HEALTH AND SPORT COMMITTEE

Wednesday 18 November 2009

Session 3

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HEALTH AND SPORT COMMITTEE
30th 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 ALSO ATTENDED:

Shona Robison (Minister for Public Health and Sport)
Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Callum Thomson

SENIOR ASSISTANT CLERK

Douglas Thornton

ASSISTANT CLERK

Seán Wixted

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 18 November 2009

[THE CONVENER *opened the meeting at 10:05*]

Subordinate Legislation

Mental Health Tribunal for Scotland (Appointment of Medical Members) Amendment Regulations 2009 (SSI 2009/359)

The Convener (Christine Grahame): Good morning and welcome to the 30th meeting in 2009 of the Health and Sport Committee. I remind everyone to switch off mobile phones and other electronic equipment.

No apologies have been received. Joe FitzPatrick has the delights of the Health and Sport Committee this morning; he is substituting for Michael Matheson. I know that he will remember the meeting for ever.

Agenda item 1 is consideration of a negative instrument. The Mental Health Tribunal for Scotland (Appointment of Medical Members) Amendment Regulations 2009 amend the Mental Health Tribunal for Scotland (Appointment of Medical Members) Regulations 2004 so as to allow medical practitioners who are fully registered to be appointed to the tribunal whether or not they hold a licence to practise.

Members have before them a copy of the regulations as well as a note by the clerk. The Subordinate Legislation Committee had no comments to make on the regulations. Do members have any comments to make on them?

Members: No.

The Convener: Is the committee content not to make any recommendation on the regulations?

Members *indicated agreement*.

Tobacco and Primary Medical Services (Scotland) Bill: Stage 2

10:07

The Convener: Agenda item 2 is day 2 of our consideration of amendments to the Tobacco and Primary Medical Services (Scotland) Bill at stage 2. I welcome the Minister for Public Health and Sport, Shona Robison MSP.

Section 8—Application for registration and addition of premises etc

The Convener: Amendment 50, in the name of Mary Scanlon, is grouped with amendments 52 to 54.

Mary Scanlon (Highlands and Islands) (Con): The policy memorandum states that the registration scheme is being kept "administratively simple". As long as an application is in the correct format, as specified in section 8, no other checks will need to be carried out, unlike in the licensing regime. There should therefore be no reason why an application cannot be granted and then confirmed to the applicant as quickly as possible. A timeframe of 21 days is considered to be reasonable. A delay could be a serious inconvenience. There could be a commercial loss to a legitimate trader who is carrying on an existing business or who wishes to trade in a new business or premises.

It is considered that inserting a set timescale into section 9 rather than into the relevant subsections of section 8 neatly implies that the granting of the application under section 8(3), the changes to the register under sections 8(4) and 8(5) and the issuing of the certificates under section 9 should all take place within the 21-day period from receipt of a properly completed application. The effect of amendment 52 would be to set a similar timescale when a registered person applied for changes to be made to their registration details.

Amendment 53 would insert the words:

"as soon as reasonably practicable".

That would ensure that changes to the register were automatically and simultaneously accompanied by due notification to the registered trader. If that were not the case and the possibility of any delay was allowed, there would be a risk that traders would unwittingly be caught out by changes or deregistrations of which they were not aware.

The final amendment in the group is amendment 54. As it stands, section 11 does not appear to specify that a new registration certificate should be issued when the Scottish Government corrects or amends registration details. Amendment 54 is

designed to remove the possibility that the trader could be left holding an inaccurate certificate.

The Scottish Retail Consortium and the Scottish Grocers Federation support the amendments.

I move amendment 50.

The Minister for Public Health and Sport (Shona Robison): The retail sector has made representations and is concerned that, without amendment 50, retailers might have to wait a great deal longer to have their applications granted. As Mary Scanlon said, we have developed the tobacco sales registration scheme to ensure that it is administratively simple for retailers and the Scottish ministers. As members will know from the draft regulations that we shared with the committee last week, retailers will be required to provide only the most basic of information. In addition, when considering an application, ministers will have to check only whether the requested information has been provided and whether the applicant is banned from selling tobacco in any premises that are specified in the application. It will be a simple process to check that and, if appropriate, grant an application. Moreover, ministers are already to be under a duty to grant an application if the conditions are met and, as a public body, they will have to do that within a reasonable timeframe. Therefore, it is not necessary to put a legal duty on ministers to grant an application within a set deadline, as amendments 50 and 52 would do.

However, I would be happy to set out in guidance a time period within which retailers should expect decisions on their applications to be considered. I should point out that such a timeline might not be achievable during the transition period, when all 11,000 tobacco retailers will apply to be on the register. Any transitional provisions that we make will reflect that. However, I am happy to have in the guidance a timeframe for the normal course of events. On that basis, I ask Mary Scanlon to seek to withdraw amendment 50 and not to move amendment 52.

The Scottish ministers will of course notify a person within a reasonable time when they have altered the person's entry in the register, but I am content for that to be set out in the bill, as proposed in amendment 53. On amendment 54, the only circumstances in which it will be appropriate to issue a revised certificate are when the register is corrected following a change in a retailer's name or address. Section 11(4) already ensures that the retailer will receive notification of such a correction. However, I am content for the bill to require a revised certificate to be issued in those cases.

The Convener: I ask Mary Scanlon to wind up.

Mary Scanlon: That was very helpful, minister—

The Convener: I beg your pardon, Mary. I see that Rhoda Grant wants to speak.

Rhoda Grant (Highlands and Islands) (Lab): I seek clarification from the minister. She said that there will be a transitional period during which it might not be possible to meet the timeframe that Mary Scanlon suggests. What effect will that have on retailers? Will they be prohibited from selling tobacco products during that period or will there be a period before the legislation comes into force during which people can apply for licences, so that nobody is affected?

Shona Robison: Basically, there will have to be a transition period during which all the retailers are registered and the certificates are issued. However, that will be a one-off period at the start of the process. The guidance will make it clear that the requirement that Mary Scanlon seeks for a timeframe will kick in after that transition period. We can make that clear to retailers.

Mary Scanlon: The minister's response was helpful. I am sure that she understands that part of the background to the debate is the landlord registration scheme. I appreciate that it was set up before her party came into government, but there have been considerable delays in that scheme for one reason or another, so the experience has not been good. More recently, under the new alcohol licensing scheme, licensees are required to undertake a considerable amount of work to apply. I do not know whether the fault is on the part of the licensees or the local authorities, but there have been considerable delays. The background is therefore the experience of similar schemes.

I am delighted that the minister accepts amendment 53 and that, in relation to amendment 54, she is content for the provision of the revised certificate to be covered in guidance. What time period are you considering setting out in guidance for the period following the transition period, which Rhoda Grant mentioned, in which there will obviously be a huge influx of applications?

10:15

Shona Robison: I see the guidance being issued around six months before the registration scheme comes into force. Retailers should have that period to prepare. The guidance will set out clearly the expectation in relation to the certificate being issued, along with all the other issues that it will cover. The registration scheme will come into force in 2011.

Mary Scanlon: In that case, I will not press amendment 50.

Amendment 50, by agreement, withdrawn.

Section 8 agreed to.

Section 9—Certificates of registration

The Convener: Amendment 51, in the name of Dr Richard Simpson, is grouped with amendments 42 and 58.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): At the moment, the display of prices is covered in section 3 and the display of warning statements is covered in section 5. Amendments 51, 42 and 58 seek to increase the level of display to the public, so that there is an immediate awareness of the selling of tobacco. Of course, that may be obvious if the prices are clearly marked and clearly indicate a relationship with tobacco, but at the moment there is no way—except by looking on the web—that a person will know that the trader is registered. Amendment 51 seeks to ensure that the registration document is displayed, I hope in a way that the minister will determine by regulation or in guidance.

I support amendment 42, in the name of Christine Grahame, which would allow for the display of a banning order when it is made. It seems reasonable that if a shop is banned from selling tobacco, it should have to display a notice to that effect in due course.

Amendment 58 would require a business to display a notice when an offence had been committed or a fixed-penalty notice had been issued. That would indicate to the public that the shop had previously committed an offence in relation to the sale of tobacco. That would support the trader, because they would in effect be saying that they had committed an offence under the act—perhaps because they had been misled by someone who was under 18, who would also have committed an offence—which would reinforce their ability to ask for identification.

That would fulfil ASH Scotland's wishes. Paragraph 92 of our stage 1 report on the bill states:

"ASH Scotland … called for the information about enforcement activities and penalties issued to be made public".

I presume that, as the bill stands, that information would be put on the website, but it would not be displayed in the shop.

I am interested to hear the minister's response to the amendments.

I move amendment 51.

The Convener: I will speak to amendment 42. It is already the position in the bill that all tobacco retailers will have to display prominently in their shop a sign that states:

"It is illegal to sell tobacco products to anyone under the age of 18".

Such a sign will act as an important reminder of the laws prohibiting the sale of tobacco to underage customers. It will also remind customers that tobacco is available in that shop. Displaying a notice of equal prominence that a retail premises is banned from selling tobacco will ensure that customers and the community know immediately that that is the case, which will mean that if they witness any contraventions of the law, they can report them to the authorities. In addition, such a notice will distinguish shops that have chosen not to sell tobacco, such as Lidl stores in Scotland, from those that are prevented from doing so by a banning order. It will also act as a name-and-shame-style deterrent for any subsequent breaches. Of course, under my amendment 42, the penalty for breaching the requirement to display a notice could be summary conviction, so it is not a trivial matter. I am interested to hear what the minister has to say in response to my comments.

Ross Finnie (West of Scotland) (LD): I support amendment 51, in the name of Richard Simpson. If we are to have a system of registration, it is appropriate that certificates should be prominently displayed. I also support amendment 42, in the name of Christine Grahame. Given that banning orders will refer to premises, it is appropriate that banning notices should be displayed to persons who use those premises, who may wonder why tobacco is not available there.

