HEALTH COMMITTEE

Tuesday 6 January 2004
(*Afternoon*)

Session 2

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HEALTH COMMITTEE
1st Meeting 2004, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
*Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING GAVE EVIDENCE:

Kathleen Bree (Orkney NHS Board)
Judith Catherwood (Allied Health Professions Forum Scotland)
Malcolm Chisholm (Minister for Health and Community Care)
Steve Conway (Orkney NHS Board)
Jenny Dewar (Orkney NHS Board)
Stephanie Lawton (Orkney NHS Board)
Kenryck Lloyd Jones (Allied Health Professions Forum Scotland)
Asgher Mohammed (Royal Pharmaceutical Society of Great Britain, Scottish Department)
David A M Thomson (Royal Pharmaceutical Society of Great Britain, Scottish Department)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Graeme Elliot

ASSISTANT CLERK

Hannah Reeve

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 6 January 2004

(*Afternoon*)

[THE CONVENER *opened the meeting at 13:59*]

National Health Service Reform (Scotland) Bill: Stage 1

The Convener (Christine Grahame): I welcome everyone to the first meeting in 2004 of the Health Committee. I have received no apologies. I remind members to switch off pagers and mobile phones. I welcome Nanette Milne, who is sitting in on the meeting to get acclimatised to the Health Committee.

I welcome also the panel of witnesses in Orkney from Orkney NHS Board. We are a bit apprehensive about doing the videoconference with them. Some of us have done one before, but it was a long time ago. I welcome, from Orkney NHS Board: Steve Conway, the director of operations; Jenny Dewar, the chair; Kathleen Bree, the director of allied health professions and nursing; and Stephanie Lawton, the head of human resources.

My first question is a simple one. Do you believe that the bill's proposed change to the structure of the national health service is necessary or appropriate? If you believe that it is, how will the change improve service delivery, which is what it is all about?

I ask one of the witnesses to act as chair of the panel and to direct questions to other members of the panel, if appropriate.

Steve Conway (Orkney NHS Board): If I may, I will answer the questions and ask the others on the panel to contribute as we go along.

In general, we believe that the bill's principles are entirely appropriate and that they will enhance how we provide the services that the bill addresses. In many cases, the bill will merely formalise and impose a statutory duty in relation to service provision that we already undertake.

The Convener: What you are saying is that the bill will just make the provision of services that are already being provided a statutory duty. Is that correct?

Steve Conway: Yes.

Jenny Dewar (Orkney NHS Board): We ought to point out that we do not have NHS trusts in Orkney, so the big restructuring due to the move to single-system working will not affect us. Therefore, we have concentrated on other aspects of the bill.

The Convener: Are members finding the sound a bit difficult?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Yes.

The Convener: I am sorry, but I am informed that nothing can be done about it. We will just have to strain a little. Can the panel in Orkney hear us clearly?

Kathleen Bree (Orkney NHS Board): Yes.

The Convener: We will move on then.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): In their written submission, the witnesses claim that there is potential for tension between regional planning and local needs and local decision making. Will they elaborate on that possibility and on the potential consequences?

Steve Conway: Yes. The first issue is about governance and non-executive directors' involvement in decision making at a regional level as opposed to their current role at board level. The second issue is how we will be able to engage patients and the public actively in the processes at a local level when we are dealing with a regional issue.

Can you still hear me?

Mr McNeil: Yes—with difficulty.

Steve Conway: It went very quiet this end for a minute.

The next conflict that we are a little anxious about is the risks for boards, particularly island boards, if we have to move from the Arbuthnott funding formula to a regional funding formula. The same applies to the voting mechanism within a regional structure. We serve a population of 20,000. If regional planning is activated on a population basis, we do not believe that we will have the fair say that we would like to have.

The other aspect that is particularly relevant to us as an island board is that in the regional context we will have to ensure that everyone appreciates the significant differences in being an island. Those differences are not just about remoteness; there are many other issues.

The Convener: Would you like to develop that? What are the other issues? Perhaps it would help if you elaborated.

Steve Conway: We have 17 inhabited islands, some of which can be reached by plane and some

of which can be reached only by boat. All the islands can be reached only in certain weather conditions. That is not something with which Highland NHS Board, for example, will be overly familiar, although it has regional complexities that we do not share, such as the mileage between locations. Not all our islands have general practitioners. We are also different from other regions in that we have only six surgeons on the mainland, and we have only one hospital.

Jenny Dewar: Another issue that we face is a problem with the recruitment and retention of staff, because we have such a small population. We see regional planning as a way to help us to alleviate those problems by working across boundaries. We welcome the statutory underpinning of that function in the bill. It will make it legal for us to work for our populations but across boundaries.

Mr McNeil: Can you identify any benefits? You have a list of concerns, but you say in your evidence that you generally support the bill. What benefits do you envisage for areas such as yours, apart from the one that you have just described?

Steve Conway: The bill is about making better use of the resources that are available. We already do a lot of regional work, in that many of our clinical services are provided off Orkney by Grampian NHS Board and other health boards. The bill formalises that type of relationship, so it makes best use of scarce resources.

Janis Hughes (Glasgow Rutherglen) (Lab): Your written submission mentions that you do not know much about community health partnerships because you do not have a local health care co-operative in Orkney. Notwithstanding the fact that you are not particularly experienced, you will have read the proposals in the bill on community health partnerships and will be aware of the consultation process that is under way. Will community health partnerships help you to improve service delivery?

Kathleen Bree: We are signed up to the principle of community health partnerships and we see them as a positive move. Although we in Orkney do not have an LHCC as it is known elsewhere, I suppose that the board operates in a pseudo-LHCC way. We certainly envisage the community health partnership developing the involvement of the community and clinical staff in decision making on the development of services, which will be good for the local authority and other organisations. The community health partnership is a much-needed development and, from our perspective on the island, it is also the way forward for sustained services.

Janis Hughes: Could anything be added to the bill to help with community health partnerships, particularly given the issues that you face?

Steve Conway: I do not think that we have identified anything to date. Perhaps other witnesses can think of something.

Jenny Dewar: Given that all health boards are currently developing community health partnerships, we are concerned that we have not seen the detail of the regulations. We would not want to see anything in the regulations that cuts across the development work that we are already doing. We would like them both to be aligned.

Shona Robison (Dundee East) (SNP): You argued in your evidence that the five-week consultation process was not long enough and went on to state that local health councils are highly thought of in the community. Will you say a little more about that? In particular, you have said:

"Centralising LHCs would disadvantage these areas."

Will you comment further on that?

Jenny Dewar: There are two things to say about that. On the consultation period, our evidence demonstrates that we did not have much time to put it together. As I said, I do not think that the local health council had the opportunity to consult the community, so what is in the evidence from us are the views of individual board members. We welcome the chance to put all that together today and to give a more cohesive board view.

I turn now to what the local health councils do and the issues that we think might arise in Orkney. At the moment, the local health council is drawn from a population of less than 20,000, and the same people generally do the same sort of community work across Orkney. If a local advisory council is put in place, as it will be, many of the current local health council members will be the people who put their names forward. Because of their health involvement, they are also the people whom the health board, with its new duty to consult the public, would look to consult. We do that anyway, but the new proposals formalise the process.

