HEALTH AND SPORT COMMITTEE

Wednesday 23 September 2009

Session 3

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HEALTH AND SPORT COMMITTEE
24th 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:

Adam Ingram (Minister for Children and Early Years)
Shane Rankin (Scottish Government Primary and Community Care Directorate)
Shona Robison (Minister for Public Health and Sport)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Wednesday 23 September 2009

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

Decision on Taking Business in Private

The Convener (Christine Grahame): Good morning and welcome to the 24th meeting in 2009 of the Health and Sport Committee. I remind members and all witnesses to switch off their mobile phones and other electronic equipment. Apologies have been received from Ross Finnie.

Do members agree to take in private, as is normal practice, agenda item 5, which is consideration of our approach to a draft report on the Public Services Reform (Scotland) Bill?

Members *indicated agreement*.

Public Services Reform (Scotland) Bill: Stage 1

10:04

The Convener: Agenda item 2 is the concluding oral evidence session in our scrutiny of the Public Services Reform (Scotland) Bill. I refer members to paper HS/S3/09/24/1—a very full paper, as members will appreciate—which summarises some of the key issues that have emerged from our evidence sessions so far.

I welcome Shona Robison MSP, the Minister for Public Health and Sport, and Adam Ingram MSP, the Minister for Children and Early Years. They are accompanied by Kirsty McGrath from the Scottish Government solicitors office; Shane Rankin, project director of the scrutiny bodies project team; Andrew Macleod, head of the patients and quality division; and Adam Rennie, deputy director of the community care division. After the Minister for Public Health and Sport has made some brief opening remarks, members will be ready to move with alacrity to questions. Helen Eadie is looking full of alacrity today. Are you first on my list?

Helen Eadie (Dunfermline East) (Lab): Yes.

The Convener: There you go—we have a bid already. That was a pre-emptive strike.

The Minister for Public Health and Sport (Shona Robison): After I have made a short opening statement, Adam Ingram and I will be happy to take questions.

First, when the changes resulting from part 4 and part 5 of the bill are implemented, what service users should see is simply a quality service that meets their assessed needs. They should certainly not see any reduction in services. However, behind the scenes the processes that drive that quality should be more effective and streamlined. The new bodies should be able to focus their improvement and scrutiny efforts specifically on the processes that are needed to ensure quality outcomes for service users.

Secondly, I am sure that we all recognise that the way in which care is delivered to people has been changing. We are moving to deliver more health care and social care to people in the community and in their own homes, and moving away from care based in care homes or hospitals. The public now expect that style of care. Services must continually adapt to the changing needs and aspirations of individuals and their families. It is right that scrutiny of the assessment of need for such services, the planning of services and their delivery should also change to keep pace with those developments.

In our view, the real changes in scrutiny that we want cannot be achieved by the current scrutiny bodies, with their existing powers and functions. Those bodies are very different organisations, with different methodologies, standards and programmes of scrutiny and improvement. The bill provides the opportunity to create two new scrutiny bodies that fulfil the Crerar scrutiny principles: public focus, independence, proportionality, transparency and accountability.

We are not starting with a clean slate. The existing bodies have work to do in performing their current scrutiny and inspection roles as well as in preparing for the changes. However, I am firmly of the view that what we are doing is right for the current situation. Although the level of change that we seek has its challenges, it is manageable in the timescales that are proposed.

Adam Ingram and I are happy to take questions from the committee on part 4 and part 5.

The Convener: This is not mandatory—it is discretionary—but would it be useful for us to ask questions about part 4 before dealing with part 5? Such an approach might assist us in preparing our report. However, members may want to blend questions on the two parts; it is up to them.

Mary Scanlon (Highlands and Islands) (Con): I have read further into the bill and would like to ask some questions about section 13, on burdens, as well as about part 4 and part 5. That is an important issue for the national health service. I would also like to ask some questions about the scrutiny provisions in part 6, which are hugely important to the NHS. I am happy to leave my questions to the end, if you wish.

The Convener: That is fine, as part of a sweeping-up exercise. I was merely offering guidance on how we might bring together evidence easily for our report, as a secondary committee, to the lead committee on the bill, which is the Finance Committee. We have only one day in which to do that.

Helen Eadie: I do not know which minister will answer my question—I leave it to them to decide.

The reports and papers that we have read highlight concerns about the lack of consultation that took place on the bill. Ministers cite the consultation that was done by the Crerar review as one reason for their view that consultation has been sufficient. We have been informed that Crerar

"sought the contribution from a range of organisations and stakeholders",

but that

"the Scottish Government set up a Project Implementation Team … to oversee the development of proposals".

The review identified as a priority the need to decide on the external scrutiny priorities for health, because it was important to get that sorted before any work was done to establish external scrutiny bodies. What do you view as the external scrutiny priorities for health?

Shona Robison: On the issue of consultation with regard to the Crerar review, there was no doubt that everybody could see the direction of travel; it was not a secret that the proposals were around. People were aware of the main thrust and focus of the proposals, if perhaps not the detail.

There was certainly adequate consultation around the Crerar review. We are now focusing on the detail: the parliamentary process has enabled organisations to give their views, and the Health and Sport Committee has taken evidence from a range of organisations. We have reflected on those views, and the decision to step back from including the Mental Welfare Commission for Scotland in the bill was part of our on-going discussions with the organisations concerned.

With regard to Helen Eadie's second question—

Helen Eadie: It was about the external scrutiny priorities for health. Crerar took the view that delegation to an external scrutiny body should take place only once those priorities had been identified. What are those priorities?

The Scottish Parliament information centre briefing states:

"The Review was clear that this should take place only after the external scrutiny priorities for health had been identified."

What work have you done on that, and what are the results?

Shona Robison: Are you referring to the quality improvement Scotland standards?

Helen Eadie: In discussing the establishment of a national scrutiny body, Crerar recommended that

"functions and resources from within NHS QIS and the Scottish Government's health directorates, as well as resources controlled by the Care Commission in relation to private hospitals and related treatment be redistributed to an external scrutiny organisation",

but that that should take place only after the Government had identified the external scrutiny priorities for health.

Shona Robison: The scrutiny priorities for health have been identified. There has been a particular focus on the establishment of the healthcare environment inspectorate—we have decided that that is a priority for the new healthcare improvement Scotland body. Such a focus is right and proper, given the high-profile

cases and the concerns that have been expressed.

The model of developing the healthcare environment inspectorate within HIS does not preclude that type of development in other areas of the health service. That will be for HIS to develop over time, and I emphasise that the body will be well placed to respond to individual issues that arise in the health service. Those issues might include a concern around the performance of a particular health board or hospital, or an emerging theme such as health care acquired infection, which we believed had to be dealt with by a body such as the healthcare environment inspectorate that could undertake a systematic examination and reassure the public that that level of scrutiny would be proportionate.

