had been involved. The witnesses may wish to comment on that point.

Before they do so, I ask them to comment further and more specifically on a point that is made on page 2 of the submission, which relates to an issue that I raised with Sir Graham Teasdale. The submission states:

> "SCSWIS will be a non-departmental public body and HIS will be a special Health Board."

Later, it says:

> "In reading the way these organisations are constituted, as per the schedules to the Act, it appears that both organisations will be independent. However, HIS would be constituted under the NHS Act. We are somewhat confused by this and would welcome clarification."

Could you expand on that point?

Dr Lyons: We are somewhat confused by the provision. It goes back to some earlier discussions that took place following the cabinet secretary's announcement last November of the intention to create the new organisations. At that stage, it was clear that the social care body, SCSWIS, would be an independent non-departmental public body. We believe that the initial intention may have been to create the health care body in the same way, but because of the tradition of NHS Quality Improvement Scotland working within the NHS, that decision was reversed in favour of creating a special health board. That scuppered any idea of the Mental Welfare Commission being included in the body, because the commission's functions have to be exercised independently of the NHS, for many reasons. I can go into those, if members would like, but it is another question.

In the bill, the two organisations appear to be constituted in a similar way, the only difference being that one is constituted, in effect, under the bill and the other is constituted by amending the National Health Service (Scotland) Act 1978. Although one will be an NDPB and one will be a health body, their constitution does not look particularly different. That is all that I am saying. I am not sure that I understand the situation any more than that.

Helen Eadie: I appreciate those helpful comments.

The Convener: Do you wish to comment on part 4 of the bill? I note that you have submitted evidence on other parts of the bill to the Finance Committee. Do not feel obliged to say anything, but we would be delighted to hear any comments that you wish to make.

Dr Lyons: Others have mentioned the issue of records inspection. In our written submission, we

express concern about whether the broad authority of anyone in SCSWIS to inspect health care records is consistent with data protection principles and the common law on confidentiality of medical information. I would like to re-emphasise that point here. It may be that health care professionals within SCSWIS will do that work. However, I would be surprised if the information commissioner did not have more to say about expanding that authority to all professionals.

Otherwise, we think that there is merit in the formation of SCSWIS, as it offers people an opportunity to deal with the way in which individual care is commissioned and managed by local authorities and the way in which that care is delivered by independent social care services. From our experience of care home issues that we have identified and discussed with both types of organisation, we can see a useful synergy there.

12:15

Mary Scanlon: I talked earlier about the tick sheet at the appendix to your submission, so it is only fair that you are allowed to talk about that now.

You say that that you do not see consistency in the bill and, with reference to the functions under parts 4 and 5, you say that care services in the independent health care sector fulfil 10 out of the 11 functions and that social services fulfil seven. However, you say that there appears to be a lack of clarity around the position with regard to the NHS, which means that you can say only that it fulfils five of the 11 functions.

I am looking for more consistency, more simplification and more clarity. However, you seem to be saying that the bill will not bring that. I do not want to put words in your mouth, of course.

Dr Lyons: In the submission, we ask whether the committee is happy to live with that uncertainty and to leave matters to secondary legislation or whether you would prefer to see something in primary legislation that ensures that there is a setting of standards and a monitoring of care against standards in the NHS in particular. We think that that would be helpful, because we see ourselves as having a role to play, especially with regard to standards for people who are subject to compulsory measures—we could, perhaps, inspect ourselves against those standards—and in situations in which we find that a person's care is not as good as we think that it should be. We at least have some standards that we can compare that with. At the moment, we use what we sometimes call the standards of the bleeding obvious or the standards of basic human decency. It would be good if we had something a little bit more concrete than that. Personally, I would like those issues to be dealt with in primary legislation. However, if we can be assured that secondary legislation will be clear in that regard, we will not die in a ditch over the matter.

The Convener: I think that Mary Scanlon knows what to ask the minister next week.

I thank our witnesses for their attendance. Before we conclude this session, I would like to clarify something. Is SCSWIS pronounced "sixwizz" or "skizwizz" or something else?

Dr Lyons: I like "sixwizz".

The Convener: We will perhaps take a vote in private on how to pronounce it.

Subordinate Legislation

Food Irradiation (Scotland) Regulations 2009 (SSI/2009/261)

12:18

The Convener: We will move on to the next item quickly, as we have a lot of work to get through today and a debate in the chamber in the afternoon.

The next item of business is consideration of a negative instrument, copies of which members have before them, along with a note from the clerk.

The Subordinate Legislation Committee considered the regulations at its meeting on 8 September and drew our attention to several defects in their drafting and scope. It noted that the regulations breached the 21-day rule in relation to the laying and coming into force of a negative instrument, but it accepted the Scottish Government's explanation of why that had occurred. It also noted that the regulations raised certain devolution issues on the transposition of European Union directives. The Scottish Government has given an undertaking to introduce an amending instrument to address those matters.

As members have no comments to make, do we agree that we are content with the regulations?

Members *indicated agreement.*

12:19

Meeting continued in private until 12:28.

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