Given that the local advisory council's role is to feed its concerns into the Scottish health council, I wonder whether there might be a conflict because the same people will be doing the same things. Where consultation has taken place but not everyone is satisfied with the outcome, people might feel that an issue ought to be raised with the board about the conduct of the consultation.

The point that I really want to make about our local health council—I am sure that it is the same in other areas—is that it has a wealth of experience and a deep understanding of health issues in our community. I would be sorry to see that dissipate with the introduction of a new structure, so I hope that any such introduction will

be managed so as to retain that expertise and commitment.

Shona Robison: Do you see a way of achieving that within the bill, or do you feel that the bill needs to be amended to reflect that and to ensure that that important role is maintained?

Jenny Dewar: I do not think that that will necessarily be achieved in the bill. In fact, I would be reluctant to see too tight a provision made in the bill, because I recognise that different health councils work in different ways in different areas. If anything, I would like there to be flexibility in the regulations and the set-up to allow boards to work with the local advisory councils and, at national level, with the Scottish health council to produce something that will achieve what we are looking for. Basically, we want to get people involved in our planning and service delivery and we want to get their views on how we provide services.

Mr McNeil: In your written evidence, you said:

"Local Health Councils are very active & highly thought of by the communities they represent as being their voice within the NHS."

Were no health council members available to give us evidence today? Were they invited along? Did you attempt to involve health council members in giving evidence to the committee?

Jenny Dewar: No, because we felt that it was your role to invite council members if you wanted their views.

The Convener: I was about to come in with a pre-emptive strike before you answered. That is a matter that we should have considered. Having made that omission, we could now ask for written evidence. You are exonerated and we are not.

Mr David Davidson (North East Scotland) (Con): Are the witnesses satisfied that the new national health council, which the minister proposes in the bill, will be more independent than the local health councils?

Jenny Dewar: Yes, because at present health council members are appointed by health boards. I have reservations about the council coming under the umbrella of NHS Quality Improvement Scotland, as it is clear that there will not be quite as much independence as there could have been, although I see that the proposal reflects the need to focus on quality issues around health care services and on having an outside view of assessing those services.

14:15

Mr Davidson: We have received evidence from other groups and bodies that are worried about the new health council being perceived as being a part of NHS Quality Improvement Scotland. Is that a concern in the Orkney NHS Board area? Do you have any evidence for that concern?

Jenny Dewar: It is a concern among people who discuss the issues, but I would not say that it is an issue for the community as a whole—it would be daft to say that. People worry mostly about health care issues when such issues affect them directly.

Mr Davidson: Do I take it from what you say that the local health council acting as a representative of the community, if you like, and working locally does a job that you think is different from that which a new national body that sits within NHS QIS would do?

Jenny Dewar: Very much so. If we wanted to continue in the same way, taking on board our statutory role in public involvement, I would poach people from the health council and use them to facilitate community involvement in what we are doing, but that is not the role of the new advisory council.

Mr Davidson: Do you want to add anything about the independence of the national health council?

Jenny Dewar: No. I think that the proposals are misleading. There will be more independence than there is at present, but I would not regard the council as being totally independent.

The Convener: If any member of the panel wishes to say something, they should indicate that.

Kate Maclean (Dundee West) (Lab): I want to ask Jenny Dewar to expand on her response to Shona Robison's question about local health councils. Many of the written submissions that we have received express concerns about the loss of local representation in the shape of health councils. I understand from your response to Shona Robison's question that you expect local advisory councils to be made up of the same local people who are interested in health issues in the area. Is that the case? If it is, would that compensate for the dissolution of local health councils?

Jenny Dewar: That would happen in Orkney because of its small population and the fact that the same people take on community involvement wherever one looks and in whatever field. However, I can see that the picture could be quite different in the Highlands or greater Glasgow, for example, where there are much bigger pools of people to take on involvement.

Kate Maclean: I presume that if the health board has a duty of public involvement, technically every person who lives in the health board area could be involved in discussions and decisions about services. Are you confident that that will

happen? Would that also compensate for the loss of local health councils?

Jenny Dewar: At the moment, we support pulling people into whatever planning processes we undertake, whether they are health council members or come from other voluntary organisations. Perhaps Steve Conway will say a few words about the healthfit day that we had in that context. Essentially, there is a culture that we are proud of. We clearly reach out. I am absolutely convinced that there is room for improvement, but if we start from the basis that we want to involve people, we are halfway there. The issue is about getting the structures and processes right so that everybody is involved and not just those who put their names forward.

Steve Conway: I will give an example of that process. In December, we had a healthfit event. We invited interest groups, commissions, members of the public and patients to a core service review. The event was split over two days, when we considered all the aspects of service provision in Orkney. That demonstrates clearly that we involve the community in the processes, and that we acknowledge the benefit in doing so.

Dr Turner: On public involvement, we could learn a lot from Orkney because all the difficulties that you have up there make Orkney a microcosm of Scotland. It sounds as though people communicate well with each other. How will public involvement improve the consultation process in the NHS?

Kathleen Bree: I am sorry; we were debating who would answer. Public involvement can advise us on where we are not consulting effectively. The process is cyclical. By engaging the public, we can learn where the gaps are and about the places that we are not managing to reach. Even if only the usual suspects are willing to get involved, public involvement can inform us how we can expand our consultation process and advise us how we can engage with other people who might be reticent or who have not wanted to be involved in the past. The process is on-going. Members of the public can be our advisers as well as being consulted.

Jenny Dewar: Involvement rather than consultation is key.

Dr Turner: Have you thought of any new ways of involving the public other than what you have done already?

Kathleen Bree: I am sorry; we did not hear your question.

Dr Turner: Have you thought of any new ways of involving the people who do not normally get involved? You seem to do the job so well because of the nature of your geography. In fact, you have answered the question in your answers to other questions.

The Convener: I just want to clarify whether making it a duty to consult will make any real difference. If you are consulting the public to find out what is wrong with their NHS, does making such consultation a duty make any difference?

Steve Conway: I do not believe that it will in Orkney. As we keep emphasising, the community is very small. Kirkwall has a population of 12,000 to 14,000. Everybody that we deal with or meet has some influence on our thinking. I do not believe that making consultation a statutory responsibility will affect the way in which we undertake that responsibility.

The Convener: No, and you would not like to speculate about the effect on other health boards. That is not your job.

Steve Conway: We do appreciate the difficulties that much larger boards will face. I do not imagine for one minute that the Health Department is using the proposal as a stick to encourage larger health boards to involve the public, but it will help to focus their attention.

The Convener: Thank you.

Helen Eadie (Dunfermline East) (Lab): The evidence that the Health Committee has received, including a submission from the British Medical Association, suggests that there should be more detail about when the power of intervention should be used. What are your views on that?

Steve Conway: The intervention by ministers is the one area that we are concerned about. We in the NHS have clear structures and procedures in relation to performance, whether corporate or individual. Although we acknowledge that the bill's proposals are to be used only as a last resort, it is hard for us to imagine a situation in which ministerial involvement against an individual could occur without its affecting the whole board structure.

Stephanie Lawton (Orkney NHS Board): Building on the principles of staff governance and best practice, we would support the full exhaustion of all available internal procedures before resorting to ministerial involvement.