That is an important part of what HIS will do with regard to external scrutiny, but it is by no means the end of the story. I do not know whether that answers Helen Eadie's question. HIS will be able to develop other services as it sees fit, but that is the one to which we have given priority.

Helen Eadie: I want to expand on the question.

The Convener: I will let you back in, but I have a list of members who want to ask questions. Please make your question short.

10:15

Helen Eadie: Infection is obviously a big issue for us all. It was a matter of concern for NHS Greater Glasgow and Clyde, which questioned what would happen when HIS and another body overlapped, for example in the work of Health Protection Scotland. What would happen in that situation?

Shona Robison: At the moment, NHS QIS and Health Protection Scotland work closely together. They have had to do that because of some of the challenges that we have faced. Those working relationships are very much in place. In fact, when I conducted the annual review of NHS National Services Scotland, of which Health Protection Scotland is a part, it spent a great deal of time talking about the work that Health Protection Scotland had done around health care acquired infection. Those links are very much there. That is one of the reasons why it is important that HIS is and remains a health body, albeit that it will be a non-departmental public body. It remains part of the health family, if you like, and that is important given the important relationships that have been built up over time. I see HIS not only maintaining those relationships with Health Protection Scotland, but enhancing them. There is the opportunity for that to happen.

Helen Eadie: I would like to come back in later with further questions.

The Convener: Yes. I want to let other members in at the moment.

Rhoda Grant (Highlands and Islands) (Lab): I have a question on the independent health care sector. We received evidence that the Regulation of Care (Scotland) Act 2001 had allowed for regulation and inspection but that that had not happened for high street health care providers, laser clinics and the like. The fact that such providers are not subject to regulation and inspection is quite worrying, given the number of new treatments that are being offered in the cosmetic industry, for example. Those treatments can be quite dangerous if they are not properly regulated to ensure that they meet standards.

Shona Robison: What has happened since the 2001 act falls under previous Administrations and our Administration. We should not underestimate the complexities of taking that work forward; I will say more about that in a moment. You are right to point out that the environment has changed since 2001, with the burgeoning of cosmetic procedures that were not around on the same scale when the legislation was enacted.

Of course, the focus of the 2001 act was very much on the services that are provided by a general medical practitioner or a dental practitioner. The thinking was very much around those types of services. Services that have been regulated include independent hospitals, private psychiatric units and hospices. There have been a number of other developments, under the previous Administration and under our Administration, around national care standards. It is not the case that nothing has been happening. For example, national care standards were developed on independent specialist clinics in 2004, on dental services—jointly with NHS QIS—in 2006 and on independent medical consultants and GP services in October 2007. All that has paved the way to the next stage of regulating those services.

It is my intention that there will be a consultation in spring next year to look at the definitions of the services that will be regulated. The matter is not simple, and there are a lot of different independent clinics out there. The definitions under the 2001 act and in the current bill would have to be adjusted to cover those services.

We will regulate after the consultation next spring. However, we will have to ensure that that is proportionate to the requirements and their costs. We will have to consider priorities in terms of where to start with independent health care that is currently not regulated. I reassure members that many such services are covered by professional bodies, which is a point of reference for anyone

who is concerned about the quality of treatment that they receive. However, I accept that, although there is work in progress, more needs to be done, particularly around the changed landscape of what is on offer in the high street. We will move that forward by consulting in the spring.

The Convener: You said that definitions in the legislation may require to be amended. For clarification, does that apply to the Regulation of Care (Scotland) Act 2001 or the Public Services (Reform) Scotland Bill?

Shona Robison: It applies to both.

Rhoda Grant: I understand that health care practitioners are members of professional bodies and are subject to regulation. What is more worrying is the high street cosmetic industry that involves not health professionals but people who, if we are lucky, have done a one-day course on delivering a treatment, which means that things can go desperately wrong. I leave you to think about that.

Shona Robison: I acknowledge that that situation exists; that is exactly why I want to consult in the spring. Many cosmetic services do not involve general medical practitioners or general dental practitioners, so they are not caught by the 2001 act or, indeed, by the current bill. It is important that we get the definitions right, so that we can then regulate. I am happy to give a commitment to do that.

Rhoda Grant: The bill could provide an opportunity for regulation and standards to be streamlined. Certainly, any plans for building new hospitals in my part of the world involve creating hubs with community services. At the weekend I visited Barra, which has a care home and a hospital together. However, both sides have to jump through hoops regarding the shared services of laundry and catering, because there are different standards and regulations on each side. They are subject to different inspections and have to tick every box for both. It seems to me that there is a missed opportunity in the bill for streamlining, so that both sides would have similar standards.

Shona Robison: We can consider whether a review of that area would be appropriate, taking account of the work that is being done on standards and outcomes for the new scrutiny bodies. I am not sure whether legislation would necessarily hamper progressing locally the issues that you describe. We may wish to consider such issues as part of our work on reshaping services for older people and considering different models of care, and to assess whether there are barriers to more joint services being developed and delivered locally. I am not sure that we need to address that issue in the bill, but I am happy to consider it.

Rhoda Grant: It would certainly be an issue for the regulations and the inspection regime.

The Minister for Children and Early Years (Adam Ingram): I think that—

The Convener: Ah, welcome! I know that you have been paying attention.

Adam Ingram: Yes. Rhoda Grant has made a relevant point about establishing consistency of practice and making standards consistent across the piece, in health or social care. We have an opportunity to move in that direction. We perhaps see that most clearly in the proposed integration of the care commission and the Social Work Inspection Agency. We are not looking for one to replicate the other, but trying to combine the best features of both.

On health and social care, there is an opportunity to establish consistent standards across the piece, particularly given the focus on outcomes for service users that now exists. Rhoda Grant is right to highlight an important point. Of course, all the relevant bodies have a duty to work together and co-operate. I anticipate that the professionals and managers in those organisations will work together to establish consistently high standards across the piece.

Shona Robison: I suspect that it would be better for the new bodies to do that once they are established. A lot of the direction of travel is towards outcomes-based approaches. I imagine that considering how they might achieve more consistency across the standards that apply could be an early priority for the new bodies. I am not sure that that is an issue for the bill; I think that it is an issue for the new bodies to think about. If, down the line, legislative change is required, I am sure that we would consider that, but it might not be required.

The Convener: I think that Richard Simpson has a supplementary.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Yes, Rhoda Grant picked up one of my questions.

The Convener: How dare she!

Dr Simpson: I am ticking off my questions.

One of the main thrusts of the Crerar report was to reduce the duplication of inspections to achieve consistency and, if not a lighter touch, an approach to inspection that is less burdensome to the body that is inspected but which still gives the public confidence. I want to follow up on Rhoda Grant's question. We are really talking about interfaces, which will still exist in the new system. The local authorities are such an interface, in that

they will have tender contracts with a number of providers, which will be inspected by the new body—social care and social work improvement Scotland or whatever we decide to call it.