However, I draw a distinction between amendment 42 and amendment 58, in the name of Dr Richard Simpson, which seems to introduce an entirely new principle. Amendment 58 provides for statements to be made both against persons who have been convicted and have a criminal record and against those to whom penalty notices have been issued and who do not, therefore, have a criminal record. It is a new departure for us to have public notices displaying the fact that persons have convictions. I do not wish to sound absurd, but the logical conclusion of that approach would be for a notice to be placed around the neck of every person leaving a district court, a sheriff court or the High Court, to display to other persons the nature of their conviction. The provision is disproportionate to the offences that we are creating.

With all due respect, I take issue with Richard Simpson's assertion that amendment 58 would support a retailer who had been misled. The fact that a retailer believed that they had been misled

would have been advanced to the court as a defence. If they were found guilty, the court will have decided that they were not misled but were guilty of the offence with which they were charged. I do not see how the provision could provide support to retailers. The evidence that has been given to the committee does not support our entering the completely new territory of displaying convictions against individuals. Notwithstanding the fact that ASH Scotland called for such a provision, we heard no evidence in support of it from any legal source. I will, therefore, oppose amendment 58.

Shona Robison: I understand that the aim of the amendments is to make the public aware of the behaviour of their local shops, thereby introducing an additional deterrent to committing an offence. The register of tobacco retailers will, of course, be made public, so members of the public will be able to find out whether their local shop has been banned from selling tobacco. Members will recall that we have also committed ourselves to looking at how we can make the public aware of any convictions or fixed-penalty notices that are issued in relation to tobacco sales offences. As part of that, we could consider how best to publish statistics to make members of the public aware of how shops in their locality are performing. I remind the committee that trading standards is of the view that the public are generally unaware of notices that are displayed in shops.

I have been advised that there are some minor but important drafting problems with each of the amendments, so I cannot support them in their present form. However, I am sympathetic to the aims of the amendments, so I would like to consider the issues further and come back to the Parliament with proposals at stage 3. At this stage, I am inclined to propose a scheme that is most similar to the one proposed by Christine Grahame, as that would enable members of the public to know whether their retailer had been banned from selling tobacco and could act as a further deterrent to breaking the law.

On that basis, I ask Richard Simpson to withdraw amendment 51 and not to move amendment 58. Similarly, I ask Christine Grahame not to move amendment 42.

Dr Simpson: On amendment 58, I entirely accept Ross Finnie's point that the court would have decided whether a person had or had not been misled and convicted accordingly. Perhaps I did not express myself properly, but I was trying to say that, notwithstanding his conviction, the shopkeeper might still feel that he had been misled and had not taken sufficient precautions to ensure that he would not be convicted in court. In such cases, I feel that notice of the enforcement action would be appropriate.

I am not proposing that we hang a sign around the neck of everyone who comes out of a district court, and it is ludicrous to suggest that that would be the result of my amendment. However, with every step we take, we must ensure that this dangerous substance is managed and controlled in the most effective way. That is simply what I am seeking to do with my amendments.

That said, I accept the minister's commitment to consider the amendments and come back with something at stage 3. I await with interest what will emerge, and I will decide at that point whether to pursue my amendments.

Amendment 51, by agreement, withdrawn.

Sections 9 and 10 agreed to.

Section 11—Changes to and removal from Register

Amendment 52 not moved.

Amendment 53 moved—[Mary Scanlon]—and agreed to.

The Convener: Amendment 54, in the name of Mary Scanlon, has already been debated with amendment 50. Mary, do you wish to move the amendment? [*Interruption.*]

Mary Scanlon: I was so delighted and ecstatic at having an amendment agreed to that—

The Convener: We will just pause while Mary gathers herself after her victory.

Mary Scanlon: I am sorry, convener. I got carried away; it is such an unusual event.

The Convener: Is there a doctor in the house?

Mary Scanlon: I did say to Helen Eadie that I might dance on the table, but I will refrain from doing so.

The Convener: You can do it when we are in private session.

Mary Scanlon: I beg your pardon, convener. I will bring myself back to order. Did you ask me about amendment 54?

The Convener: Indeed. Are you moving it?

Mary Scanlon: No. [*Interruption.*] Oh, sorry—I think that I am moving it.

Ross Finnie: The minister is supporting it!

The Convener: Are you moving it, Mary?

Mary Scanlon: Yes.

The Convener: I can tell that you have been overwhelmed. That was an unusual slip for you.

Amendment 54 moved—[Mary Scanlon]—and agreed to.

Section 11, as amended, agreed to.

Section 12—Tobacco retailing banning orders

The Convener: Amendment 21, in the name of the minister, is grouped with amendments 21A and 55. I draw members' attention to the fact that if amendment 21 is agreed to, amendment 55 cannot be called.

Shona Robison: I am aware from stage 1 discussions of the desire for the banning order scheme to be as robust as possible. Having listened to those discussions and taken subsequent soundings, we propose a number of changes to section 12. The first is amendment 21; related amendments 22 to 27 will be considered shortly.

At present under the bill, a person can be banned from selling tobacco products if they receive three enforcement actions in two years. A relevant enforcement action can be either a criminal conviction or a fixed-penalty notice for offences under chapters 1 and 2. Where one of those enforcement actions is a conviction, there will be a period of time between the offence being committed and a conviction being obtained, and concern has been expressed that the time delay could lead to the conviction falling outwith the two-year period and therefore no longer counting towards a banning order. The system could be circumvented by, for example, a refusal to pay a fixed-penalty notice, which would trigger criminal proceedings that might last longer than the two-year period that counts towards the banning order.

Amendment 21 seeks to address that by altering the current provisions to allow courts to issue a banning order if a person receives three enforcement actions, at least one of which is within the two months preceding the council's application for a banning order and where the conduct to which the actions relate took place within a two-year period. The changes will strengthen the bill by closing a loophole and delivering the policy that three offences within a two-year period makes a person liable to be banned.

10:30

While I understand the sentiments behind amendments 21A and 55, I believe that it is inappropriate and, indeed, disproportionate to reduce the number of enforcement actions that will trigger a banning order from three to two in a two-year period. As drafted, the bill matches similar banning order provisions that are in place elsewhere in the United Kingdom. The changes that I propose in amendment 21, coupled with Richard Simpson's proposed amendment providing for escalating fixed-penalty notices, are proportionate and address the concerns that were expressed during stage 1. The bottom line is that the combined measures will ensure that a person who breaches the law does not go unpunished. Accordingly, I will move amendment 21, and I ask Richard Simpson not to move amendments 21A and 55.

I move amendment 21.

Dr Simpson: The committee was certainly of the view that the punishment provisions in the bill as introduced were inadequate. The concern was that someone could repeatedly offend over a period of time that would allow them to continue committing offences at regular intervals without being banned. That seemed unreasonable. I accept that the minister's amendment 21 tightens the position somewhat, but I am uncertain about whether it tightens it sufficiently. The third paragraph that amendment 21 seeks to insert in section 12(3) means that the three relevant enforcement actions must take place within a period of two years. That still means that someone could commit three offences in the space of two years and one month, and not be banned. That is my understanding; the minister will correct me if I am wrong. We need to have tough enforcement. As I said in discussing previous amendments, the retailer might feel aggrieved about a conviction on the first offence. However, in my view, if a second offence is committed, there is no excuse and the individual should not be selling tobacco. That is why I will move amendment 21A.

As the convener indicated, amendment 55 will fall if amendment 21 is agreed to. Amendment 55 was lodged in order to amend the original provision. If amendment 21 is defeated, I hope that amendment 55 will be agreed to.

Shona Robison: The line must be drawn somewhere, and we must agree where. I believe that what we have set out in amendment 21 is a proportionate response that will ensure that those who breach the provisions are punished. I ask members to support amendment 21.

Amendment 21A moved—[Dr Simpson].

The Convener: The question is, that amendment 21A be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST

Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)

McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 21A disagreed to.

Amendment 21 agreed to.

The Convener: Amendment 55 is pre-empted. Amendment 56, in the name of Dr Richard Simpson, is grouped with amendment 57.

Dr Simpson: As the minister indicated, the amendments in this group fit with previous amendments that I have moved. However, they would allow the sheriff greater flexibility. Amendment 56 would delete the phrase "(not exceeding 12 months)" from section 12(5), which would leave the decision up to the sheriff. The effect of amendment 57 would be to make it clear that the penalty on the first offence should not exceed 12 months and that, beyond that, the sheriff could decide. It would be an escalating process—if a second offence took place, the sheriff could decide on the length of the ban that would be imposed, rather than being limited to 12 months, which would be the case if section 12(5) remained as it is.

I move amendment 56.

Ross Finnie: I am all in favour of sheriffs having discretion within a band, but Richard Simpson seems to believe that the band should be infinite—although I am not sure that that is what he is saying and I do not want to put words in his mouth. It might be normal to say that the upper limit for an offence should be two or three years, or whatever, and then to allow the sheriff to decide on the appropriate penalties for first and subsequent offences.

If we agreed to amendments 56 and 57, we would delete an upper limit and leave the length of the ban entirely to the sheriff's discretion. The sheriff could hand down a ban of three years, five years or 10 years. That seems to leave sentencing for this offence open to a great deal of inconsistency, and I am not sure that I think that that is desirable. If a trader were to lose the right to sell for a period of 12 months, that would be pretty serious, and there might an issue about whether a trader would be able to return to trading normally after that period of time, having lost his or her clientele.

The 12-month period is proportionate to what the legislation seeks to do, and amendment 56 would leave the situation open ended. It would provide too much discretion for sentencing for the offence, without specifying the nature of the sentence. I therefore have difficulty in supporting amendments 56 and 57.

Shona Robison: I assume that the intention behind amendments 56 and 57 is to give sheriffs the power in granting a banning order for a second or subsequent time to specify a period greater than the maximum period of 12 months that is proposed in the bill. Notwithstanding the fact that I think that a maximum period of 12 months for a banning order is proportionate, the amendments are technically flawed and would not achieve that effect. First, they would allow the sheriff to impose a period of less than 12 months. Secondly, as the provisions relate only to the person, they would have the effect that conduct in one premises might affect the carrying on of business at another. Again, that would be disproportionate if it involved a chain of shops in which the conduct of tobacco sales was without fault.