The Convener: Will you develop the notion of staff governance, please? What is meant by that term? You state in your written evidence:

"Staff Governance is not included as a statutory duty of Boards."

Will you please develop the point, linking it to the power of intervention?

Stephanie Lawton: NHS Orkney fully embraces the principle of staff governance and supports its

implementation locally. We fully implement the partnership information network guidelines—the PIN guidelines—which allow for individual performance and, if necessary, corporate performance to be identified and measured. We view the intervention of ministerial powers very much as a last resort. We assume that other policies would be exhausted first.

The Convener: I think that the next question is a colleague's. Take over please, David.

Mr Davidson: That is very kind of you, convener. We do play a team game down here now and again.

The point about staff governance's not being a duty has been laboured—it is mentioned twice in the submission to the committee. What provisions would the witnesses have liked there to be in that regard, bearing in mind the fact that the minister proposes to lodge an amendment at stage 2 to place a duty on health boards and special health boards to ensure that they have in place systems to monitor and improve the governance of NHS employees? Are there any particular things that the committee should take from your ideas on staff governance?

Jenny Dewar: Before the bill's publication, the board had three governance duties, only two of which were statutory and which were to do with clinical governance and financial governance. Retaining staff governance as a non-statutory duty would have given the wrong message to our staff about the importance that we attach to it, so I thoroughly welcome the news that an amendment is likely to appear at stage 2.

Mr Davidson: I repeat the final part of my question: what views should the committee take on board when we come to discuss the minister's proposal at stage 2?

Jenny Dewar: I did not quite catch that, but I would be looking for the duty to be present and for it to be statutory. We would need the same flexibility as exists in relation to other issues in how boards implement the duty, bearing in mind the fact that boards must provide a system of governance.

Mr Davidson: Convener, perhaps we might ask Orkney NHS Board to send us something in writing about staff governance.

The Convener: Is the panel content to provide that?

Jenny Dewar: Yes, absolutely.

The Convener: Thank you very much.

Helen Eadie: I have a question about equal opportunities, which is a very important issue for the Scottish Parliament. What do the witnesses feel about the proposed measures for giving health bodies a duty to encourage equal opportunities when they carry out their statutory functions? How do you envisage the measures' being put into effect?

Stephanie Lawton: NHS Orkney fully supports the implementation of equal opportunities and has in place the necessary policies and procedures. A local race equality scheme is in operation and we monitor our requirements regularly in accordance with the Race Relations (Amendment) Act 2000. Race equality in Orkney is not a major concern, but we recognise that we have a responsibility and a requirement to monitor race equality matters and to promote equal opportunities, so we do that.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I would like to ask a supplementary question, after Helen Eadie has responded.

Helen Eadie: The points that I wanted to raise have largely been covered in the answers to my questions, but I would like the witnesses to give examples of disability issues that they encounter in relation to public involvement and equal opportunities, because I imagine that the engagement of people with disabilities in public participation is a matter of concern in Orkney, as it is everywhere.

14:30

Jenny Dewar: It is possible that issues around consultation are different in Orkney because they are centred on access. It is difficult for a person with a disability who lives on an island to come to Kirkwall for a meeting, although we make good use of electronic whiteboards and videoconferencing links.

It is also difficult—although I do not think that we do too badly at this—to ensure that people on the remote islands know what is going on. There are certainly channels of communication between staff. On the islands that have small populations, the general practitioner or the family health nurse provides a key focus and a means of disseminating information and receiving people's views.

The real problems relate to access; they include transport and, for carers, the difficulty of finding someone to look after the person for whom they care—he or she might have to come from another island. The problems are practical, but they are not without solutions.

Mike Rumbles: I want to clarify a point about public involvement and to follow up Duncan McNeil's question, when the suggestion that we should have invited the local health council to attend today's meeting seemed to be put to one side. As I understand it, the invitation to attend today was made to NHS Orkney.

In your submission you said that local health councils are "highly thought of" in the community. That goes to the heart of one of the matters that the committee has been concerned with in its work on the bill and, indeed, in its work on the Primary Medical Services (Scotland) Bill, which we considered recently. In the National Health Service Reform (Scotland) Bill that we are now considering, the intention of section 5 is to underpin public involvement legally in order to ensure that patients—the people to whom services are delivered—

"are involved in …

(a) the planning and development, and

(b) decisions of the Health Board".

I think that Duncan McNeil was making the point—I do not want to put words in his mouth—that if Orkney has a good local health council, which provides an effective voice for the community, it might have been useful to have brought that council along today so that we could hear that voice.

Do you believe that Orkney NHS Board currently involves the public effectively in its decision-making process?

Steve Conway: Yes. I accept that you regard it as an oversight that we did not bring someone from the local health council to today's meeting. That was not a consideration, however—

Mike Rumbles: May I interrupt? I am not saying that there was an oversight on your part. I was not expecting someone from the local health council necessarily to attend, but I am interested in the background to your current thinking about public involvement.

Steve Conway: I accept that. Perhaps it would be helpful if I returned to the core service review, which is the best example that I can give of our commitment to public and patient involvement. That review represented probably the most fundamental and significant review of health care provision that our board has undertaken in recent history. It will inform the way in which we will work for at least the next 5 years. We are very sure that we involved all the interest groups, the local health council, patients and the public in that consultation. We will continue to involve them as we develop the review's findings.

In addition to that, two representatives of the local health council attend all board meetings. They are sent the papers a week in advance of meetings so that they can consult other members of the health council.

Kathleen Bree: We also have representatives from the local health council on our corporate management team and our joint management team. In addition, a local health council representative is present at many of our clinical effectiveness steering group meetings. We have quite a list of committees and groups that are part and parcel of our decision-making process and on which the local health council is represented.

Jenny Dewar: I mentioned culture earlier. When a working group or committee is set up, a representative of the local health council or someone from the public is included when membership is being considered. It is usually easier to go through the local health council, because a member of the public is probably involved in the local health council anyway. We acknowledge that we need to work hard at widening that representation further but, for the moment, that is the way the process works, although we will develop it further.

Mr Davidson: I will take Mr Conway back to something that he said earlier. He said that he would be concerned about equality of funding if there was a move towards regional finance planning. That is obviously a crucial issue for Orkney; I am sure that it will be a crucial issue in other parts of Scotland, as well. Will you expand on why you are so concerned about equality of funding, given that there will be powers to treat patients outwith the board, and that money may flow a bit more easily with the patient? What would you like to see in the bill?

Steve Conway: I would like the bill to include more rounded recognition of the funding formulae that are used and an acknowledgement that there is a perception—in many cases, it is the reality—that the funding formulae that exist today can disadvantage island NHS boards. That might be compounded by any regional impositions that are placed on us, unless they are based fairly on the services that we provide and where we provide them.

Mr Davidson: You also said in your written submission that you were looking for the

"power to choose the way we spend the funds, as Scottish Executive directives don't always fit Orkney's situation."

Do you have anything to add to that comment?

Steve Conway: I confess that I was not in the organisation when that submission was produced for the committee, but I think that the basis of that comment was the fact that we spend 10 per cent of our annual allocation on treating patients off the islands. We therefore have to be careful about how the funding arrangements balance, compared to other boards that fund only provision within their own boundaries, other than the national services.