I have two questions about that. Does the bill adequately provide for a duty of co-operation that will reduce the number of inspections and avoid duplication? Secondly, does the bill allow for the pre-accreditation of service providers as a group so that they do not have to go through re-accreditation with each of the 32 local authorities, as happens at the moment? If the bill dealt with those two issues, it would help to bring about a substantial reduction in the administrative burden on the voluntary sector, which, as you know, is under huge pressure.

Shona Robison: I think that I am right in saying that Community Care Providers Scotland raised an issue around that in its evidence.

Local authorities are responsible for arranging services to meet the needs of a wide range of people and when they do that through contracting with independent providers, they need to establish and monitor contracts and so on, to ensure that they discharge their duty of care to the individuals concerned. CCPS suggested that there should be a duty on local authorities—in section 84, I think—to consult and take account of inspection reports and gradings in all service retendering exercises. We would want to discuss that specific request further with the Convention of Scottish Local Authorities. I can see why such a duty is being called for, and I have some sympathy with the request.

Dr Simpson: That is a slightly different issue, which is about whether the tendering process takes into account the quality assurance work that has been done. As you know, the Local Government and Communities Committee is looking into such matters following the "Panorama" programme, which indicated clearly that tenders are awarded to providers that offer poorer quality but lower costs. However, that is a separate issue.

10:30

My question is really about pre-accreditation. Can the right to bid be reserved for service providers who are accredited and, therefore, whose quality is assured? At the moment, if a voluntary organisation wants to apply to a local authority to provide a service it must go through a pre-tendering process and it could have to do that with 32 different local authorities. We must get rid of that sort of bureaucracy. The new centralised body, by accrediting service providers that meet quality standards in the services that they provide, would enable that pre-tendering process to be removed, which would reduce red tape and bureaucracy considerably.

Shona Robison: So SCSWIS would have a list of approved providers, if you like.

Dr Simpson: Yes. It would not determine the tender outcome, which is a separate matter.

Shona Robison: I am with you; I understand.

Adam Ingram: That approach has not been considered and it ought to be. That is something that we should take away with us and perhaps address in stage 2 amendments.

Clearly, the point that Shona Robison made about local authorities' contract compliance work and how that crosses over into inspections is another issue that is exercising us. We obviously want to cut out duplication of effort. We need to think some more about both those issues and I hope that we can bring something back at stage 2.

The Convener: I have not forgotten that Mary Scanlon has a supplementary on duplication.

Mary Scanlon: Yes, I do. It is an appropriate time to raise the point that Rhoda Grant mentioned. The hospital in Barra is an ideal example of the issue, because it is both a hospital and a care home. I refer you to the Mental Welfare Commission's evidence, which points out that

"HIS can recommend improvements to the NHS."

The MWC's submission also states that

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

and that

"investigation of incidents and adverse events"

is not clear either.

The MWC's submission includes a tick sheet that indicates areas in which regulations will be made. Last week I raised the point that, while the care service in Barra will be subject to 10 out of the 11 functions outlined in parts 4 and 5 of the bill, at the moment we know that the NHS will be covered by only five out of 11 functions. The main reason for that lack of clarity is that, for the NHS, regulations will specify inspections. So we know how one half of the building will be regulated and inspected, but we do not know how the other half of the building, which is part of the NHS, will be regulated and inspected. Sir Graham Teasdale and many others confirmed that point at last week's meeting. In responding to that, minister, can you also say when the regulations will be made?

Shona Robison: I assure you that the regulations will be drafted before stage 2.

I saw the MWC's table reflecting its view of the functions in relation to the NHS and I disagree with

its analysis for a number of reasons. I will take them one by one. On the function of recommending improvements, the MWC says that, with regard to the NHS, it is

"Unclear. Regulations specify content of inspections".

As you say, the MWC makes a similar comment about the functions of investigating incidents, and of issuing improvement notices and condition notices. That will all be able to happen under HIS because of the governance arrangements for the NHS, which go back to the National Health Service (Scotland) Act 1978. It is clear that ministers have extensive powers of intervention in the NHS when it comes to service improvement and when it comes to taking direct action. Over the past few years there have been occasions when fairly drastic action has been taken to address health board performance and improvement.

In the NHS, we tend to carry out service improvement through partnership. At the moment, that work is taken forward with NHS QIS, and the approach has been very effective in driving up standards and ensuring service improvement. Those methodologies will move across to HIS, which, as an independent body, will be able to look at whatever parts of the NHS need to be looked at and will report to ministers on the appropriate action that needs to be taken. I do not accept that there will be any inability to take action, whether through improvement notices, condition notices or anything else. In effect, HIS will send reports to ministers, who, I assure you, will take appropriate action. That has certainly proven to be the case with the current system under QIS.

Mary Scanlon: The minister might not agree with the Mental Welfare Commission for Scotland. However, in its own evidence, QIS says:

"In contrast to the other functions of HIS, each of the areas above introduces a responsibility in relation to independent healthcare services, the equivalent of which will not be applicable to"

the

"NHS".

The organisation seeks "a common approach" and goes on to say:

"While the NHS is heavily performance managed it is not formally regulated as such, and the sanctions that can be invoked are less explicit."

The fact is that we need more clarity and consistency.

Shona Robison: But QIS is absolutely right. The governance arrangements will be different. HIS, as you have outlined, will regulate the independent health care system in a particular way. The NHS's governance arrangements might be different, but that does not mean that they are any less effective. In fact—

Mary Scanlon: But we do not know what the arrangements are. That is the problem.

Shona Robison: I have just explained what they are. QIS, as is, or HIS, as will be, can be required to examine a particular situation in the NHS; indeed, QIS looked at the issue of health care acquired infections in its report on outbreaks at the Vale of Leven and other hospitals. That work led to the establishment of the healthcare environment inspectorate, which has significant powers and responsibilities.

As for the NHS's general governance arrangements, I can assure you that if any part of the NHS—an individual hospital, for example, or a health board—requires to be looked at, HIS will carry out that work. Under the arrangements, ministers are accountable for the NHS and, as is laid down in statute, it is up to them to take any appropriate decisions. Of course, that is different to what is laid down in statute for the independent health care sector. I agree that the legal bases for the arrangements for the independent health care sector and the NHS are different, but that does not mean that, as far as outcomes are concerned, failings in the NHS would receive any less attention than failings in the independent health care sector. I assure you that action will be taken to address failings in the NHS, but it will be taken by ministers.

Mary Scanlon: That is the problem. As you say, action will be taken after failings come to light. What we want is a service that will be scrutinised equally, that will be proactive and that will try to prevent failings.

The Convener: Mary—

Shona Robison: It is important that I come back on that, convener.

The Convener: I will let you answer the question, minister, but I must tell Mary Scanlon that she has had a very long supplementary and that I am now going to let in other members, who have been waiting quite a while.