The amendments that I have proposed that relate to banning orders will strengthen the scheme, so amendments 56 and 57 are unnecessary. I ask Richard Simpson to withdraw amendment 56 and not to move amendment 57.

Dr Simpson: The suggestion that sheriffs would not act in a proportionate matter is interesting, to say the least. As the bill is drafted, an order can be specified for a period "not exceeding 12 months", so the sheriff has the power to make an order of less than 12 months if they so wish; I do not accept the minister's point that there is a difference between what she says and paragraph (a) of the new subsection that amendment 57 would insert. A sheriff would still be allowed to make a ban of less than 12 months.

However, if an individual were to get a second banning order—which would mean that they had committed another series of offences—they should no longer be allowed to sell tobacco. We really have to treat that substance with severity and differently from other commodities. Ross Finnie's implication that tobacco is just like any other retail commodity is not correct. [*Interruption.*]

The Convener: Bear with me a minute, Richard. I will let Ross Finnie speak after you have finished; I will let the minister respond, too, because the issue should be aired.

Dr Simpson: I will press amendment 56 and I intend to move amendment 57. Tobacco is such a serious commodity that anyone who reaches the point of being given a second banning order—which means that there have been six offences—should not be allowed to sell tobacco again.

Ross Finnie: Tobacco is not being rendered an illegal substance by the bill. I have commented previously that that might be the more appropriate route to go down. The provisions apply to offences related to selling tobacco—if tobacco were an illegal substance, I would have more sympathy with the point, but we have got ourselves into

difficulty by trying to control how tobacco is sold. Only tobacco and alcohol are controlled in this way.

The Convener: We will leave the discussion at that. The question is, that amendment 56 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST

Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 56 disagreed to.

Amendment 57 not moved.

The Convener: Amendment 22, in the name of the minister, is grouped with amendments 23 to 27.

Shona Robison: This group of amendments arises from our desire to block a potential loophole in the banning order scheme, which is provided for in section 12. The Society of Chief Officers of Trading Standards in Scotland has expressed concern that there is nothing in the bill as drafted to prevent a person who is subject to a banning order from handing over the tobacco retailing premises to, for example, a family member, while, at the same time, continuing to be involved in its day-to-day running. Two of the amendments in the group are of a substantive nature; the others are technical and consequential amendments that arise from the proposed changes.

I will speak first to the substantive changes that are proposed. Amendment 23 seeks to close the potential loophole that has been identified by creating a new section that will allow local authorities to apply to the court for an ancillary order to ban a person who is subject to a banning order from being connected to or having control over a person carrying on a tobacco business in the premises to which the ban applies.

Amendment 24 creates a new section for provisions that currently sit in subsections (6) to (9) of section 12. The provisions are updated to include appeals against the proposed new ancillary orders. They also address the concerns that have been raised about potential abuse of the appeal system, by allowing a sheriff principal to vary the banning order period, rather than only to reduce it. That means that the length of the banning order and of any associated ancillary order could be extended if the sheriff principal felt that it was justified. That might act as a deterrent to vexatious appeals.

Amendments 26 and 27 create a new offence of breaching a banning order or ancillary order. It carries the same penalty as carrying on a tobacco business while unregistered.

I turn briefly to the technical and consequential amendments in the group. Amendment 22 will delete the banning scheme appeal provisions that are set out in subsections (6) to (9), which we propose to move to a new section under amendment 24. Amendment 25 inserts a further new section after section 12, restating and updating the provisions that are currently made in section 12(9) requiring ministers to be notified if a tobacco banning order or an ancillary order is made and to be notified of the outcome of any appeal to the sheriff principal.

Taken together, the amendments strengthen the provisions of the bill.

I move amendment 22.

Amendment 22 agreed to.

Section 12, as amended, agreed to.

After section 12

Amendments 23 to 25 moved—[Shona Robison]—and agreed to.

The Convener: In light of what the minister has said regarding stage 3, I am not of a mind to move amendment 42. I reserve my position until stage 3. The minister has mentioned technical deficiencies.

Amendment 42 not moved.

Section 13—Offences relating to the Register

Amendments 26 and 27 moved—[Shona Robison]—and agreed to.

Section 13, as amended, agreed to.

Before section 14

10:45

The Convener: Amendment 16, in the name of Mary Scanlon, is in a group on its own. Mary will have recovered by now, so I ask her to speak to and move her amendment.

Mary Scanlon: On the registration scheme, the financial memorandum states:

"Costs to the industry will … involve the one-off labour cost needed to fill in a simple registration form."

We discussed the process earlier. In moving my amendment, I simply seek clarity that there will be no charge for registration.

I move amendment 16.

Shona Robison: We made it clear from the outset that, in establishing a national register of tobacco retailers, our intention is to keep the registration process administratively simple by allowing tobacco retailers to register free of charge either online or through a simple, paper-based system. In drafting the bill, therefore, no provision was made to give Scottish ministers the authority to charge for registration. Any future Administration that wished to levy a charge would require to amend the legislation to give them a statutory basis on which to do so. In those circumstances, the proposed change to the bill is unnecessary and I therefore ask Mary Scanlon to withdraw her amendment.

Mary Scanlon: Thank you. That was helpful. I lodged my amendment to seek clarity, so I am pleased that that is on the record. I am also pleased to note the confirmation that ministers will have no authority to charge for registration. I therefore think that the amendment is unnecessary and I seek leave to withdraw it.

Amendment 16, by agreement, withdrawn.

Sections 14 to 17 agreed to.

Before section 18

Dr Simpson: I will not move amendment 58 but, again, I might return to the matter at stage 3.

Amendment 58 not moved.

Section 18 agreed to.

Section 19—Programmes of enforcement

The Convener: Amendment 28, in the name of the minister, is in a group on its own.

Shona Robison: Amendment 28 responds to recommendations in the stage 1 report. The provisions in section 19 restate the existing statutory duty on local authorities to consider annually whether to carry out a programme of enforcement action. However, I appreciate that concern has been expressed that the provisions might give councils too much discretion over the matter. Rather than their being required to consider annually whether to carry out an enforcement programme, the amendment simply requires them to do so. In view of the increased emphasis on enforcement, that change is undoubtedly justified, particularly when we consider that local authorities have been given specific additional resources of £1.5 million a year to support their efforts under the enhanced tobacco sales enforcement programme, which was officially launched in February. COSLA has indicated that it has no objection to the change.

I move amendment 28.

Dr Simpson: I did not lodge an amendment to section 19 because the minister gave an undertaking to come back on the matter. I welcome her amendment, but I do not believe that it goes far enough. It is important that the Government has a central role in monitoring enforcement programmes. Ministers should be notified of such programmes so that they can ascertain whether they are adequate. The minister should also have powers by way of regulation to order a local authority to carry out a more robust enforcement programme.

The amendment improves matters considerably, but it leaves it to local authorities to decide what constitutes a reasonable enforcement programme. That could prove to be inadequate. We have had problems with the test purchasing of alcohol, which is highly variable—I for one am certainly not satisfied with the programmes that have been carried out, which are clearly constrained by local authorities' budgets. I will support amendment 28, but I give notice that I will wish to lodge amendments at stage 3 to tighten the requirements further.

Shona Robison: All that I will say is that we have agreed with COSLA a monitoring process for the targets that local authorities are to achieve and SCOTSS is reporting to us every six months on progress towards achieving those targets. That is a proportionate and appropriate way to proceed. It is not helpful or a requirement for us to micromanage every local authority. The expectation about what should be achieved from the resource is clear. Amendment 28 will ensure that councils are under no illusion about what is required of them, as that will be in statute. That is proportionate.

Amendment 28 agreed to.

Section 19, as amended, agreed to.

Section 20—Fixed penalties

Amendment 10 moved—[Shona Robison]—and agreed to.

Section 20, as amended, agreed to.

Schedule 1

FIXED PENALTIES

The Convener: Amendment 29, in the name of Dr Richard Simpson, is in a group on its own.

Dr Simpson: Amendment 29 attempts to provide flexibility over the amount of the fixed penalty. It would amend schedule 1 at line 35 on page 17 of the bill to say that

"Regulations … may provide for the amount to be different depending on whether, during a prescribed period, the offender has been … issued with a fixed penalty notice or … convicted of any offence".

The amendment would allow regulations to prescribe the amounts in greater detail.

I move amendment 29.

Shona Robison: I thank Richard Simpson for raising the issue with me. Amendment 29 would strengthen the fixed-penalty notice scheme by allowing ministers to raise the fixed-penalty level according to the number of offences that had been committed. Members know that our draft regulations provide for increasing the fixed penalty by £200 for every offence that is committed in a year. Retailers and trading standards officers have been consulted on that and are content with our proposals. I am happy to support the amendment.

Amendment 29 agreed to.

The Convener: Amendment 30, in the name of the minister, is grouped with amendments 31 and 32.

Shona Robison: The amendments will strengthen the fixed-penalty notice scheme. Without amendments 30 and 31, the chance would always exist for a council to take a late payment, even when court proceedings had started, which would reduce the incentive to pay the fixed penalty on time. The Scottish Government believes that it is appropriate to commence criminal proceedings against a retailer that has failed to pay a fixed-penalty notice on time.

Amendment 32 is a technical amendment to remove an unnecessary provision in paragraph 8(3)(b) of schedule 1. The words are not required because, if proceedings have commenced, the penalty notice will have been withdrawn under paragraph 9.

I move amendment 30.

Amendment 30 agreed to.

Amendments 31 and 32 moved—[Shona Robison]—and agreed to.

Schedule 1, as amended, agreed to.

Sections 21 to 24 agreed to.

After section 24

The Convener: Amendment 33, in the name of the minister, is in a group on its own.

Shona Robison: Amendment 33 is another amendment that responds to a recommendation in the stage 1 report. As they are now, local authorities will be the principal enforcement authorities for tobacco sales law. However, the police have of course a general responsibility for enforcing the law. I accept ACPOS's view that it would be valuable for the police to have similar powers of entry to those that the bill provides for local authorities.