Kathleen Bree: I think that that comment was made about health improvement rather than about service delivery. Although I was not privy to that

comment, I think that the board was trying to emphasise that we sometimes have national directives that are relevant for health improvement, but do not necessarily address the priorities that we have in Orkney. For instance, the emphasis in Orkney would be more on alcohol than on drugs. I am not saying that we do not have some sort of drugs problem, but it is not our main problem; if we consider drugs, alcohol and substance misuse, alcohol is our top problem area. Therefore, when a national initiative on drugs comes out, we need more flexibility so that, rather than focus mainly on drugs problems, we can focus our resources on alcohol problems.

Mr Davidson: That is very helpful for clarity's sake. Thank you.

The Convener: I thank the witnesses very much. We have finished our questions, but is there anything about which we ought to have asked but have not and on which you want to say something?

Steve Conway: No. Thank you very much for the opportunity to be here.

The Convener: I suspend the meeting for five minutes to allow the videoconferencing equipment to be taken out.

14:39

Meeting suspended.

14:45

On resuming—

The Convener: For our next panel of witnesses, I welcome David Thomson, who is the chairman of the Royal Pharmaceutical Society of Great Britain's Scottish department and Asgher Mohammed—have I said that properly?

Asgher Mohammed (Royal Pharmaceutical Society of Great Britain, Scottish Department): Yes.

The Convener: Thank you. Asgher Mohammed is a community pharmacist in Paisley and a member of the Royal Pharmaceutical Society. From the Allied Health Professions Forum Scotland, I welcome Judith Catherwood, who is the convener, and Kenryck Lloyd Jones, who is the secretary. I refer members to papers HC/S2/04/1/2 and HC/S2/04/1/3, which are the written submissions from our witnesses.

Mr McNeil: In today's written evidence and in previous submissions, many organisations have expressed broad support for the development of community health partnerships. Are the structural changes necessary to improve service delivery? How will the changes affect the divide between acute and primary care, and that between health and social care?

The Convener: I think that the witnesses heard the previous panel of witnesses. As with them, this panel does not have a chair because different organisations are giving evidence, so I ask people just to pitch in.

Asgher Mohammed: My experience of local health care co-operatives in the past five or six years is that where the finance that comes to the health board should go in primary and secondary care has always been debated. It is essential that we bring down the barriers between primary and secondary care; the bill's provisions on that are to be welcomed. Changes to structures will also mean more change at grass-roots level. When practitioners work at the coalface, they need to address the changes that make a difference to people. The ethos of the bill is excellent because it is patient centred.

As for the effect on health and social care, it is obvious that different models of LHCCs operate throughout Scotland, but we in Paisley have always had good relationships with our local authority colleagues. That has been essential in allowing us to do all the good work that we have done. We could not have done that without our colleagues. The bill will cement such partnerships and we welcome it.

Judith Catherwood (Allied Health Professions Forum Scotland): For the allied health professions, the dissolution of trusts and the creation of unified health boards and community health partnerships bring many benefits. We support the changes very much, because our services have by nature been small and the creation of trusts generated operational difficulties in delivery of our services. The bringing together of services and the ability to deliver AHP services throughout a board area and across health and social care partnerships will be of great advantage to us. It will affect occupational therapy in particular, because occupational therapists who work in local authorities and those who work in health will have added advantages from working more closely together.

Kenryck Lloyd Jones (Allied Health Professions Forum Scotland): As the allied health professions think more of themselves as having a specific role, increasingly some are concentrated in acute settings and some are concentrated in primary settings. The professions are also increasingly aware of the differences between the two settings and of the need for joined-up thinking on service delivery and planning.

David A M Thomson (Royal Pharmaceutical Society of Great Britain, Scottish Department): The bill can build on the current structure's strengths and allow more multidisciplinary working across the perceived barrier between primary and secondary care, which is a relatively artificial barrier that should be removed. That involves schemes such as medicine management projects—which handle patients' transfer between primary and secondary care—and a drug misuse project under which partnership working with social services supports patients using health care intervention and social care intervention at the same time. The bill offers the potential to build on such projects and to enhance dramatically the quality of patient care.

Mr McNeil: In evidence from the trade unions, we heard about problems and barriers to people working together; for instance, when occupational therapy is delivered for a local authority through the health service. Such problems arise because of different wages and conditions, for example. Have you come across such problems?

Judith Catherwood: Yes. I work in Elgin in Moray, where the OT service is moving towards integration. One difficulty is the differences in terms and conditions, particularly in pay and career structure. I cannot comment more, but there is a difficulty.

Asgher Mohammed: Duncan McNeil asked earlier whether the new structures are necessary to make a difference. If they are to make a difference, all the players must be involved at the level at which they can make a difference. We need the AHPs and pharmacists at the helm, along with our colleagues in the nursing and medical professions. Sometimes, we are not up there and we cannot make decisions for patients. The new structures will be good, but only if we are involved. It is important for the AHPs and pharmacists to be part of the structures, but the bill does not say explicitly that we should be there. We feel that we are sometimes marginalised. Both groups of professions should be involved in every structure in CHPs and above.

Mr McNeil: You argue the case for that strongly in your written evidence.

Dr Turner: What do you hope that the role of your respective organisations will be within the ambit of the new developments? How do you see your role developing?

Kenryck Lloyd Jones: We must remember that the AHPF is an organisation that has existed for only the past couple of years and that it still has no direct funding. To bring together the allied health professions, even at a national Scottish level, means bringing together a diverse range of professions. The challenge is how to do that locally. We must ensure that inclusion of allied health professions means that all the professions that make up the AHPs contribute to the decision-making structures. That is the challenge and it is what the AHPF has set out to achieve throughout Scotland.

Dr Turner: Will there be difficulties in doing that? Until now, the organisation has been very much medical and nurse led.

Kenryck Lloyd Jones: We accept fully that there will be difficulties, but that is not a reason not to do the work, which is necessary. If the Scottish Executive's targets on everything from service standards to waiting lists are to be met, the allied health professions will have a crucial role. Therefore, the work must be done.

David A M Thomson: We must develop to accommodate expectations through the national strategy for pharmaceutical care. Much service development comes through the community pharmacy network—which enhances patients' access to direct supply for minor ailments—and through the delivery of model schemes for pharmaceutical care. The network will need to be supported by individuals who are positioned within the structure and who can help to develop local systems.

Asgher Mohammed: We would expect pharmaceutical advice at board level on the health improvement strategy, which is one of the bill's main focuses. Below that, we need pharmaceutical advice at community health partnership level and below that we have pharmacy locality groups, which are where the hard work will be done. We need good leadership at every level and we need to work with other professions.

It is essential that all the professions have their say. The experience in Paisley was that the LHCC's not being general practitioner led made a huge difference to how it developed: it developed in a more multidisciplinary way. Much of the success of the Have A Heart Paisley national demonstration project was due to people working together at grass-roots level.

Dr Turner: Those are excellent answers. It is important that the bill work for the patient. If pharmacists are to do more for patients, do you envisage difficulties with how patient information will be communicated backwards and forwards? I take it that that is a big worry in being involved at different levels with patients.