Shona Robison: It is important that I reassure Mary Scanlon on this point. We do not simply react to incidents—although I should stress that we certainly do react to any incidents that arise. The system is very proactive; it is, after all, a performance management system with constant monitoring and evaluation from the centre—perhaps far more than you realise—of the performance of services and boards and indeed of every aspect of the NHS. We are, therefore, able to pick up at an early stage if things are not going to plan or standards are not being met as they should be. I assure you that, if that is the case,

swift action is taken to address that. The system will be proactive.

Michael Matheson (Falkirk West) (SNP): I will deal with some of the practicalities of the proposed reforms, particularly around the merger of some organisations. As ever, the process of change management is never easy or smooth, and I suspect that bringing together different organisations that have different cultures, methodologies and approaches can result in difficulties, particularly around the time when they are starting to work as a single unit.

I am anxious to ensure that the frequency and the quality of the inspection process during the course of the merger is fully maintained and remains credible, in order to provide service providers and users with that assurance. What action is currently being taken to ensure that that process is managed as effectively as possible, so that we can protect the integrity of the change process?

Adam Ingram: Obviously, the key objective of bringing together organisations such as the care commission and SWIA is to integrate the methodologies, standards and programmes of scrutiny. However, the focus is clearly on improving outcomes for service users. For that to happen, we need a whole-systems approach to issues such as the planning, commissioning and delivery of services. For example, a care commission inspection of an old folks home does not tell us whether a person who is in that home should be there in the first place—it might be that there would have been a better outcome for that user if they had had a community care placement or support at home, for example.

How that is to be done is a matter for the professionals and managers within the system to work out. I recognise that that will not happen overnight and that it will have to be worked at to bring it to fruition.

On your point about the changeover from the current practice to the new body, everyone who is involved in the current round of inspections will continue to do that work. Obviously, a key task is to ensure that there is no loss of focus on the current rounds of inspections. Indeed, I have commissioned a new round of child protection inspections, which, as you know, are Her Majesty's Inspectorate of Education led.

That focus cannot be lost. Inspectors will still be conducting their programmes of inspection while managers and others are engaged in sorting out the new organisations and the new approaches. Obviously, ministers have to keep on top of that situation, but I assure you that the issue that you highlight is recognised, and people will be ensuring that the focus on the key task of inspection is not lost.

Michael Matheson: The second point that I want to raise is a matter that was brought to the committee's attention by CCPS. It pointed out that the care commission, acting on an independent basis, is responsible for investigating complaints that are made against the voluntary or independent sector around the quality of service provision, but that there is no similar approach in relation to the quality of commissioning and service provision by local authorities, as complaints in that regard are handled by the local authorities themselves, which CCPS says compromises the independence of that investigation process. CCPS seeks a level playing field.

10:45

I confess that I was somewhat confused by its evidence and I think that it misinterpreted some of the processes that are at play. However, have you been able to reflect on its concerns? I hope that my interpretation of what it was trying to say is correct. If not, I am sure that CCPS will write to me.

My understanding is that, if a family is concerned about the way in which care is provided in a nursing home, they can raise concerns with the home and if they are still concerned they can take the matter to the care commission. If they are concerned about the way in which the assessment for the care home placement was carried out, they can complain to the line manager at the local authority and the complaint will go through the local authority's complaints process. CCPS suggests that there should be an independent aspect on the commissioning side. What are your views on that? Personally, I think that there are professional standards issues that complicate the matter somewhat, but it would be interesting to know whether you think that there is a need for an independent investigatory role on the commissioning side.

Adam Ingram: As I said in my previous answer, looking at planning, commissioning and delivery across the spectrum will be one of the tasks of the new body, SCSWIS. I refer to the report of the fit-for-purpose complaints system action group—that is a bit of a mouthful. The group was established in response to Crerar. Interestingly, its report suggested that, as a general rule, the complaints-handling function should not be embedded within bodies that have an inspection and regulation role, but that an exception could be made to protect particularly vulnerable service users. That is what happens with the likes of the care commission. Because vulnerable people in a care home may not wish to make a complaint direct to the provider, it is possible for them to complain direct to the care commission. There is no intention to

change that. It will still be possible for vulnerable service users to go direct to the care commission.

At the same time, we do not want to allow direct complaints to the new bodies on the issue of commissioning, for example. We want the Scottish Public Services Ombudsman to play a new role in setting up the appropriate complaints-handling system. I think we have already flagged up that that approach will come through in amendments at stage 2.

I hope that that deals with the issues that you highlighted.

Michael Matheson: Just to be clear, my understanding is that, if a family is concerned about the commissioning aspect, they can pursue the matter locally with the commissioning service, such as the local authority.

Adam Ingram: Yes.

Michael Matheson: If they are dissatisfied with the outcome, they can go to the Scottish Public Services Ombudsman. What will be different? Will the ombudsman set out what the pathway should be within the local authority and how the matter should be handled?

Adam Ingram: The ombudsman will work with the bodies to design a new complaints-handling system. The preferred outcome is to address complaints more efficiently, effectively and timeously. The idea is to reform the complaints-handling system to improve outcomes for service users, and the ombudsman's office will now have another string to its bow. As well as handling complaints, it will help to design the complaints system in each of the bodies, such as the local authorities.

Michael Matheson: Will the same design be applied across all 32 local authorities for consistency in approach?

Adam Ingram: Absolutely. That is the intention.

The Convener: I make it plain to the committee that, although we will not scrutinise the bill at stage 2—it will be for the Finance Committee to deal with it—any member can go along to the Finance Committee to discuss the particular aspect that we are dealing with. The complaints process is of substantial interest to the committee. Members can also move amendments to the bill at that stage.

Michael Matheson: The process does not prevent someone from raising a complaint against an individual professional with the regulatory body if they have concerns about their professional conduct. That, again, is somewhat different from the independent voluntary sector.

Adam Ingram: Yes, absolutely. That is correct.

The Convener: Ian McKee has not asked any questions, yet. I will let other members back in if they are itching, but I will let Ian ask his questions first.

Ian McKee (Lothians) (SNP): As for anyone who comes in lower down the batting order, some of the points that I was going to raise have been partially dealt with.

I agree with you that we are looking for an integration rather than a simple merging of organisations. However, I wonder whether the Government has underestimated the difficulties involved in the process. For example, some of the staff of the organisations that are to be merged will come from a civil service background whereas others will not. Some organisations have a way of working that gives them access to individual case notes, whereas other organisations look more at general procedures and do not have that culture. Therefore, there is a question about who will be able to see people's case notes in the future.

We have seen the example, in practice, of the formation of community health partnerships. There has been some integration between health and social work at the top level, but there are an enormous number of areas at grass-roots level in which that integration has not taken place at all because it has been a top-down scheme rather than a bottom-up scheme.

I wonder whether you have underestimated the difficulties involved in the process. How do you feel that such problems will be overcome?