Amendment 33 will therefore insert a new section to grant the police powers of entry to premises other than private dwelling-houses where they have reason to believe that an offence is being committed under tobacco sales law. If they cannot gain entry with that power, the police will be able to apply to a sheriff for a warrant to enter that could allow them to use reasonable force to gain entry. Before granting a warrant, the sheriff would have to be satisfied that reasonable grounds existed for suspecting that the tobacco sales laws had been breached.

I move amendment 33.

Amendment 33 agreed to.

Section 25—Presumption as to contents of container

Amendments 34 to 36 not moved.

Section 25 agreed to.

Sections 26 and 27 agreed to.

Section 28—Crown application

Amendment 37 moved—[Shona Robison]—and agreed to.

Section 28, as amended, agreed to.

The Convener: After the suspension, we will move on to part 2, which the Cabinet Secretary for Health and Wellbeing will deal with.

10:55

Meeting suspended.

11:03

On resuming—

Section 29—Contractual arrangements for the provision of primary medical services

The Convener: We move on to part 2 of the bill. I welcome the Cabinet Secretary for Health and Wellbeing.

Amendment 1, in the name of Mary Scanlon, is grouped with amendments 2 to 5.

Mary Scanlon: I find myself supporting Labour, the SNP and the Liberal Democrats by proposing to delete part 2 of the bill. All parties in the Parliament, apart from the Scottish Socialist Party, not only supported the inclusion of measures for commercial providers in the Primary Medical Services (Scotland) Act 2004, but robustly

defended those measures. I am sure that the Labour Party will equally robustly support my amendment, which seeks to retain the commonsense approach of the bill that the Parliament passed six years ago.

The first point to make is that, despite the ability of commercial providers to set up shop, so to speak, in Scotland, none has chosen to do so to date. The British Medical Association has confirmed that the demand for GP services is increasing. Our ageing population, the increasing availability of treatments and increasing public expectations all result in increasing demand for GP services year on year. Despite the acknowledgement of increased need, the BMA and the Scottish Government propose a measure that is designed to prevent the possibility of alternative sources of provision.

Community Pharmacy Scotland stated in its written submission:

"There is no guarantee that the existing practice model will survive for another 10, let alone 60 years and without the possibility of alternative methods of provision the situation could arise where medical services could not be provided for people living in 'hard to doctor' areas such as remote and rural regions or in areas of deprivation within our cities."

If part 2 of the bill were deleted and the existing legislation were allowed to remain, it would be possible for GPs to hold surgeries in pharmacies, with a salaried GP being employed by the pharmacy.

The Confederation of British Industry submission highlights that the majority of the European states with the most respected and successful health care systems have developed successful partnerships with the private and voluntary sectors. In France, Spain, the Netherlands and Switzerland, public-private partnerships have been successful not only in providing general medical services but in tackling public health issues.

As there are no commercial providers in Scotland, my colleague Helen Eadie and I visited a walk-in centre at Canary Wharf and a health centre in Tower Hamlets, both of which are run by the independent company Atos Origin. The walk-in centre is open from 7 am to 7 pm and serves the 80,000 employees at Canary Wharf as well as local people and tourists in London. It has reduced the time and financial cost of work absenteeism by reducing preventable ill health, and it allows accessible attendance at GP appointments during the working day. There has also been a significant reduction in the number of people who present to local accident and emergency units. Surveys show that 97 per cent of patients find the care good or excellent. The primary care trust has a seat on the Atos board to ensure good working relations.

In Tower Hamlets, which is the second most deprived area in London, the primary care trust discontinued the contract for the health centre GPs because they did not meet key performance indicators and did not serve the needs of the community, more than 30 per cent of whom are Bengali. Atos has been given a five-year contract to provide general medical services and there is no doubt that, if it does not achieve the standards, it will lose the contract.

Helen Eadie and I spoke to managers of the primary care trust as well as to doctors who have worked in the health centre before and after the Atos contract was awarded. The primary care trust confirmed that Atos has better software and better attention to detail. It gives monthly reports to NHS London and has better data management. The health centre regularly meets the key performance indicators on issues such as complaint response and generic prescribing. Many GPs continued to work in the centre after the contract was awarded. There is now greater focus on addressing health inequalities, better marketing, reduced staff turnover and better continuity of care with a more stable provision of doctors. The centre meets all its targets for health checks, immunisation and screening, and there has been a considerable improvement in the management of chronic disease. The practice now attracts patients from elsewhere in London.

Should the opportunities for different types of provision not remain and should the Parliament ban commercial providers of GP services, we will deny patients throughout Scotland access to modern health services that are accessible during the working day. Rhoda Grant has stated that, like me, she covers

"an area where GPs have opted out of delivering services and where it has fallen to nurses and first responders to deliver them."—[*Official Report*, *Health and Sport Committee*, 3 June 2009; c 2063.]

Atos or another private company could not opt out, as it would lose its contract.

I could also go on about Tom McCabe and the support that he gave for the Primary Medical Services (Scotland) Bill, but I will leave that. Shona Robison and Stewart Stevenson gave their full support to commercial providers at the time of that bill. The BMA said that the changes that it would facilitate would

"revitalise general practice in Scotland."

I fully support the independent contracting of GP services in Scotland and commend the excellent work that is done every day in GP practices throughout Scotland. There is no patient gain in access or care from creating a monopoly of provision in the sector, but there is much to lose in

flexibility and a modern approach to GP services and potential walk-in centres.

I move amendment 1.

The Convener: Thank you for that very full submission.

Dr Simpson: I have some sympathy for Mary Scanlon's position, not least because the previous bill proved to be adequate, and as far as I know it has been tested in respect of private services on only one occasion—although the minister may correct me on that. I understand that the Harthill situation was the only one in which anything close to a private operator has sought to provide general practice services.

It seems to me that, within the basic principle of a mutual NHS and according to the principle that is espoused by the Government and my party—that we should focus on the patient—the primary issue is that there must be provision of primary care services, rather than how they are provided. I ask the cabinet secretary to indicate what she would do if a general practice could not be provided under the proposed legislation, because under those circumstances the exclusion of a possible private model might mean that patients could not have access to a service.

I agree that that scenario is probably as unlikely as the occurrence of a private sector application has been in the Scottish context since the Primary Medical Services (Scotland) Act 2004 was passed but, nevertheless, such situations may arise because the pattern of general practice is undoubtedly changing. In the past few years, there has been a substantial shift from partnerships towards more sessional doctors. The pattern has not been as severe in Scotland as it has been in England, but it may only be a matter of time. In England, the number of sessional doctors employed in the primary care services has risen from 5 per cent to 20 per cent. We must recognise that we are moving away from a partnership arrangement.

My concerns relate to rural areas and to small towns and villages where branch surgeries perhaps never existed. The population is ageing, so people are less likely to be able to use public transport, which is often inadequate anyway, to get to surgeries in time. They therefore require services to be provided much closer to them.

Another point in favour of Mary Scanlon's amendments is that, particularly around Edinburgh and Glasgow, people often have fairly lengthy commuting distances. Therefore, even with the extended hours that the cabinet secretary has brought in to provide improved access to general practice—correctly, in my view—individuals may not get back to the practice in time.

In general practice we have, in effect, abandoned the Saturday morning surgery, which was something to which those individuals used to have recourse. Certainly, in my own practice—I am going back 10 or 15 years, and Dr McKee probably has the same experience—the only days that we closed were Christmas day, boxing day and new year's day. We then introduced an Easter holiday but we did not close on the other public holidays, because we had a substantial commuting population and staying open meant that those patients could come to the practice, perhaps for management of their chronic condition, at a time of their convenience.

That has all been abandoned: I do not think that any practices now have such working hours, and Saturday morning surgeries have also been abandoned, in effect, to be replaced by an out-of-hours service. The issue therefore arises of the provision of the service for commuters that is becoming increasingly prevalent in England. Would such a service be provided by a GMS contract or a section 17C service? I would like the minister to answer that question.

Against Mary Scanlon's amendments is the fact that the model that she looked at—the Atos model—is a London model. London has some very peculiar problems in relation to general practice: it still has a far higher proportion of single-handed practitioners, many of those practitioners are working out of dismal practice premises, and there are serious problems in recruiting general practitioners. Therefore, a pragmatic solution adopted by the UK Government to introduce both polyclinics and the sort of services that Atos offers is entirely appropriate to the circumstances in London. Such services have not been introduced in Scotland because we do not have a shortage of general practitioners. Therefore, we do not have the same need for such solutions, apart perhaps from in the circumstances that I have described.

11:15

Another concern is that there is some evidence—I gather that a committee of MPs is looking at this issue—that differential funding is available for such private contractors. Evidence suggests that their operations are considerably more expensive, but they are favoured in the present situation. That is inappropriate and does not allow for reasonable competition.

My other concern about the restrictions under part 2 of the bill is that they will not tackle the problems of accident and emergency services, which are under massive strain. Indeed, as the cabinet secretary will know, NHS Lanarkshire and NHS Ayrshire and Arran have recently sought an extension to the derogation from the European

working time directive. I know that A and E services account for only part of that pressure, but that nevertheless displays the significant pressures that they face.

We know that growth in demand for A and E services is huge. It is a serious issue that we should tackle. A and E consultants whom I talk to certainly indicate clearly that they now see a disproportionate number of people who should really be seen in general practice. If the bill tackled that issue, that would be fine, but I suspect that we might hem ourselves in if we go for the total elimination of private companies that might be able to provide a supporting service.

At the moment, my view is that I will not support the amendments in the name of Mary Scanlon. I will listen to the cabinet secretary, but I will reserve my position until stage 3 of the bill before making a final decision on whether to vote to delete part 2.