David A M Thomson: Absolutely. The developments under "The Right Medicine: A Pharmaceutical Strategy for Scotland" will introduce computer and information technology links between community pharmacies and other prescribers so that community pharmacists will be

able to access NHSnet. There is a trend towards communication being exchanged electronically. Such links are probably 18 months to two years away so, until then, communication will need to be paper based. The arrangements will be in line with developments as they happen at the coalface. Communication is important but I think that it will be resolved by the introduction of IT.

The Convener: David Davidson also has a question.

Mr Davidson: As usual, I must declare that I was once secretary to the royal Scottish pharmaceutical society or, rather, the Scottish department of the Royal Pharmaceutical Society.

Mike Rumbles: Get it right, David.

The Convener: Can you remember what it was?

Mr Davidson: It was a long time ago, in another life.

Will you explain to the committee the important difference between the Royal Pharmaceutical Society and the Scottish Pharmaceutical General Council, which are the two organisations that interface with the Executive? In many cases, the people who will be most affected by the bill will be the contractors—such as community pharmacists—although I appreciate that Mr Thomson comes from a hospital background. The committee needs a fair understanding of the differences and the effects that they will have. The context is that the new pharmacy contract is still under negotiation, but it will be a critical part of how the CHPs will roll out. Will you give us some background information on that?

David A M Thomson: The Royal Pharmaceutical Society represents all pharmacists in Scotland and is the professional body for pharmacists. The Scottish Pharmaceutical General Council represents the interests of contractors, which are the high street pharmacies. We work extremely closely together. By virtue of its size, Scotland affords positive close and collaborative working.

The on-going discussions on development of the new contract are, I guess, entering a stage that will see the introduction of the more local services, so that it will be possible to handle minor ailments through community pharmacies. Those who are least able to afford medication will not be required to access the GP network in order to avoid paying directly for medication.

A medication review is being undertaken within the pharmacy setting in order to improve the quality of current care. Model schemes will be introduced to target patients who have specific disease states; for example, people with severe and enduring mental illness, the frail elderly and people with more chronic diseases such as asthma and epilepsy. The review also deals with the management of repeat supply, which accounts for about 80 per cent of prescription volume. That element will be transferred to the community pharmacy network and will be handled by the community pharmacist, who will have the important communication links back to the initial prescriber.

On the back of that, elements such as supplementary prescribing—which is being introduced just now—will radically change how health services will be delivered through pharmacies in the future. The services will be very patient focused, which will be to patients' advantage.

Mr Davidson: The pharmacy contract is not yet in place, yet it will be a major part of CHP delivery in communities. Would the Royal Pharmaceutical Society and the SPGC care to submit further evidence on the role of the pharmacy contract within the development of CHPs, given that the Minister for Health and Community Care has not really defined where this is going to come from and how it is going to run?

David A M Thomson: We would welcome that opportunity.

The Convener: I must mention our time scale: we would need that evidence as soon as possible before we move on to the next stage of the bill.

Mr McNeil: I want to return to the idea that, as everyone has agreed, the process must be a "development of team working", to use the words of the AHPF Scotland submission. Can such team working be achieved only by having X representatives on the health board and X representatives on the community health partnerships? In practical terms, can your organisations and networks sustain that level of activity? You are coming from a position in which you claim exclusion, to the opposite end of the spectrum, where you are represented at every level. Can you get agreement within your organisations about an appropriate level of involvement? Is that the only way in which you can achieve the influence that you seek in relation to the improvement of service delivery?

15:00

Asgher Mohammed: Both our organisations are relatively small. Experience of LHCCs throughout Scotland has been patchy. Some LHCCs have delivered an awful lot and team working has been great in each organisation. The problem is that LHCCs have not worked well in some areas because people have been excluded. That is because people have been given a choice and, although choice is sometimes very good and

I welcome it, sometimes it means that some professions become less able to promote their input to patient care. Both our organisations would have to be on the CHPs for us to have a voice by right. That is what we seek.

Kenryck Lloyd Jones: We are not necessarily talking about moving from a position of exclusion to one of inclusion. That is a rather extreme statement; as has been said, experience has been patchy. However, we seek a more systematic way of involving the allied health professionals, who, as has been stated, are a very diverse community. At the moment, those who fulfil an AHP role are at least minded to consult and include other members. For example, a dietitian will know that, to represent the allied health professions, they should consult physiotherapists, occupational therapists or radiographers. If that were to be taken away and if we were to have a representative who was a member of one of the allied health professions simply by coincidence or lucky chance, that person could consider themselves to be there to put forward what they happened to think and not necessarily to consult other colleagues in the same way that they would have done if they had had a specific representative role. That is why we have been quite strong in asking for diverse representation in the first place, instead of representation of a small interest group.

David A M Thomson: There are two aspects to that—the competence and the level of input relevant to their competence that the individual concerned can provide, whether they are a pharmacist, an AHP or whatever. At the moment, there is no requirement for a pharmacist to have a position at board level in the new structure, even though the drugs bill represents a massive commitment and the pharmacist could make an input in that area.

We should not throw out the good work that has been done with the LHCCs. From the outset, pharmacists and health professionals have battled to get representation on the LHCC structures. The danger is that that good work might be written off and lost when the community health partnerships are introduced, which would have a hugely detrimental effect on the local structure.

Mike Rumbles: I want to pursue the issue of the allied health professionals' diversity. There are about 11 different sets of professionals altogether in your grouping. You talk about the unsatisfactory nature of your representation on LHCCs, which you say has been ad hoc or down to chance. You argue for more systematic representation through the system of community health partnerships, boards and so on. Given that you embrace 11 different professional organisations—such as that for podiatrists and chiropodists—with 11 different interests, how would you recommend that we ensure that those interests are represented systematically? We could end up with a situation in a particular health board in which all your representatives were from a particular profession, such as chiropodists and podiatrists. What are you arguing for? How do you want things to pan out?

Judith Catherwood: I am a dietitian and Kenryck Lloyd Jones is a policy officer from the Chartered Society of Physiotherapy, but we represent the Allied Health Professions Forum Scotland. The forum has developed during the past few years and we now have an allied health professions officer at the Scottish Executive. A natural coming together of our professional groups has evolved during the past few years.

In health boards, it is natural for different senior people within the allied health professions grouping to take on different roles, depending on their level of expertise—as David Thomson said—or their level of interest in a particular topic. For example, in my area the podiatry lead took the lead in diabetes developments but she represented both herself and me; dietetics obviously has an impact on diabetes. We came to a good agreement about that situation and it worked satisfactorily. Equally, I might represent the AHPs in another capacity. Such work is about bringing us together and giving us the opportunity to have a voice. At the moment, that work is patchy and some health boards do not have much input from the allied health professions. We are happy to come to a compromise within our grouping, provided that there is a systematic way to include us.

Mike Rumbles: So you want representation, but it should be left to you to decide who the representatives are.

Judith Catherwood: Because of the different situations in different health boards, there needs to be flexibility. We heard from NHS Orkney, but the way in which it seeks to involve its AHPs might be different from that of NHS Glasgow. It depends on the size and scale of the health board.