Adam Ingram: We have some experience of this. In the previous session, we passed primary legislation to allow the joint inspection of children's services. The same arguments, points and comments were made then. The British Medical Association, the General Medical Council and others were concerned about such issues as access to health records. However, those issues were resolved by establishing a code of practice for access to health records and I expect the same type of thing to happen for the joint inspection of adult services.

No issues have arisen from the joint inspection of children's services and I do not expect us to run into specific difficulties in the joint inspection of adult services. We are bringing people together from across the spectrum of scrutiny agencies to work together, and the template that was established for the joint inspection of children's services is useful in forecasting what might happen in the joint inspection of adult services.

Ian McKee: I hope that that will be the case, although, given the functions of HIS, there might be far greater need for bodies to look at individual case notes, which causes some worry among

professional bodies—and it will probably cause worry among patients when they discover it.

Adam Ingram: That is where the code of practice is imperative. The intention is to consult on this and to try to get consensus across the piece. It is vital that we have access to these kinds of records.

Shona Robison: We are very aware of sensitivities and we need to reassure people about that. Nothing in the bill is contrary to the Data Protection Act 1998. The code of practice is a good solution; it has been tried and tested. It is a case of reassuring people while that is being developed. As Adam Ingram said, it is important that we ensure that the services are as effective as possible, without any barriers.

Ian McKee: I accept that you are looking for integration, which we have all agreed is a good idea, but why do you persist in saying that there will be a Scottish health council, which seems to be the opposite of integration, especially considering that, with the advent of directly elected health boards, the function of a Scottish health council would seem superfluous?

Shona Robison: The Scottish health council has had an important role, not least because it has been developing participation standards, which will be extremely important in ensuring proper consultation and involvement of the public in health board activities. The governance arrangements around the Scottish health council may change as it becomes part of the new HIS body. I understand where you are coming from. The governance arrangements of health boards would of course be modified by direct elections, although we should remember that the elections are being piloted and that change will not happen overnight. The role of the Scottish health council within the existing structure will be important for some time. Regardless of whether the health board is directly elected, it is still important to have a body that ensures that public involvement is of a sufficient quality to meet the participation standard, for example. Even with direct elections, there is a role for a body to ensure that the public are involved, particularly in relation to service change and redesign. That role should continue.

Ian McKee: I have a final short question. If you think that that is important, would it not be a good idea to say that the Scottish health council "shall" be established, rather than that it "may" be established? Under the bill, you are leaving it to HIS to decide whether it is established.

Shona Robison: I do not think that you should read anything untoward into that wording in the bill. It is to do with the way that legislation is phrased. There is every intention that the Scottish health council will continue, albeit with amended governance arrangements within HIS. The Scottish health council is doing a lot of important work around the public involvement standard, which we want to continue. The word "may" is merely a word in the bill; it does not give any indication of any direction of travel. We are very committed to having the Scottish health council, albeit under the new arrangements of the new body.

The Convener: I do not know that we all agree that "may" is just a word in the bill. "May" and "shall" are big words in legislation. So is an "and" or an "or" in a list of clauses.

11:00

Dr Simpson: We have taken evidence from a number of bodies—including NHS Quality Improvement Scotland and the Mental Welfare Commission for Scotland, as well as a written submission from the Law Society of Scotland—that expresses considerable discomfort at the breadth of the ministerial powers in the bill for creating, altering or even disbanding bodies without there being further recourse to Parliament. It has been pointed out that many of the bodies concerned were set up by primary legislation that was approved by Parliament, but the Government will now take powers that will enable it to do pretty well what it likes with them. Having been one, I understand that ministers wish to seek as many powers as they can in order to be as flexible as possible in addressing the changing circumstances that health and social care services face, but some of us—not only those who have given evidence—feel a little uncomfortable at the breadth of the powers that the Government seeks.

Shona Robison: I will try to reassure you on that point. The order-making powers in part 2 of the bill provide an alternative parliamentary procedure that allows ministers to introduce proposals to improve the exercise of public functions—and for that reason only—without the need for primary legislation. It is not the case that ministers would be able to make any changes without recourse to Parliament, because changes would be made under the affirmative procedure. In fact, we are describing it as a super-affirmative procedure in that it could not be done without full statutory consultation, parliamentary scrutiny and approval by affirmative resolution of the Parliament. That should reassure you that Parliament would have to approve any changes before they were made.

It is important to explore what the changes might be, because that might also help to reassure you. Because of the safeguards and preconditions in section 12, any changes would have to be proportionate to the policy objective, so it would not be possible to remove the judicial role or

interfere with the procedural safeguards that a body such as the Mental Welfare Commission provides.

I will give you a scenario to describe what we mean when we talk about public functions. We are in fairly stringent financial circumstances that will continue over the next few years. At some point, ministers may feel that we should consult on and discuss merging bodies' payroll and back room functions. That may be an important measure to consider in the near future and it is the kind of thing that it would surely be good to be able to do through affirmative procedure rather than having to introduce primary legislation.

I will give another example. At the moment, the Mental Welfare Commission and the Mental Health Tribunal for Scotland both collect information on the number of orders that are made and the period for which they are made, but they suggest that only one of them should do so. Without the power in the bill, primary legislation would be necessary to enable that. That does not make any sense to me for a practical measure that would be subject to parliamentary scrutiny and is concerned with tidying up and ensuring efficiency.

By giving those examples, I have tried to show you the thinking on the power. Of course, no such changes could happen without the Parliament's approval. That is the ultimate safeguard and an important one.

Dr Simpson: It is extremely helpful to have that on the record, minister. You gave a clear reply and good examples.

Does section 12 require that the bodies themselves be consulted about a proposed transfer? I am trying to read it again to find out. As you said, Parliament will certainly be consulted. You may want to come back to us on that.

Shona Robison: We will check that and come back to you on it.

Dr Simpson: The Law Society of Scotland has expressed concern that, notwithstanding the withdrawal of the Mental Welfare Commission for Scotland from the process so that there can be further consultation on precisely how it will slot into any new arrangements, the commission still appears in a number of parts of the bill. It has been suggested that the commission should be entirely removed until consultations are completed and new proposals are made.

Shona Robison: We have just discussed the power to improve the exercise of public functions that relates to schedule 3. It would be wrong to remove the Mental Welfare Commission for Scotland from that schedule. I have given members an example of an active discussion that is under way between the commission and the Mental Health Tribunal for Scotland. I think that it be would be wrong to exclude any public body from the schedule and hope that I have reassured members about our intention. Of course, changes could not be made without parliamentary approval, but it is not intended that the power should be used to alter fundamentally the functions of any of those public bodies. It is about the ability to look around the edges, tidy up and make more efficiencies in public bodies. It is sensible, in the current climate, to have that ability.

Helen Eadie: I want to follow up Richard Simpson's questions. The Subordinate Legislation Committee considered these matters yesterday. The Mental Welfare Commission for Scotland was considered in our papers, and it was pointed out to us that we must remember that justice aspects as well as health aspects need to be taken on board. Colleagues around the table will bear in mind that not only health responsibilities are involved, which is another reason why it might be inappropriate to do what Shona Robison suggests.