Ian McKee (Lothians) (SNP): I agree with many of Richard Simpson's points. Indeed, when I started in general practice many years ago, our first debate was whether to continue the habit of holding surgeries on Christmas day. We decided that times had moved on and that such a practice was no longer appropriate—I would certainly not suggest returning to that—but we still held evening surgeries every night of the week, which went on till about 7.30 and provided a valuable service to working people. Indeed, the authorities at the time came down very heavily on any GP practice that tried to discontinue evening surgeries, as that was seen as a failure to provide a proper service to the people whom the practice was supposed to look after. For a variety of reasons, the pendulum seems to have swung far too far the other way, given that we now have a substantial number of people, especially commuters, who cannot see their registered GP at the time that they wish.

I have no information on what Atos does in Tower Hamlets, but I know something about its activities in Canary Wharf. I know as a matter of fact that every person who attends the Canary Wharf walk-in facility has already been paid for by the NHS, because other doctors are being paid to provide a service to look after them. Those who attend the facility are either commuters—who have a registered GP in their home town who is paid to look after them but cannot do so because they are not in the locality—or people who live locally. Indeed, half of those who attend the Canary Wharf walk-in centre are registered with a local doctor. It is not surprising that slightly higher standards of service can be obtained if we pay double for every patient, but that cannot be regarded as an efficient way of providing health services.

I strongly believe that the solution to the problems that have developed due to the diminishing hours of availability of GPs can be solved in a mutual health service that is owned by the people of Scotland rather than a service in which the people of Scotland are just consumers. We should sort out that problem within the health service.

Health boards already have all sorts of mechanisms for dealing with situations in which conventional general medical services cannot be provided. When I worked as a general practitioner in an area of deprivation, the way in which the health service was organised meant that GPs who practised in such areas earned much less money. The issue came to a head when we looked for another GP to join our list but could find no one because the money being offered was too little. The situation was resolved by entering into an arrangement with the health board whereby we became employees. In any part of Scotland, it is within the ability of the health board to overcome difficulties in finding general practitioners by seeking solutions that are suitable for the area.

I believe that elected health boards will be more sensitive to the needs of people in communities, because they will have to answer to the people who elected them.

I do not support Mary Scanlon's proposals, because they would mean that we would do more damage to a mutual health service by trying to repair something that can be repaired within a national health service of which we can all be proud.

Helen Eadie (Dunfermline East) (Lab): We must remember that the vast majority of people have private sector GPs, many of whom are members of the CBI—the CBI volunteered that information to us—and that there are precious few salaried GPs. We will create a distortion in the marketplace by following the cabinet secretary's position without having any safeguards. I will hear what she has to say later about a community co-operative approach to the mutual sector and her views on the Royal College of Nursing's lobbying of the committee, which was important.

It is fundamental that patients are at the forefront—that is crucial to the point that Richard Simpson made. Patients are being denied treatment in Scotland's modern society: patients in Fife are being denied bariatric surgery and patients are being denied infertility services without any possibility of appeal. In a modern society, there is almost a need for a European convention on human rights approach to the matter. I do not know about any right to treatment under that convention, but a right to treatment should exist.

Our national health service is unique in Europe. It is funded in a way that is different from how

other health services in Europe are funded. Fundamentally, patients must have a right to treatment. If that treatment cannot be provided in the health service, we must think about how it can be provided.

Even if we disagree to Mary Scanlon's amendments, which we may do, private sector companies will still be able to become involved in a limited way in a structure that is different from that which we saw in London. It is not just London that has walk-in centres—there are such centres in Manchester and Liverpool. Indeed, I think that there are six such centres altogether in the United Kingdom. Richard Simpson was right: they were set up for specific reasons to address specific issues. It is not the way forward to suggest that it would be appropriate to have them in Scotland, because our demographics are very different and because of our different-sized cities. We must think about that.

Ian McKee made a point about double payments. The fundamental point is that NHS money should always follow the patient. In Norway, for example, the standard is that it does not matter whether the private sector or the state provides the health service for people—it is the state that must always pay. I agree that double payments must never be made. Patients in Scotland have a right to treatment and they should not be denied it. I have mentioned only two examples in that context, but I am sure that others can mention cases in which no treatment is possible. It is criminal for any member to put up with that. We should address that issue first and foremost.

I reserve my position until I hear what the cabinet secretary has to say about the issues that I have raised and issues that the Royal College of Nursing raised. RCN professionals are the sort who could be engaged in establishing the type of company that we have agreed. Establishing community co-operatives in rural and hard-to-doctor areas would address the point that was made about those areas. That would be a way forward, provided that, once a GP arrives in the co-operative, he or she becomes a member of its management committee.

Ross Finnie: Mary Scanlon referred to the position of the parties and the position that we are now in. I am bound to say that, as private competition has emerged in England and Wales, I have not been attracted by what I have seen. As always, we get back to the rather difficult position that the private sector has not provided additional doctors or resource but has created competition within an existing level of provision. The private sector might have developed interesting models, but that is not the only way that they could be delivered. I have been disappointed that the national health service in England has not responded to some of the improvements.

That is not quite the position in which we find ourselves in Scotland. I am nervous, because we do not make use of the current contractual provisions. I have taken steps to pursue that matter with ministers. There is nothing to prevent slightly different models of collaborative activity, although there is a nervousness among doctors about having to resile from their existing contract in order to enter into different arrangements. That might be unfortunate, but perhaps practices could provide a service in a better way by entering into collaborative arrangements with other practices, especially in rural areas. It seems odd that they do not have the confidence to establish different working arrangements, which are perfectly permissible within the existing legislation. The one requirement is that doctors would have to give up their individual contract.

As Ian McKee said, the matter is capable of being resolved within the health service as it stands. This debate has highlighted that we are perhaps not imaginative enough in making use of the contractual arrangements under the existing regulations to solve problems that arise.

A different issue arises with Richard Simpson's proposals on introducing different forms of contractor, which it is difficult to separate out from the debate. However, we will explore that when we get to the relevant amendments, so I will not cover it now.

On Mary Scanlon's amendments 1 to 5, the patient experience might have been improved for those in Canary Wharf, but we have to consider the generality of those who are operating in competition, which is now absolutely established in England and Wales—the health service there is a very different animal. I am bound to say that I am not convinced about simply setting up competition within a finite resource. If someone suddenly introduces 2,000 new doctors by magic, by waving a private sector banner, that is fine. That is a different proposition, but it is not what is happening in England and Wales. I find it difficult to support the amendments.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): This has been a considered debate and I have taken a lot of notes. I will try to respond to as many of the points raised as possible—I hope that I will be able to read my handwriting.

I will continue in the spirit of consensus. I understand the sincerity with which Mary Scanlon lodged amendments 1 to 5 and I appreciate that an important and complex debate lies behind them. As members know, amendments 1 to 5 would remove the whole of part 2, on primary

medical services. In doing so, they would undermine our objective of ensuring that any holder of a PMS contract, as the first and sometimes the only point of contact with patients, is directly involved in the NHS. The bill expects contract holders to demonstrate that through the involvement of a medical practitioner or, in the case of section 17C contracts, another health care professional, as well as through involvement in the clinical care of patients or in the running of services on a day-to-day basis. Part 2 also proposes to clarify and amend the list of persons who are eligible to contract with health boards for the provision of primary medical services. It will remove the current, very wide power that boards have to make contractual arrangements with any person.

11:30

I will start by addressing one of Helen Eadie's points. I put up my hands and concede that, in the past, I might have contributed to the simplistic view that the debate is purely about public versus private. At the moment, general practitioners are, in the main, independent contractors. A better way of characterising the discussion is that it is a debate about whether contractors are directly involved in the running of health services or whether they have a more arm's length relationship with the NHS.

The bill expressly does not prevent companies from holding contracts; it specifies certain criteria that those companies must fulfil, which include the involvement of a medical practitioner or other health care professional and the requirement to do with involvement in clinical care or the running of services. The bill and the amendments that we will debate in a later group include some important flexibilities that would allow us to respond to changes in the current model of general practice. In that regard, I listened extremely carefully to the comments that the committee made at stage 1.

Mary Scanlon cited a number of countries where what she described as the public-private relationship works well. She is entitled to do so, and she is correct to a great extent, but I urge a degree of caution, because other countries have different models of primary care. In some of the countries that she cited, it is common to pay to see a GP, so there are important differences, and it is not possible or helpful to try to draw precise analogies.

I will not knock what is happening at Canary Wharf or in Tower Hamlets because, unlike Helen Eadie and Mary Scanlon, I have not observed it at close quarters. However, some important points about that have already been made by Richard Simpson and echoed by Ross Finnie. The organisations in question exist in London, where there are particular and very peculiar circumstances, which it cannot be said are replicated here in Scotland.

That said, from what I have heard there are flexibilities around how the contracts in question work that have much to commend them. Mary Scanlon mentioned flexibilities around the treatment of long-term conditions and access, both of which I aspire to achieve. I simply take the view that, as Ross Finnie said, it is not the case that those flexibilities and those improvements in how we deliver general practice can be delivered only through that commercial model. I believe that we can deliver them within the NHS by developing the model that we have.

I accept that there is work still to do on long-term conditions, but the quality and outcomes framework has already considerably improved the management of long-term conditions in primary care and general practice. I am on record as saying, and have said on many occasions, that I want improved access to general practice. The extended hours that Richard Simpson referred to have gone some way towards providing that, but I have a strong appetite for working with general practice to further improve access for patients, because, as a matter of principle, we should make access to primary care and general practice as convenient for the patient as possible. I agree with Richard Simpson that the patient should be at the centre of all the discussions on that. I do not disagree that some of the service developments and flexibilities that Mary Scanlon talked about are desirable; I simply dispute that we need commercial contracts in order to deliver them.

Richard Simpson made a considered and valid contribution and I agree with many of his points. He asked how, if the bill is passed, the law would cater for the situation in which a health board could not deliver GP services in what are known as hard-to-doctor areas. He rightly and fairly acknowledged that that is a highly unlikely scenario, given that we do not have a shortage of GPs in Scotland, and that, if such a scenario did arise, it would be more likely to do so in rural areas. The answer to his question is that health boards would have the option of employing salaried GPs. If other amendments that we will discuss later are passed, the bill will give ministers the power, by way of regulation, to allow health care professionals other than medical practitioners to hold general medical services contracts as well as section 17C contracts, as is already possible. We will discuss other amendments later that are about social enterprises being involved in holding contracts.