Mike Rumbles: To be a little parochial about the matter, in my constituency there are three or four LHCCs. Let us say that there will be three community health partnerships and that your organisation will be represented on all of them. I could go to one meeting and your organisation would be represented by a dietitian, but it might also be represented by a dietitian at the other two meetings. You are arguing against the ad hoc approach in the current system, but will the new system not also have an ad hoc approach?

Kenryck Lloyd Jones: It might be a little over-deterministic to say that you want pro rata representation of every profession.

Mike Rumbles: I am only probing.

Kenryck Lloyd Jones: We must recognise that the allied health professions are regulated by a single body, the Health Professions Council. That body regulates a range of diverse professions and when it sends representatives to other bodies, or indeed to the Scottish Parliament, it does not necessarily think that it has to send one representative from each profession. The allied professions are mature; they know that physiotherapy is different from radiography, but they ensure that their approach reflects the natural evolution of the health professions. That is recognised in the developments at the Scottish Executive, which now has an allied health professions officer, and in the AHP positions at NHS Education for Scotland.

The professions remain distinct and they have their own professional bodies, but there is an increasing coming together and a recognition of team working is evolving. How does that work in practice at the local level? Perhaps dietitians will be good in one area and physiotherapists will be good in another area, but people might be happy with that. What should be measured is whether people feel sufficiently represented—if they do not, perhaps they can tackle the problem in their groupings. That is what is likely to happen.

The Convener: I follow your point.

Mike Rumbles: That is a good response.

Janis Hughes: Your organisations have made strong cases, both today and in your written submissions, for inclusion in community health partnerships. I do not think that the committee disagrees that representation on CHPs should be as wide as possible and should encompass, as far as possible, all the health groupings that exist in the health service.

How will community health partnerships improve service delivery in respect of working with agencies other than health agencies, such as local authorities and other outside organisations? At the moment, LHCCs focus pretty much on staff in health-related services, but how will things evolve?

David A M Thomson: There will be evolution. Most of my experience in this area is with joint addiction teams, which support individuals through rehabilitation programmes. Health aspects are catered for—probably through a methadone support facility—but the social problems that may have led people towards a habit in the first place are also catered for. There is partnership, which is helped when there is coterminosity between the health board and the local authority. For example, Glasgow City Council and the Greater Glasgow NHS Board have good working relationships in joint addiction teams. Addiction is the area in which I have seen joint working at its best.

Judith Catherwood: Another example, from my profession, would be work that has taken place in schools. In Moray, we have what is called a collective—which I think is the precursor to a community health partnership—and we have worked closely with our local authority, with which we are coterminous. Dietitians have had the opportunity of going into schools to educate pupils about healthy eating and health improvement. We have also been able to work with teachers and other agencies within schools to develop initiatives that encourage children to eat in a different way. We have worked with the catering service and have helped with the implementation of "Hungry for Success". Joint working has opened doors for us that would not be open were we just closeted within the NHS.

Helen Eadie: I want to move on and ask about the powers of intervention. Should the definition of intervention, and of the circumstances under which the power of intervention will be used, be included in primary legislation or in regulations?

Asgher Mohammed: In Argyll and Clyde NHS Board, for the first time in Scottish history—I think—four chief executives lost their jobs overnight. I do not think that that has happened before and it happened because of the intervention of the Scottish Executive. There are two sides to this: sometimes you need a carrot and sometimes you need a stick. When all else has failed, it can be absolutely necessary for the stick to come out.

Helen Eadie: Should that power be included in the legislation or in regulations?

Asgher Mohammed: Yes, I think it should. Very occasionally, the power will be required as absolutely the last resort. However, that would happen only when all else has failed.

The Convener: I am sorry, did you say that the power should be in regulations, or in the primary legislation?

Asgher Mohammed: It would be better to have the power in regulations. In the unusual circumstances of its being necessary, the power should be there. We would hope that people would be mature and that things would not get to that stage; but, if it was absolutely necessary and in the interests of patient care, the power should be used as a last resort. That is my personal view.

The Convener: Would anyone else like to comment? This is an interesting seam.

David A M Thomson: The power would be used at the final stage. Governance issues that are covered in legislation for our professional bodies would, I hope, limit the requirement for intervention. Furthermore, the local performance programme would highlight issues before that final

stage was reached. However, I agree with Asgher Mohammed: there must be a deterrent that could be used if all else has failed.

Helen Eadie: If you feel that there should be an ultimate sanction, should it be in regulations or legislation? There is a distinction and it is important for the committee to know your view.

David A M Thomson: I would favour regulation.

Kate Maclean: Why would you favour regulation rather than having something in the bill? In other evidence, we have heard of concerns that, if the definition of intervention is not in the bill, people who deliver health services will not know what ministers' powers will be and when they will be used.

David A M Thomson: So that it would be embedded within the NHS regulations.

Mike Rumbles: Convener, is there not confusion between—

The Convener: Yes. I am looking at section 4, which lays out "the powers of intervention in case of service failure". If members look at that section of the bill they will see that the provision to intervene is in the primary legislation.

15:15

Kate Maclean: The powers of intervention are stated in the bill, but what Helen Eadie asked about and what I am asking about is whether the definitions should be in the bill or in regulations. I understand that there is more flexibility if the definitions are in regulations, because if the definitions are in the bill it is difficult to add something, as legislation would have to be changed to do so. Is that why you think that it is better for the definitions to be in regulations rather than in the bill?

David A M Thomson: It may be appropriate for us to submit a written statement after the meeting.

Mr Davidson: It would be nice to have the Royal Pharmaceutical Society's view on how to deal with the matter because—as many members have said—we have received evidence that people want to see what the rules are so that health professionals can get on with their job. They want there to be a clearly defined procedure before the minister steps in so that they know that intervention will not take place at the whim of any future minister—I will not blame the current one. That is the idea that is emerging from the evidence that we have received.

It would be helpful if you could clarify why you favour the regulation system, which gives the ministers total flexibility unless the whole of the Parliament is united against it; that flies in the face of what the bill is intended to do.

Mike Rumbles: The bill gives a tremendous power to Scottish ministers. The proposed new section 78A(2) states:

> "The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable".

The point that we are making is that Scottish ministers will have a very open-ended power. Should that power be narrowed down? Is that wide power suitable or should it be narrowed?

David A M Thomson: As I said, it would probably be more appropriate to submit the answer in writing.

The Convener: I presume that there have been cases when such powers have been tested, when chief executives have been dismissed or whatever and there has been a test of what has been defined as a failure. That would give us guidance. It would be interesting to receive a written response. Rather than try to amend the bill on the hoof, we will now move on.

Mr Davidson: I will move on to the proposal to dissolve local health councils and set up a new national health council. Is your organisation satisfied that a new national health council, such as the one proposed by the Executive, will be more independent than the current local health councils? I ask you to comment on the fact that the minister has suggested that the new national health council should be placed within NHS QIS. Does that create an identity problem about the individuality and independence of the new national health council?

Kenryck Lloyd Jones: There is always concern when a body is to be set up about whether it will be reflective of the communities that it is supposed to represent. It is a question of how things will be done. The Allied Health Professions Forum has not had detailed discussions on the matter, so it would be wrong of me to say that anything that I will say is reflective of its policy. However, there are general concerns that public involvement should be seen to be working. That means that the public must know who their representatives are and how they are represented rather than discover after the fact that they were represented.