The Health and Sport Committee is not the lead committee—the Finance Committee is. The Subordinate Legislation Committee has not concluded its report yet, but it will do so in two weeks. That report might have implications and might raise issues for the Health and Sport Committee. I am unhappy about the process, because we will have to arrive at views on matters, but will not be able to vote at stage 2. We will be able to move amendments in the Finance Committee at stage 2, but we will not be able to vote on proposals. That is certainly a concern from me.

I see that the convener has a quizzical look.

The Convener: The Parliamentary Bureau allocated the work.

Helen Eadie: Huge issues have been raised for the public, though. A very big bill is going through; indeed, it is so big that Michael Clancy of the Law Society of Scotland, the Lord President of the Court of Session and others highlighted that when they wrote to us. There are suggestions that our parliamentary bodies could be abolished, although they ought not to come under ministerial responsibility. We hear what the minister is saying, but we are certainly not happy. Does she want to respond to what I have said?

Shona Robison: On the Mental Welfare Commission for Scotland, I stress again that the power cannot be used to remove any necessary protection in the existing legislation. The preconditions in section 12 provide safeguards. I am talking about the exercise of public functions, and have given good examples to illustrate that. Of course, nothing can happen without the say-so

of Parliament through its use of the affirmative or super-affirmative procedure.

The parliamentary commissioners and ombudsmen are, of course, public bodies, which is why they were included in schedule 3. That schedule also includes the Scottish ministers, which might or might not be reassuring. If Parliament takes the view that the order-making powers should not apply to the parliamentary commissioners and ombudsmen, John Swinney will consider that matter seriously before stage 2. We understand that there may be issues, and he is prepared to listen to what people have to say. However, we must distinguish between parliamentary commissioners and ombudsmen and other public bodies for which ministers set budgets. We are in territory in which it is important that efficiencies are made where they can be. If that means considering backroom functions such as payroll and finance, we should have the powers to do that, subject to parliamentary scrutiny.

Helen Eadie: The issues about order-making powers and whether the procedure is affirmative, super-affirmative or simply negative have huge significance. When a minister proposes such changes, committees will not carry out the same scrutiny as they do with primary legislation. I am sure that other members also feel disquiet about the potential for huge issues of principle simply to go through in an order. As Richard Simpson rightly pointed out, ministers love to have such powers, but Parliament has the right to scrutinise their use on behalf of the public that it represents.

Shona Robison: I reassure Helen Eadie again—

The Convener: Sorry, but I want to make a point about the affirmative procedure. Under that procedure, the committee would take evidence if an issue was relevant to us.

Helen Eadie: We have not done that very much in the time in which I have been a member of the committee—once, I think.

The Convener: We can do it, though. We are perfectly able to do it. It is a matter for committee members.

Helen Eadie: The only time in the eight years for which I have been a member of the committee that we have done that was in relation to prescription charges. The issue is important, although it is a matter for Parliament to decide, not for me. It is a political argument.

The Convener: I want to move on but, to return to the process, it is always a matter for the committee to decide when it wants to take evidence. If anyone has been remiss, it has been the committee: it is not a matter for witnesses or Government ministers whether a committee tests instruments under the affirmative procedure. That is a matter for us.

Helen Eadie: The Law Society of Scotland, the Lord President and many public organisations have raised huge disquiet in submissions to this committee and to the Subordinate Legislation Committee. That must be borne in mind.

I have other questions to which I really need answers.

The Convener: Make them short, please, because we want to make progress.

Helen Eadie: The bill is important. If we do our homework and prepare our questions, we are entitled to ask them.

The Convener: Indeed—but I want to move on and let Mary Scanlon in, too.

Helen Eadie: I want to return to the points that were raised earlier about the independent sector and ask about points that have been raised with us about dental services. Dentists are saying that the bill has huge resource implications. The question that needs to be asked is whether the Government plans to amalgamate the inspections of dental premises with HIS. That work is currently undertaken by NHS boards and NHS Education for Scotland. There are many issues for dentists, who are concerned about the proposal to give authorised persons the powers to enter and inspect premises at any time, which would result in disruption to practices and patients. There are also concerns about what thought has been given to the definition of the term “authorised persons”. What persons would be included for dental services and would they hold a regulatory qualification, which is currently required for officers in the Scottish Commission for the Regulation of Care? That was part of the question that Richard Simpson asked earlier. The Government must respond to those concerns, which were submitted to us in evidence from dental practitioners throughout Scotland.

Shona Robison: I have two things to say about dental services. First, dental services that are wholly private, of which there are not many, will come under the ambit of the independent health care services regulation that we talked about earlier. There will be a consultation in the spring on how we will proceed with that. Secondly, the vast majority of dental services are mixed practices that are part NHS and part private. The NHS element is already part of the process of visits to premises that NHS boards undertake to ensure that they comply with the required standards.

I ask Shane Rankin to comment.

11:15

Shane Rankin (Scottish Government Primary and Community Care Directorate): The intention is to ensure through regulation who the authorised person is.

Shona Robison: There is no intention to disrupt dental practitioners' practices. However, there is an intention to ensure that the appropriate regulations are in place. As I said, the complexity is that many dental practices are shared, in that they are partly private and partly NHS. The intention is to consider regulations in the spring for practices that are wholly private.

Helen Eadie: That is helpful. It ties in with Rhoda Grant's earlier point about different services in her local community. The Royal College of Nursing and others have raised the issue of invasive cosmetic procedures that could be set up by another type of health professional. Would the bill cover such procedures? Do you plan to have the bill also cover alternative health practitioners? Some procedures might be regarded as cosmetic—for example, laser treatments—but others might be considered alternative health treatments.

Shona Robison: That question illustrates the complexity of the situation and is why the consultation will be around definitions, so that we can come to conclusions and clarify who will come within the ambit of the regulations.

The Convener: That is helpful. The committee, like the public at large, has concerns about the proliferation of various kinds of treatment. I want to let Mary Scanlon in now.

Helen Eadie: I have more questions, so can you come back to me afterwards?

The Convener: Let us hear whether Mary Scanlon covers your questions.

Mary Scanlon: We heard information earlier about new functions for the Scottish Public Sector Ombudsman. Given that, I have a supplementary question on the points that Michael Matheson raised about Community Care Providers Scotland, which said in its submission:

"The bill does not give SCSWIS any powers to investigate or to respond to … complaints"

about the number of hours of care a week, the community care assessment or the care management review. I think that all of us around the table have people at our surgeries every week with such complaints. Can you confirm that the SPSO will consider not only the points that Michael Matheson raised but the issues that CCPS raised?

Shona Robison: I think Adam Ingram has answered that.