Finally, I question whether we could guarantee that, in really hard-to-doctor areas, the private sector, by which I mean the commercial sector,

would be willing and ready to fill the gaps at the extreme end of the market. I question whether the economics would stack up. I acknowledge the points that have been made, but I question whether the magic—or not so magic—solution to those problems is necessarily the kind of model that we see south of the border.

Richard Simpson's point about A and E was well made. There is an issue about how we ensure that patients do not end up in A and E when they should be seen in primary care. Frankly, that remains a challenge, almost regardless of the contractual arrangements that we arrive at through the bill.

I hope that that is an exposition of my position as well as a brief response to some of the points that have been made. I ask Mary Scanlon to withdraw amendment 1 and not to move her other amendments. However, on the suspicion that she might not agree, I encourage members to vote against her amendments. We will discuss other amendments later that I think will address some of the points that members made. Of course, I remain willing to continue to work with the committee during stage 3 to address, as far as we can, some of the legitimate points that have been made.

Mary Scanlon: I thank all committee members and the cabinet secretary. The amendments stimulated an important and interesting debate, not just on the amendments but on wider issues such as A and E, to which all members contributed enormously.

I say to Richard Simpson that I think that the commuting question is a genuine issue. As a commuter from Inverness who stays in a different place for three days a week, I know that commuting is difficult. It is difficult to get a prescription or to see doctors at certain times. We should not assume that everyone who commutes between Edinburgh and Glasgow has easy access to a doctor.

People often do not present early for diagnosis of medical problems. I emphasise to the men on the other side of the committee table that men in particular tend not to present early. A walk-in centre provides an opportunity to avoid taking a day off work and to present early.

Everybody has talked about the London model, but that was all that Helen Eadie and I could see in the time that we had. We asked the clerk whether it was possible to see the mobile units that operate down in Devon and Cornwall. However, given the time constraints, it was simply not possible to do that. I apologise for mentioning only the London model, but that was all that we had time to see, given that there are no commercial providers in Scotland. It was important that we made the visit, although I regret the fact that we were unable to see the Atos mobile units that go around rural areas. They would be important in and relevant to the area that I represent.

Richard Simpson's point about A and E was first class. I reiterate that there was a significant decrease in the number of presentations at the local A and E because of the walk-in centre at Canary Wharf. Ian McKee said that people were paying twice—actually, there was a saving at A and E because considerably fewer people presented there.

I share Ian McKee's view: I am very proud of our health service. I do not wish to deny that. I commend each and every person who works in that service.

When Helen Eadie and I were asking about the people who presented at the walk-in centre, we found that quite a few of them had gone along for a second opinion. That is an important point. Some people were not quite sure that their diagnosis was right, so they sought a second opinion. It could be said that their service is therefore paid for twice, but I believe that many patients are entitled to a second opinion. I am not sure about that, but quite a lot of people did ask for one.

I thank Helen Eadie for her excellent contribution to the debate, and for making the point about patients being at the forefront. The right to treatment is based on a right to access. Helen Eadie mentioned infertility and bariatric surgery, which is a huge issue, but there must be a right of access in order to have a right to treatment in the NHS.

There are six walk-in centres in England, not just one. I agree with Helen Eadie that NHS money follows the patient. I appreciate the fact that Ross Finnie is not attracted to what has happened in England and Wales, but the competition that he mentioned was certainly not what I saw—although I cannot speak for Helen Eadie. I did not see that at Tower Hamlets. The doctors who worked in that service had the same NHS contract but a different employer. Private doctors did not appear out of nowhere by magic; they were the same doctors who had worked for the primary care trust; they just moved on to another employer.

The cabinet secretary talked about an arm's-length relationship. I had thought that the private provider would be distant from the NHS but, as I said earlier, a member of the primary care trust that awarded the contract sits on the provider's board. The NHS and Atos Healthcare—that is the only example that I can give, because it was the only one that I saw—work together very closely.

I accept that different countries have different models, and that none is quite identical to ours. I

thank the cabinet secretary for acknowledging the issues that have been raised by the committee. The points that have been raised—by our doctors' party and others—have been measured and considered.

The Convener: There is a new party.

Mary Scanlon: There is a new party, yes. I can base my comments only on what Helen Eadie and I were able to see at first hand. I will not repeat what I said earlier about how impressed I was by the chronic disease management, the treatment of long-term conditions, access, screening and immunisation.

On hard-to-doctor areas and the commercial sector, and referring to the existence of pharmacies with consulting rooms on every high street and in pretty well every village in Scotland, it appears from the submission by Community Pharmacy Scotland that it would be standing by and willing—should it prove necessary—to have a GP practising within high street pharmacies. That might be one model; I did mention it.

11:45

Nicola Sturgeon: Listening to Mary Scanlon extol the virtues of walk-in centres in England, we should not lose sight of the fact that there are different models of primary care service around Scotland. In every part of the country, there are health centres and community hospitals with GPs that are co-located with minor injuries units, social work services, dentists and other aspects of primary care. Let us not falsely claim that all those exciting things are happening in England through commercial involvement and that none of them is happening in Scotland. Within the NHS model in Scotland, there is much of that innovation and better integration in primary care, which I believe is a good thing.

The Convener: I invite Mary Scanlon to press or withdraw her amendment.

Mary Scanlon: I press the amendment, convener.

The Convener: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Scanlon, Mary (Highlands and Islands) (Con)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

The Convener: The result of the division is: For 1, Against 7, Abstentions 0.

Amendment 1 disagreed to.

Section 29 agreed to.

The Convener: I do not mean to be patronising, but I thank members for the quality of that debate.

Section 30—Section 17C arrangements: persons with whom agreements can be made

The Convener: Amendment 74, in the name of Dr Simpson, is grouped with amendments 60, 61, 62, 75, 76, 63, 77, 78, 67, 68, 70, 79, 80, 72 and 73A.

Dr Simpson: Apart from amendment 73A, the amendments address the issue of how to effect the wish of the committee that is expressed in paragraph 139 of its stage 1 report. The report states:

"All members of the Committee consider that there can be no guarantee that the existing model of general practice will survive in the long term. For example, there may come a time when a health board may struggle to secure primary medical services for a particular community, whether that be in a rural location or a disadvantaged urban area. One possible future development might be that a community might wish to form a co-operative to contract for a GP practice if the health board had been unable to secure primary medical services through any of the currently available options".

Amendment 74 seeks to open the door to community co-operatives and other social enterprises.

Amendment 75 is a technical amendment to allow such bodies to come in and the agreements to be with the party represented by the co-operative or social enterprise.

Amendment 76 seeks to define the co-operatives, basically saying that their purposes should be beneficial to the communities and that they should operate on a not-for-profit basis. I foresee that situation occurring in the not-too-distant future. Indeed, co-operatives have been established in England that are working extremely well. The bill should allow the opportunity for such co-operatives to be established in Scotland, as an alternative structure.

Amendments 77, 78 and 79 are technical.

Amendment 80 requires the board to satisfy itself about the links, beneficial purposes and not-for-profit operation of such organisations.

Amendment 73A is slightly different in that it seeks to ensure that there is an affirmative resolution so that the matter can be discussed by the committee in full when alternative forms are

proposed or when it is proposed that alternative health professionals should run GMS contracts.

I move amendment 74.

Nicola Sturgeon: The Government's amendments in the group seek to respond to the committee's comments at stage 1. They seek to provide further flexibility in defining those who are eligible to hold a primary medical services contract, by expanding the current definition of a qualifying company. As currently defined, a qualifying company is restricted to a company limited by shares. These amendments expand that definition to mean any company.

That will allow many social enterprises to become holders of primary medical services contracts, provided that they also meet the existing criteria of having a medical practitioner or, for section 17C contracts, a health care professional, as one member of the company, and that all other members are individuals. All members of any such company will have to meet the criteria for involvement in patient care.

I have informally consulted some voluntary sector representative bodies, and they have broadly welcomed the amendments. CEiS co-authored a paper that was sent to the committee by Senscot social enterprise network and it has also indicated informally that it is content with the amendments. Obviously I do not speak for those organisations, and the committee might want to speak to them directly, but the representatives of the bodies to whom we spoke welcomed the amendments because they will provide further flexibility.

Richard Simpson's amendments would introduce additional groups into the list of those who are eligible to hold a primary medical services contract, namely community co-operatives and other social enterprises. I have some sympathy with the amendments as they broadly seem to be trying to do what the Government amendments seek to do, but they do not define community co-operatives and other social enterprises, nor do they require the members of those organisations to meet the criteria for involvement in patient care. For those two reasons I am not able to support Richard Simpson's amendments.

I have some sympathy with the intention behind the amendments, but the flexibility offered by the Government amendments to the types of legal person able to hold a contract, together with my amendments to be debated in a later group that will allow nurses or other prescribed health care professionals to hold GMS contracts, will mean in practice that many social enterprise organisations that might wish to become contractors in primary medical services will be able to do so. Of course, members of such organisations will still need to meet the involvement criteria, but that is an important condition.

For those reasons, I hope that Richard Simpson will acknowledge that we have gone some way towards addressing the committee's points, and I ask him to consider withdrawing his amendment 74 and supporting the Government amendments, which, if they are all taken together, will deliver the flexibility that he is looking for.

Rhoda Grant: I support the amendments in this group, particularly Richard Simpson's amendment on community co-ops, because that is important to the bill.

The other amendments insist that a GP should be involved in the company that is delivering the service, and that is not feasible for a community co-op. The Office of the Scottish Charity Regulator rules mean that each co-op would probably be set up as a charity, which would not allow an employee to sit on the board. That is different from what the Government amendments are saying. However, it could not be argued that a community co-op has no interest in the delivery of medical services, because it would be made up of people from the community to which the services would be delivered, so there would be an interest there, even if the GP could not sit on the board because that is against charity regulation.

I come from a rural area, and know that there is good practice out there, when GPs who might be looking for people to share in their practice or who want to sell their practice involve the local community in recruiting a new GP. That has been very helpful. It is important to take the extra step, especially in communities in which co-ops have taken the lead in community development. It is important to allow them to recruit their GP to meet the needs of their community.