Mr Davidson: Do you have any comments on the perceived independence—or not—of the new health council?

Kenryck Lloyd Jones: NHS QIS is a relatively young body. All the bodies that we are discussing have a quasi-independent role. Whether the health council is perceived as being independent depends very much on one's initial view of quangos as a whole, rather than the situation in this particular case.

Asgher Mohammed: At LHCC level, we have always found local health councils to be very useful. They give added value to our discussions. I tend to favour the view that was expressed from Orkney and believe that the new health council should be independent. If it comes under NHS QIS, that will be like having the person who checks and the person who punishes in the same department, which is not very fair. It would seem more logical and objective for the health council to be independent.

Mr Davidson: Are you suggesting that the role of the health council should be to address patients' requirements, whereas NHS QIS should be responsible for regulation of standards?

Asgher Mohammed: Yes. The health council should examine NHS QIS. If not, who will police the police?

The Convener: What an interesting answer. I am not saying that the others are not interesting, but that answer was quite challenging.

Shona Robison: We have heard concerns expressed that the loss of health councils will mean a loss of local representation. Do you think that the duty on health boards to ensure public involvement will in some way compensate for that loss? How do you think it will improve public consultation in practice?

Judith Catherwood: The Allied Health Professions Forum Scotland has not discussed that issue in detail, but we welcome the fact that there will be an onus on boards and organisations to include the public in discussion and to have genuine consultation. In fact, there will be more than consultation—the public will be involved in key decision making. We are not opposed to that.

I am not hugely familiar with the different systems that are proposed, but at the local level health councils bring a great deal of expertise and provide a focal point where one can usually find the right person to serve on a group. They offer the support that is necessary for people to be involved, which is important. The new organisation should give the public a voice and the necessary training. I use the word "training" in a strange sense, but people need considerable support if they are to be members of a formal organisation such as an NHS board or a working group. I hope that whatever structure is put in place gives the public that opportunity.

David A M Thomson: We must also build on the strengths of the previous structure. The benefits gained from engagement with local health councils are embedded in the new structure. Pharmacies have used the local health councils often and well and their contribution is valued extremely highly. I do not want that to be lost.

Shona Robison: One of the roles that local health councils have now and will not have in the future is advocacy. They act as advocates on behalf of patients and members of the public. Are you concerned that they will no longer have that role?

David A M Thomson: That does not give me too much direct cause for concern. The community pharmacy network in Scotland is visited by 600,000 patients on a daily basis. The network was established mostly by private money, so if we do not look after our patients, we will not have a business. There is a commercial aspect to the issue, although it relates to the health service. In a way, pharmacists act as their patients' advocates—they look after their local patients. There is huge loyalty to pharmacies—80 per cent of people use the same pharmacy on an on-going basis.

Shona Robison: I was thinking more about the role of health councils in helping people to find their way through the health service system—whether it be to make a complaint or to find out some information. The local health councils have played a very important role with regard to advocacy in its widest sense; however, that key role will be removed from them. Would you prefer them to retain that function?

David A M Thomson: Although that is certainly a strength of the local health councils, the likes of Epilepsy Scotland also have patient support groups. Such members' interest groups might take on some of that role instead.

Asgher Mohammed: Having public involvement at board level is an excellent step, because health care professionals sometimes forget that they serve patients. Such public involvement is a great asset that we would not want to lose. As far as making complaints is concerned, most people should know which mechanisms to use. No matter whether they are in a doctor's surgery, pharmacy or health centre, they should find it easy to complain and know who to complain to. It does not matter whether the CHP or the health board takes on the issue, as long as patients and the public find the system open, transparent and easy to use.

As I have said, it is good to have public involvement at health board level. Indeed, we need that representation at every level, including in CHPs and health boards. Without those people, we will lose the added value that their involvement brings.

Shona Robison: I have a further question for the allied health professionals. Across your professions, have you had any experience of public involvement in shaping your own services? How could we achieve such an objective in future?

Kenryck Lloyd Jones: As an example, direct access to physiotherapy is very popular. Indeed, in surveys that we have carried out with the general public, eight or nine out of 10 people have said that they would prefer to go directly to a physiotherapist—or, to mention another area, a dietitian—rather than go via a GP. Such an approach might also save a lot of GP time. The idea is to involve the public by providing them with access to the professions.

That said, as far as complaints are concerned, we should perhaps distinguish between public and individual involvement. After all, the public in its abstract form is different from the individual, and we need different systems for those two areas.

We should remember that a patient's involvement in his or her treatment is now very much to the fore as far as education is concerned. Therapy is not merely carried out on people—in other words, someone does not come along and perform it—but happens through consultation with the patient as an agreed procedure. In the same way, the planning and delivery of services should involve the patient community and should not be something that they simply turn up to and receive.

Judith Catherwood: Although most AHP services have tried to involve the public, doing so has been quite a challenge. However, the opportunities presented by the introduction of community health partnerships and of statutory responsibilities with regard to community planning will allow us to have an interface with the public that might not have been as readily available before. As a result, community planning and public consultation will help us in that respect.

The Convener: Section 5 puts a duty on health boards to consult the public on

"the planning and development, and … decisions of the Health Board or Special Health Board affecting the operation … of … services."

Such statements are all good and grand. However, there is a difference between anecdotal consultation and rigorous and thorough consultation and I note that the explanatory notes do not mention any extra money being made available for that work. If health boards will have a duty to consult the public, can such consultation be done for nothing or at neutral cost? If not, where will the money come from to enable proper consultation exercises to be conducted? If the money is not available, such statements are simply motherhood and apple pie.

Asgher Mohammed: In Paisley, we have had public representation on the executive group, the clinical governance group and other groups. Those public representatives have been paid for their time. It is not really fair on people to expect them to do something for nothing. People give up their time, energy and effort to help, so I think that we should pay them to come. So long as the payment reflects what people are doing and how much time is involved, that is fair and we ought to fund it.

The Convener: I was thinking not only about paying people to turn up, but about funding a consultation exercise in which people would be paid to run, in a professional manner, whatever consultation procedure was being used, so that the resulting data would have some value.

15:30

Asgher Mohammed: If you want good-quality work, you have to pay for it. It is better to pay to get the quality, so that you know exactly what you are getting. There should be provision for payment to be made, but that is not reflected in the bill. I agree that there should be funding, but it is not there at present.

The Convener: Separate from delivery of front-line services?

Asgher Mohammed: Yes.

The Convener: Do other witnesses want to comment?

Judith Catherwood: I agree. Any enhancement of the current system of formal consultation will take time. It takes time to co-ordinate the process, to collate all the comments and to put them into a document that the board and others can consider. That will certainly account for a bigger part of the resource that the NHS boards will need, so there will have to be a dedicated resource. How that will be funded I have no idea, but it will take money.

Helen Eadie: I would like Judith Catherwood, and anyone else who wants to answer, to amplify the point about the challenge of public consultation. The inference that I took from what you were saying was that that is a developing area of work and that different pilot projects are being undertaken across Scotland. What pilots are you aware of and what costs might have been involved in them? In an urban or semi-rural area, who pays to transport people to such meetings? Have you come across such problems before?