Adam Ingram: I made the point earlier that the SPSO will have additional strings to his bow in terms of designing complaints-handling systems. I therefore hope that Michael Matheson's points will be addressed at stage 2 by amendments that we will lodge.

Mary Scanlon: So they will be included—that is helpful. I listened carefully to Richard Simpson's points about section 12, which is entitled "Preconditions". I would like clarity on the provision to remove burdens in section 13, which is a sweeping power. Section 13(1) states:

"The Scottish Ministers may by order make any provision which they consider would remove or reduce any burden, or the overall burdens, resulting directly or indirectly for any person from any legislation."

I am not a lawyer, but that appears to me to be a sweeping power. My questions are for both ministers. What sort of burdens were you thinking about in that respect? What do you want to do through the power in section 13 that you cannot do just now? I note that section 13(2) states that

"'burden' means … an administrative inconvenience"—

we can think of a few of them—and

"an obstacle to efficiency, productivity or profitability".

Can I get clarity about what that means?

Shona Robison: What that means is what I referred to earlier by way of example: the merger of payroll or finance functions, the collection of information on orders by both the Mental Welfare Commission and the Mental Health Tribunal for Scotland and back room functions. Those are the type of measures that I was talking about.

In terms of the preconditions in section 12, which act as safeguards, I confirm to Richard Simpson, who asked about consultation, that if the Scottish ministers propose to make an order under the provisions, they must

"consult such organisations as appear to them to be representative of interests substantially affected by the proposals".

That would cover the affected organisation and other relevant organisations.

None of that could be done without full statutory consultation, parliamentary scrutiny and approval by affirmative resolution. Even if there were no motion to annul, an order would still have to be approved by Parliament and the scope of any inquiry into any aspect of it could be as big as Parliament wished. That is the type of thing that we are talking about.

Mary Scanlon: There is tremendous scope for the sharing of services, not just within the NHS but between councils. However, I would like it on record that the phrases "any burden", "any person"

and "any legislation" relate only to economies of scale in relation to shared services.

Shona Robison: That is laid out in the preconditions in section 12.

Dr Simpson: It is in section 13(2).

Shona Robison: Thank you.

The Convener: We have a chorus of help. The definition of "burden" is in section 13(2).

Mary Scanlon: Let us move on to part 6. Ian McKee opened up the line of questioning on scrutiny and user focus. Can you give us some clarification of how you see the public involvement? Sections 92(6) and 93(4) state that ministers may or must consult any

"person they think fit."

What does that mean? There are so many bodies in the health service, I am not sure what would make ministers think one "fit".

Shona Robison: I think that it is just a legal term that covers the organisations that have a bearing on and a relevance to the issue. It is just a legal expression.

The point about user focus is an important one. There will be a user focus duty to encourage the bodies to be proactive, innovative and accountable in engaging with users. They will also have to be transparent about the outcomes of their efforts. A lot of work has been done by the existing organisations, over the years, to improve the way in which they involve users and carers—carers are also covered by the duty. We want them to build on that good work and good practice to ensure that users are involved at all levels.

The care commission has a really good practice of involving service users not just in the decision making around the table but in the inspections. Users go out and buddy the inspectors so that they get user feedback about what they see on the front line. There is some really good practice on many different levels, and I am keen for us to build on that in the new bodies.

Mary Scanlon: My final question is one that I raised last week, regarding NHS QIS's written submission. If the regulation of independent health care is to be extended beyond the existing arrangements, it is essential that provision is made for full cost recovery. What do you expect in that regard?

Shona Robison: The same principle would apply to a fee-charging regime, in that we would expect the costs to the sector to be covered by the fees.

Clearly, in terms of the independent health care sector, the issue would be part of the consultation next spring. However, the principle will remain the same as it is for fee levels under the care commission, which is that they should move towards full cost recovery, albeit with the recognition that that might take a lot longer than was envisaged when the legislation was first enacted. We have been responsive to concerns in the current economic climate. We could have made the fees higher than they are for the care home sector, for example, but we have chosen not to do that. The principle of full cost recovery is the right one, and it will apply to the independent health sector as well, but we will have to discuss the timeframe for getting there.

The Convener: On that point, in evidence to us, Community Care Providers Scotland said that the funding for the care commission should be re-examined and perhaps scrapped because it would cut out transaction costs that are charged for at various stages. It also said that SCSWIS should be centrally funded.

I appreciate that we are talking about integration and making a better service and not just about saving money, but it would be good if we could save money by avoiding duplication and bits of paper flying around unnecessarily. Why are you not considering doing what Community Care Providers Scotland suggests?

Shona Robison: I hear the argument, but I suppose that the counter-argument is that, because the transaction is between the local authority and the care provider, there is some transparency about the fee. If we were going to fund the body in its entirety from the centre, there would be a £13 million funding gap. If you are asking why we do not take the fees directly rather than through the local authority, the counter-argument is that, if the local authority collects the fees, there is a transparency about the fees in the relationship between the local authority and the care provider.

I do not deny that there is a debate to be had about that. An important point is that, particularly in the current financial climate, central Government cannot cover the cost of the fees as there would be a £13 million gap that we are not in a position to fill. Also, I do not think that we want to provide funds centrally; it is right and proper that fees are charged for the regulation and inspection regime.

Helen Eadie: A number of witnesses who submitted evidence to the committee cited the fact that, although they had been involved in discussions with the Scottish Government, those discussions were not about whether the proposed bodies were needed or suitable. That is a matter of some concern.

Among those who responded in that way were some fairly big players such as the RCN, the

Association of Directors of Social Work, and South Lanarkshire Council. They all felt that there should be a move towards one body. There is a big debate to be had about whether we should have a NDPB that is independent of Government or whether it should simply be a Government agency. That is clearly a matter of concern.

At the moment, we will have SCSWIS and HIS, one of which will be an independent body and one of which will not. When I was a councillor back in the mid-90s, local government reform had a huge impact on staff morale across the sector. If you are going to reorganise and reform, might it not be as well to take the big hit all at once and do the big move to one public body rather than have the confusion of two bodies?

11:30

Shona Robison: Although HIS will be established under health legislation, it will be independent. With regard to discussions about the proposed bodies, I return to my earlier answer. The Crerar review was an extensive piece of work that gave organisations the opportunity to feed into the process, and there is now an extensive parliamentary process in which bodies can give their views on the detail of the proposals.

The committee may recollect that, during the parliamentary debate on the Crerar recommendations, the proposal for one body was roundly rejected—well, that might be too strong a phrase, but the vast majority of members who spoke in the debate, including members of Helen Eadie's party, raised the concern that moving to one body was a step too far. They took the view that it would be more appropriate to proceed with two bodies at present. There is a debate to be had about whether we need one body or two, but that was the prevailing view of many—including the Scottish Government—at the time.

Involvement in change is undoubtedly difficult for people when the change concerns such an extensive redesign of bodies and services. People will be anxious, and it is our job to reassure them, particularly in relation to some of the practical elements in the bill. The Transfer of Undertakings (Protection of Employment) Regulations ensure that people's terms and conditions are protected, and the Government has a policy of no compulsory redundancies.