Aside from that, allowing community co-ops to be involved would have a beneficial impact on communities in hard-to-doctor areas in inner cities and so on, because it would grow stronger communities in areas where there may be community breakdown. We have not really spoken or thought about that issue, but it would be a knock-on benefit. We need to include in the bill a provision that deals with community co-ops, as they are quite distinct from the other categories listed in the bill.

Ross Finnie: I will address first the cabinet secretary's amendments, which are helpful. I was concerned that companies limited by guarantee were not covered by the bill, as they have no shareholders. As the cabinet secretary said, the amendments extend to a number of other organisations that are constructed in that way. I have pursued with her the other arrangements that

might be entered into under existing contractual operations.

I have some sympathy with what Richard Simpson is trying to do. In his amendments, he is trying to keep matters relatively simple and provide greater clarity than was evident in the general discussion that took place at stage 1. I am not trying to be clever, as I might not have come up with anything better, but amendment 76 would insert two new subparagraphs in the 1978 act. The reference to community co-operatives having links or pursuing purposes beneficial

"to the community for which the primary medical services are to be provided"

is interesting but, unfortunately, the amendment does not necessarily link community co-operatives to the provision of those services. There is a slight disjunction in the flow of the provision, which is a little awkward. That is important because, notwithstanding the important points that Rhoda Grant made in relation to charity law, there should be a more direct link to the purpose of community co-operatives. I know that that is difficult—Rhoda Grant made the point well—but I do not think that subparagraph (i) of the new paragraph that would be inserted by amendment 76 gives quite the same coverage as other provisions in the bill. When winding up, Richard Simpson may want to consider the suggestion by the cabinet secretary and others that he lodge the amendment again in a form that fits more naturally with the other categories listed in new section 17CA(2) but affords a form of arrangement for community co-operatives that is very different from those prescribed in paragraphs (a) to (f).

Helen Eadie: I refer members to my entry in the register of interests, as in the past I have been sponsored by the Co-operative Party. I am a lifelong supporter of the co-op ideology, so it is with great pleasure that I support Richard Simpson's amendments this morning. We should keep in mind the fact that there are many forms of social enterprise. The memoranda and articles of association that can be drafted and designed provide for a variety of community co-operatives and social enterprises. We should not get too hung up on the use of the term "community co-op". It is fundamental that we accept that co-ops are at the heart of mutuality—they gave birth to that idea.

I am pleased that the cabinet secretary has responded so positively to what the committee has been trying to achieve, but it is important to include in the bill the definitions that Richard Simpson sets out in amendments 74 and 76, because there is always a danger that someone may try to establish a social enterprise that does not correspond to what we understand a community co-operative or social enterprise to be. It is important to require that the community co-operative

"has sufficient links, and pursues purposes beneficial, to the community",

because there is a danger that, otherwise, a company could come along in disguise and try to set up a community co-op.

The cabinet secretary made the point that the community co-operative or company limited by guarantee would have to have a medical practitioner as a member of the board. We have to approach that with a degree of caution, given what is normal in many social enterprises. I hear what Rhoda Grant says, but in many social enterprises—I have been involved in setting up many—there is another issue that needs to be taken into account: in a rural setting, or even in a big city, there might not be such a professional on the board in the beginning, but once someone has been appointed they can become a member of it. The issue would be the danger of not allowing something to happen. I do not know whether I am getting my point over, or whether the cabinet secretary understands the point I am making.

The cabinet secretary is saying that if a GP is not a member of the board to begin with, the community enterprise cannot exist, but once a GP has been appointed it would satisfy the criteria. The danger is that an enterprise in a rural area of the Highlands and Islands might not have that person in the beginning, but it would satisfy the criteria later on. I hope that amendments that we agree to today or at stage 3 ensure that there is provision for that, because it is important to provide for it.

12:00

Mary Scanlon: I, too, would like to put on the record the excellent work of community co-operatives and social enterprises, some of which were present in the Parliament's garden lobby last night.

I am concerned about the issues that are raised by this group of amendments. There is a proposed extension to community co-operatives and social enterprises, but it is limited to one type of organisation: those that have a medical practitioner involved in patient care. That is not flexible enough. I will give two examples from the Highlands to illustrate why.

This morning, we received the guidance on the retirement provision and the reasonable absence provision. I hope that I have taken in the information in the short time that we have had. My first example is a retired GP—I know one—who wants his practice to be taken over by a family member but has to wait until they graduate. Such a GP might retire from the practice and employ

another doctor to run it in the interim until his daughter can take over, but under the new arrangements he would be given a retirement period of only six months, so it would not be allowed. The proposals appear to have unintended consequences and they are restrictive.

My second example is a disabled GP who is unable to commit to providing medical services but still has a commitment to his or her patients and the NHS and wishes to maintain their practice by employing another doctor.

The proposals limit the provision of general medical services too much, so I will not support the cabinet secretary's amendments. They are not flexible enough in terms of patient access, patient care and the setting up of a diverse structure of organisations.

Nicola Sturgeon: The six-month period that Mary Scanlon refers to relates to new contracts. In established contracts, the transitional period for a GP retiring is five years. I hope that that deals with her concern.

I think that, Mary Scanlon aside, there is a fair degree of consensus on what we are trying to achieve here. I certainly hope that members will back the Government amendments, because I believe that they take us in the right direction.

Although, as I said at the outset, I have sympathy with the motive behind Richard Simpson's amendments, they contain certain key terms such as "community co-operative", "social enterprise", "not-for-profit basis" and, indeed, "community" that are not defined anywhere in law. I take Helen Eadie's point that there are different forms of community co-operative, but the fact is that we are trying to pass legislation and need to provide a legal definition of such terms.

As I said earlier, I believe that the Government amendments provide a large proportion of the flexibility that members are looking for. If Richard Simpson agrees to withdraw amendment 74 and not move the others in this group, I will be happy to continue the discussion to see whether we can do anything more to close the gap between the Government's position and the views of committee members, certainly Labour committee members. I cannot give an absolute guarantee that we will be successful in that, but I am certainly willing to continue to discuss the matter and see what is possible.

Dr Simpson: We have had another very useful debate and I welcome and support the Government amendments, which provide greater flexibility with regard to the form of the companies that might be involved. However, there is still a debate about whether the requirement for a medical practitioner—or, if the other amendments are agreed to, some other health professional—to be involved in the company, in whatever form it takes, still excludes community co-operatives that do not have any health professionals and prevents them from playing a role. There might well be communities, particularly in villages, where no health professionals are in residence or where the health professional does not want to be part of the co-operative.

I will withdraw amendment 74 not because of any assurance that the Government will lodge similar amendments at stage 3 but because of the assurance that we can discuss where my initial, perhaps slightly ham-fisted, attempt to define these things is inadequate. I accept that it is necessary to define these matters properly. In view of the Government's undertaking to work with us to reach an agreement on amendments that either the Government or I can lodge at stage 3, I will withdraw amendment 74 and not move amendments 75 to 80.

I will take the convener's advice about what to do with amendment 73A, because it links to amendment 73 about eligibility.

The Convener: You do not need to deal with amendment 73A at the moment.

Dr Simpson, we would never call you ham-fisted, but you do have to ask the committee's permission to withdraw your amendment.

Dr Simpson: I got a lot of help from our support staff, but perhaps I did not make things as tight as I might have done.

The Convener: The point is that you cannot just withdraw your amendments; you have to seek leave to withdraw them.

Amendment 74, by agreement, withdrawn.

The Convener: And that is subject to amendment 73A still being live. [*Interruption.*] The clerk tells me that we will come on to that. I believe that that is a technical expression.

Amendments 60 to 62 moved—[Nicola Sturgeon].

The Convener: Do members object to a single question being put on these amendments?

Members: No.

The Convener: The question is, that amendments 60 to 62 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)

Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 1, Abstentions 0. [*Interruption.*]

The clerk is saying that we should vote on amendments 60 to 62 individually. Do members wish to vote for them individually or en bloc?

Members: En bloc.

The Convener: We have voted for them en bloc. I love correcting the clerks for a change.

Amendments 60 to 62 agreed to.

Amendment 75 not moved.

The Convener: Amendment 81, in the name of Ian McKee, is grouped with amendment 82.

Ian McKee: I agree with the cabinet secretary that, whatever institution is providing patient care, it must demonstrate involvement in patient care. Further, I believe that that involvement must take place in the community in which that care is being provided.

Under the bill as it stands, it is possible for a health care professional who provides a minimal service in primary care—as little as one day a week for something like 42 weeks a year—to provide that service anywhere in the national health service in the United Kingdom. That means that a health care professional who provides a service in London could apply to provide a health care service in Wick. However, even within Scotland—if we leave the issue of the UK aside for the moment—there are great differences between primary care practices.

I was inclined at first to lodge an amendment that said that the health care professional who is involved in patient care should be a member of the practice in question but, through discussions with colleagues, I realised that, especially in deprived areas, some practices come up with innovative solutions within their mini-area or community and that the law of unintended consequences could mean that such an amendment would prevent such developments.

Nevertheless, I see no reason why we should agree that a health care professional who works in the health service only one day a week should be able to provide services all over the country. That is not a hypothetical situation: in England, one organisation runs between 35 and 40 practices throughout the United Kingdom. I feel that if such a situation were to occur in Scotland there would be little difference between that and an ordinary commercial company providing a service, which is something the cabinet secretary has said she wishes to discourage.

Amendment 82 deals with the same principle as amendment 81.

I move amendment 81.

Dr Simpson: The restrictions and definitions that the cabinet secretary has laid down in the paper are adequate. I would be slightly concerned if the provision limited doctors to only one health board area, as lots of practices go across two or three health board areas. If a doctor were working in only one section of such a practice, they would not be able to contract with the health board for the other part of the service.

The way in which the bill is written assures me that we have sufficient restrictions with regard to involvement. I do not think that amendment 82 is necessary and I will oppose it.

The Convener: It is rather nice to see our two doctors opposing each other for a change. They were getting too pally for a while—

Dr Simpson: It is because you said that we were in the doctors' party.

The Convener: You were setting up your own sub-group, I know.

Ross Finnie: I share Richard Simpson's view but I have a question for Ian McKee. I am concerned that the amendments might have the unintended consequence of preventing a newcomer from being employed in a different health board area. For example, some person might decide that they want to establish a practice in the Highlands although they are currently employed by NHS Greater Glasgow and Clyde and all their experience has been within that health board. Perhaps Ian McKee or the cabinet secretary could clarify that.

12:15

Mary Scanlon: As Ian McKee was speaking, I was thinking not just about the scenario that Ross Finnie has outlined but about locum doctors. Many self-employed, independent contracting GPs find themselves working as locum doctors, providing an out-of-hours service in various parts of Scotland. As Rhoda Grant will be aware, the out-of-hours service in the Highlands is so difficult to staff that it has been known for doctors to come from Poland and Germany for a weekend shift. I appreciate what Ian McKee is saying, but I am concerned that the amendments would have unintended consequences.

Nicola Sturgeon: Amendments 81 and 82 introduce an additional requirement that contractors to a primary medical services contract with a health board must have sufficient

involvement in patient care not just anywhere, but in the specific health board area. In responding to the committee's stage 1 report, I said that I would consider whether the involvement criteria should be more tightly drawn. Amendments 81 and 82 would certainly do that. However, as we have heard from committee members today, another view is that we should not be any more restrictive in drafting the involvement criteria.

As on many other aspects of the bill, there is fierce debate on the issue. Notwithstanding that, there are technical issues about the drafting of the amendments. For that reason I ask Ian McKee not to press them today, although I give him an undertaking that we will have further discussions with him and other members of the committee with a view to lodging at stage 3 amendments that specify further the involvement criteria that will require to be met.

Ian McKee: I thank those members who have taken part in the debate on my amendments. They have given me cause to reflect. The principle behind the amendments is the most important thing: I feel that unless some modification is made to the bill it will open the door to commercial intrusion in a way that we do not want in the rest of the bill, but I appreciate that I have perhaps been a little ham-fisted.

Dr Simpson: You, too?

The Convener: Join the ham-fisted club.

Ian McKee: I am glad that my concerns have been taken on board and happily seek leave to withdraw amendment 81.

Amendment 81, by agreement, withdrawn.

Amendment 76 not moved.

Amendment 63 moved—[Nicola Sturgeon].

The Convener: The question is, that amendment 63 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 1, Abstentions 0.

Amendment 63 agreed to.

Amendment 77 not moved.

Amendment 2 not moved.

Section 30, as amended, agreed to.

Section 31—Eligibility to be contractor under general medical services contract

The Convener: Amendment 64, in the name of the cabinet secretary, is grouped with amendments 65, 66, 69, 71 and 73.

Nicola Sturgeon: The amendments in this group will enable the Scottish Government to react quickly to any future changes in circumstances that might require more flexibility in the way in which health boards contract for primary medical services. I am grateful to the committee for highlighting the issue at stage 1.

The amendments propose the introduction of a regulation-making power that will allow Scottish ministers to amend the list of those who are eligible to hold a general medical services contract. Such regulations will have the effect of extending the list to health care professionals other than medical practitioners, and could be used to permit only a particular type of health care professional to hold a contract. For example, it would be possible for future regulations to apply only to nurses or more generally, depending on the circumstances at the time and on what is decided to be appropriate. The amendments also decree that the regulations will be subject to the affirmative procedure.

I move amendment 64.

Dr Simpson: I thank the minister for lodging amendment 64 and for the way in which it is phrased. It refers to "health care professional", which means that we need to discuss, debate and define that term.

The RCN raised the point, and in its stage 1 report the committee concluded that the RCN's position was "measured and reasonable". We requested the amendment that the Government has now lodged, but there are other groups to which the provision might apply in future. I am thinking particularly of physician assistants, whose role is growing in England. As circumstances change, the provision could apply to them. As drafted, the amendments in the group will be extremely helpful in allowing for the potential extension of the role, depending on how general practice develops. I therefore support the amendments.

Mary Scanlon: I put it on record that many nurses and health care professionals are more than capable of holding a GMS contract, but I still think that what is being proposed is too restrictive. I do not think that the bill gives sufficient flexibility, as I have said previously, and I do not support the amendments.

Nicola Sturgeon: Richard Simpson is absolutely right. As drafted, the amendments will allow a future Government to make regulations that allow nurses and a range of different health professionals to hold GMS contracts. The amendments will give ministers flexibility to restrict the application of such regulations to nurses or to any other group. The amendments therefore provide the additional flexibility that the committee asked for at stage 1.

It is for Mary Scanlon to vote as she sees fit, but given that the thrust of her objection to the bill seems to be that it does not provide enough flexibility, it is a bit strange for her to vote against amendments that will deliver more flexibility. That is just a passing observation.

The Convener: The question is, that amendment 64 be agree to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

ABSTENTIONS

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 0, Abstentions 1.

Amendment 64 agreed to.

Amendment 78 not moved.

Amendments 65 to 70 moved—[Nicola Sturgeon].

The Convener: As no member objects to a single question being put on amendments 65 to 70, the question is, that amendments 65 to 70 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

ABSTENTIONS

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 0, Abstentions 1.

Amendments 65 to 70 agreed to.

Amendments 79, 82 and 80 not moved.

Amendment 71 moved—[Nicola Sturgeon].

The Convener: The question is, that amendment 71 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

ABSTENTIONS

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 0, Abstentions 1.

Amendment 71 agreed to.

Amendment 72 moved—[Nicola Sturgeon].

The Convener: The question is, that amendment 72 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 1, Abstentions 0.

Amendment 72 agreed to.

Amendment 73 moved—[Nicola Sturgeon].

Amendment 73A moved—[Dr Richard Simpson].

The Convener: The question is, that amendment 73A be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Grant, Rhoda (Highlands and Islands) (Lab)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

AGAINST

Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)

Grahame, Christine (South of Scotland) (SNP)
McKee, Ian (Lothians) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 73A disagreed to.

The Convener: The question is, that amendment 73 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Finnie, Ross (West of Scotland) (LD)
Fitz Patrick, Joe (Dundee West) (SNP)
Grahame, Christine (South of Scotland) (SNP)
Grant, Rhoda (Highlands and Islands) (Lab)
McKee, Ian (Lothians) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)

ABSTENTIONS

Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 7, Against 0, Abstentions 1.

Amendment 73 agreed to.

Amendment 3 not moved.

Section 31, as amended, agreed to.

Section 32—Orders and regulations

Amendments 59 and 17 not moved.

The Convener: Amendment 38, in the name of the minister, is in a group on it own.

Nicola Sturgeon: Amendment 38 changes from negative to affirmative the procedure under which the Scottish ministers may make regulations in relation to section 17. Section 17 allows ministers to make regulations to provide for the provisions in the bill relating to the register of tobacco retailers to apply to

"vessels, vehicles and other moveable structures subject to such modifications as they consider necessary or expedient."

We lodged amendment 38 in response to recommendations made by the Subordinate Legislation Committee and endorsed by the Health and Sport Committee. We have drafted regulations that will allow retailers who sell tobacco from vehicles and moveable structures to apply to be on the register of tobacco retailers. The regulations are in line with the street traders scheme. No regulations have been drafted yet in relation to vessels, as initial consultation did not indicate that tobacco was sold from such outlets. However, as Rhoda Grant said earlier, there may well be a need to regulate in that way.

I move amendment 38.

Amendment 38 agreed to.

The Convener: Amendment 39, in the name of the minister, is in a group on its own.

Nicola Sturgeon: Amendment 39 requires all regulations made in relation to the fixed-penalty notice scheme under schedule 1 to the bill to be subject to affirmative procedure. Schedule 1 includes powers to allow ministers to make regulations setting the amount of the fixed penalty, the period in which the fixed penalty can be given and the deadlines for payment. The bill currently allows ministers to make some regulations under schedule 1 by negative procedure and some by affirmative procedure. Amendment 39 is in response to recommendations that were made by the Subordinate Legislation Committee and endorsed by the Health and Sport Committee.

I move amendment 39.

Amendment 39 agreed to.

Section 32, as amended, agreed to.

Section 33 agreed to.

Schedule 2

MINOR AND CONSEQUENTIAL MODIFICATIONS

Amendment 18 moved—[Ian McKee]—and agreed to.

12:30

The Convener: Amendment 40, in the name of Mary Scanlon, has already been debated with amendment 12. If amendment 40 is agreed to, I cannot call amendment 19, as it will be pre-empted.

Amendment 40 not moved.

Amendment 19 moved—[Ian McKee]—and agreed to.

Amendment 4 not moved.

Schedule 2, as amended, agreed to.

Sections 34 and 35 agreed to.

Long Title

Amendments 41 and 5 not moved.

Long title agreed to.

The Convener: That is grand. That ends stage 2 consideration of the bill. We were racing towards the end there. I thank the cabinet secretary for attending and for some interesting debate.

Alcohol Misuse (Legislation)

12:31

The Convener: Without a pause for breath, we move straight on to agenda item 3, which is on the approach to forthcoming proposals for legislation. I ask members to look at paper HS/S3/09/30/3 from the clerk. As members will be aware, it is expected that the forthcoming bill on tackling alcohol misuse in Scotland will be introduced in the Parliament shortly and that this committee will be appointed lead committee. We move from cigarettes to alcohol—is there no end to the excitement for us? Where next?

The paper invites us to agree to instruct the clerks to issue a call for written evidence following introduction of the bill; to consider in private possible candidates for oral evidence following consideration of the written evidence that is received; to delegate to me responsibility for arranging for the Scottish Parliamentary Corporate Body to pay, under rule 12.4.3 of standing orders, any witness expenses in respect of consideration of the bill; and to consider in private drafts of our stage 1 report on the bill. Those are our usual practices. Do members agree to do all that?

Members *indicated agreement*.

Meeting closed at 12:33.

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