I pay credit to the organisations for the leadership that they have shown—that is important, and they have worked hard to keep their staff informed and up to date with what is happening.

The Convener: I have a question that has not so far been raised. The clerk's paper for today's meeting states:

"NHS QIS highlighted the fact that HIS will face a challenge in getting to grips with the regulation and scrutiny function of its role as not all parts of the Regulation of Care (Scotland) Act 2001 … have yet been brought into force … As a result, it will be important that all parts of the ROC Act are in force before the creation of HIS."

Will you comment on that?

Shona Robison: We are consulting next spring, and we will then need to draw up a timetable for the implementation of the Regulation of Care (Scotland) Act 2001. Adjustments will need to be made through regulation, as the act covers—as members might recall from our discussion—only services that involve a general medical practitioner or a general dental practitioner. The other examples that we discussed, such as cosmetic functions, would also need to be adjusted through regulation. We will work on the timetable for that implementation, but I am not sure whether it will be feasible before HIS is up and running. We will consult and consider what can be achieved in a reasonable timeframe, and we will act as quickly as we can.

The Convener: I thank everybody, even those who have played a silent but very supportive role. We will move on to the next item on the agenda.

Petitions

Ice Rinks (PE1138)

Local Leisure Activities (PE1173)

Sports Facilities (PE1205)

11:33

The Convener: Item 3 is consideration of three petitions, which deal with the continued provision of ice rinks and other local and national sports facilities. The petitions were referred to the committee late last year, and members agreed to consider the issues that they raised as part of our pathways into sport inquiry.

As part of our oral evidence taking in that inquiry, we heard from representatives of all three petitioners. I refer members to meeting paper 3, which sets out the substance of the petitions; the relevant paragraphs and recommendations in our "Pathways into sport and physical activity" report; and the response from the Scottish Government on the issue of ice rinks and other sporting facilities.

If members have no comments, are we content to close the petitions on the basis of the response from the Scottish Government on the provision of ice rinks and sports facilities?

Members *indicated agreement*.

Subordinate Legislation

Meat (Official Controls Charges) (Scotland) Regulations 2009 (SSI 2009/262)

11:34

The Convener: We move on to the final item on the agenda, which is consideration of five negative instruments. Members have a copy of each instrument, as well as a note from the clerk.

The Meat (Official Controls Charges) (Scotland) Regulations 2009 provide the basis for charging for official controls that are conducted to ensure the verification of compliance with feed and food law and animal health and welfare when animals are slaughtered for human consumption. The Subordinate Legislation Committee asked the Scottish Government two questions on the compliance of slaughterhouses with European Commission regulations and reported to us that it was content with the response that it received.

If members have no comments, is the committee content not to make any recommendation on the regulations?

Members *indicated agreement*.

Feed (Hygiene and Enforcement) (Scotland) Amendment Regulations 2009 (SSI 2009/263)

The Convener: The regulations amend existing regulations to grant enforcement powers to the Food Standards Agency in relation to animal feed hygiene. The Subordinate Legislation Committee raised several issues with the Scottish Government to do with the clarity of the regulations and the powers that they confer on ministers. The committee reported that the regulations could have been clearer in setting out the limitations of the enforcement powers granted and that normal drafting practice was not followed, in that there was a failure to reference other relevant instruments.

Do members have any comments?

Rhoda Grant: I would not have thought that the lack of a reference point would have any real impact on the regulations. Why has the Subordinate Legislation Committee flagged up the issue? Is it just being very, very—

Michael Matheson: That is what the Subordinate Legislation Committee does.

The Convener: The issue has come up on previous occasions. I am afraid that not following good drafting practice is a pretty frequent occurrence.

The options are that we can decide that we are content with the regulations; we can request that a Government official appear before us; or we can move a motion to annul the regulations. Do we want to follow any of those routes? Shall we agree to make no recommendation on the regulations?

Members *indicated agreement*.

Dr Simpson: I think that Rhoda Grant has just volunteered for the Subordinate Legislation Committee.

The Convener: Oh dear—although I will not call it a gulag because I know that Helen Eadie is on it. We are not to call it that; it is a very important committee.

Helen Eadie: It is not just me who is on it.

The Convener: I know. Ian McKee is on it, too. I think that that is where the Canadian proposal came to light, but we will not dwell on that, as our discussion is still being recorded by the official report.

Natural Mineral Water, Spring Water and Bottled Drinking Water (Scotland) Amendment Regulations 2009 (SSI 2009/273)

The Convener: The regulations amend existing regulations by implementing in Scotland directive 2009/54/EC, on the exploitation and marketing of natural mineral waters. The Subordinate Legislation Committee reported that the regulations breached the 21-day rule that applies to the period between the laying and the coming into force of a negative instrument but that it was content with the Food Standards Agency's explanation.

If members have no comments, is the committee content not to make any recommendation on the regulations?

Members *indicated agreement*.

National Health Service (Optical Charges and Payments) (Scotland) Amendment (No 2) Regulations 2009 (SSI 2009/288)

The Convener: The regulations amend existing regulations to add an additional category of person to whom payments are to be made by a health board for the supply of an optical appliance. The Subordinate Legislation Committee raised an issue with the Scottish Government because it appeared that regulation 8(2A) had a retrospective effect without the authority of the parent statute, which would mean that it breached the general principle that subordinate legislation may not have retrospective effect unless that is expressly provided for in the enabling powers.

In its response, the Government stated that the parent regulations allow for the descriptions of persons to whom the regulations apply

"by reference to any criteria".

The Government considers the setting of a date on or after which such reimbursement applies to be part of the reasonable criteria that it can specify. The Subordinate Legislation Committee was not convinced that setting a retrospective date was covered under reasonable criteria.

The committee also reported that the instrument breached the 21-day rule but was satisfied with the Government's explanation. In light of that, the committee drew the regulations to our attention and to Parliament's attention on the ground that they apply retrospectively even though they do not have the explicit power to do so under the parent regulations.

If members have no comments, is the committee content not to make any recommendation on the regulations?

Members *indicated agreement*.

Public Health etc (Scotland) Act 2008 Designation of Competent Persons Regulations 2009 (SSI 2009/301)

The Convener: The regulations prescribe the qualifications and training for persons to be known as health board and local authority competent persons for the purpose of exercising specified public health functions under the Public Health etc (Scotland) Act 2008. We are glad that we do not have similar regulations for MSPs. The Subordinate Legislation Committee had no comments to make on the regulations.

If members have no comments, is the committee content to make no recommendation on the regulations?

Members *indicated agreement*.

The Convener: We now move on to item 5, which is consideration of the committee's approach to its draft report on the Public Services Reform (Scotland) Bill. As agreed, this item will be taken in private.

11:39

Meeting continued in private until 12:31.

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