Judith Catherwood: I have quite limited experience, but you will be aware that NHS QIS recently published new standards for food, fluid and nutritional care, and in Grampian, where I work, we are looking to involve the public in a focus group exercise to try to get views from them on how we could improve the service and better implement the standards. That will obviously involve money, including, as you said, money to cover people's time and their expenses for getting to venues. We will need some help to facilitate that and somebody to pull together all the comments.

That is just a small-scale example of what could eventually be a large undertaking.

Mr McNeil: We heard evidence from Borders NHS Board that the new structures that it has put in place have eliminated duplication of jobs and cut out levels of bureaucracy, so that the board can generate funds that can be allocated to the whole area of consultation. Apart from that, are not we talking about an on-going dialogue with patients at that level, rather than just the big consultations that take place on changes in services? Are not we talking about a cultural change?

Recently, pharmacists have been communicating very effectively with their customers. People were coming to me and saying, "My community pharmacy is under threat." In the right conditions, we can communicate effectively, and at no great expense, on issues that affect individuals and their communities. I wanted to say that on the record, because I do not think that it is the committee's view that consultation should be let go because it will cost money. Consultation may cost money, but we can generate that money through the new structures that we put in place. Do you agree?

Kenryck Lloyd Jones: Very much so. As you say, the culture is changing and evolving. The emphasis is now very much on inclusivity in all aspects of service provision.

The Convener: I think that the question, however, is whether savings can be made elsewhere in the bill that would pay for any additional costs. The question is quite simple. I think that that is what Duncan McNeil was asking about.

Mr McNeil: No. I think that I have made my point. I would like a response from the panel, convener.

David A M Thomson: Any redesign exercise, which is basically what we are discussing, could be directed at saving costs. As the example relating to pharmacies shows, a communication exercise can be conducted quite effectively without costing huge amounts of public money.

Mr McNeil: That is fine.

Helen Eadie: The minister has pledged an amendment that would require health service bodies to encourage equal opportunities when they perform their statutory functions. What do you think of the proposed amendment to give health bodies a duty to encourage equal opportunities? How do you envisage that proposal's being put into effect? You might also want to comment on the cost implications of the proposal, as equal opportunities usually do not come without costs.

Kenryck Lloyd Jones: I am sure that every health board would say that equal opportunities are at the forefront of what they do. Nevertheless, making explicit the encouragement of equal opportunities would help to focus the agenda. I think that that was mentioned earlier in another context. Such an approach can be welcomed.

I do not know what you think the additional costs might be, but it is clear that equal opportunities should not be compromised to cut corners in respect of costs. Most professions would agree that equal opportunities are paramount. Just as equal opportunities are paramount for patients, they are paramount in respect of how the health service operates.

Asgher Mohammed: I have a personal view. From what I know about the Stephen Lawrence inquiry and what is happening throughout Britain, it has been mooted that there is institutionalised racism in the NHS, the police and the judiciary. If there is, we must welcome the proposed duty in the bill and matters must then be monitored. Will there be equal opportunities in reality, or will lip service simply be paid to them?

Helen Eadie: That is an important question, but can you think of any particular examples for which the proposed duty will have cost implications? I do not want to lead the witnesses but, to be going on with, I was thinking about issues relating to race relations, languages, disability and access. Do the witnesses want to comment on such issues?

The Convener: It would be useful if the witnesses wrote to the committee about those issues, if they want to, because it is hard to be put on the spot and asked to deal comprehensively with such matters. The committee would be interested in hearing about cost implications for the witnesses' professions, if there are any. Important points have been raised. Race as well as disability issues could be dealt with—that would be extremely useful.

Asgher Mohammed: I have not experienced such problems myself.

The Convener: We did not presume that you had, but the point was well made.

I thank the witnesses for their evidence. There will be a suspension before the minister arrives. We have a long agenda to get through.

15:38

Meeting suspended.

15:45

On resuming—

The Convener: I welcome Malcolm Chisholm, the Minister for Health and Community Care; Lorna Clark, the bill team leader; and Iain Dewar, a member of the bill team at the Scottish Executive.

Janis Hughes: Much of the detail about community health partnerships will be left to regulations and guidelines; that detail has been consulted on recently. As you may know, we have spoken to a number of witnesses during the course of our discussions on CHPs and one of the issues that have been highlighted is that the local health care co-operative set-up can be patchy in different parts of the country. We would like assurances from you that the CHPs will not replicate the patchiness and the occasional inefficiencies of the LHCC network.

The Minister for Health and Community Care (Malcolm Chisholm): That is the intention. We do not generally want structural upheaval. We want CHPs to evolve from local health care co-operatives and to build on their strength. We want to get rid of what you describe as their "patchy" nature. There are, however, some excellent LHCCs throughout Scotland. I caught bits of the previous session, when the members of the Royal Pharmaceutical Society said that they wanted guaranteed representation. We will ensure that that takes place. When LHCCs were started, that was one of the issues on which there was no guidance; it was all left to local flexibility and freedom. There are strengths in that, which we do not want to lose because the last thing that we want from CHPs is a top-down situation. We have to be careful to get the balance right between local flexibility and certain standards. Who is represented on the committee of the CHP is something that we will want to lay down in regulations.

I regard CHPs as being a key policy and a key part of the bill. When people ask me why we do not have foundation hospitals in Scotland, I tell them that we have CHPs. We have our own reform agenda, of which CHPs are one of the most exciting parts. We want to try to make the planning and delivery of health care more responsive to the needs of local populations and to develop more services in primary care settings. The most important thing is perhaps that we have a vehicle for integration with social care and specialist services. In contrast with England, our attempt to develop single-system, integrated working is the most distinctive feature of our health reform agenda. We want single systems in a decentralised context, which is where CHPs are key.

Janis Hughes: We welcome that response. The witnesses from the Allied Health Professions Forum Scotland were keen that they be represented, and they wanted specific guidelines—or regulations—about membership. You have reassured me that those will be introduced.

One of the other areas that we have touched on in our evidence taking has been coterminosity with regard to CHPs. At the moment, LHCCs by and large expect that their boundaries will change; some may become larger and others may become smaller. That may lead to much more confusion with regard to coterminosity. How are your thoughts developing on that issue?

Malcolm Chisholm: It is a big issue, not least in a constituency such as that of Janis Hughes. Work is being done by local health systems in partnership with local authorities, and there are no proposals for community health partnerships to straddle local authority areas. In certain cases, however, they will cross two health board boundaries. We probably need to make a small amendment to proposed section 4A(1) of the National Health Service (Scotland) Act 1978 to make it clear that in some cases two health boards may be introducing a scheme of establishment. That is as far as it goes. We do not expect CHPs to straddle local authority areas. We will, in principle, have coterminosity with the local authority area. However, in the larger areas, for example Glasgow, there will be several CHPs for a particular local authority area, whereas in areas where the population is smaller, such as the Borders, there may be only one CHP in each local authority area.

The Convener: I have a more technical question. When you referred to the detail of the CHPs, you talked about the pharmacists and you mentioned regulations. However, you have also referred to guidelines. I can see why there has to be flexibility but, given the statutory import of regulations as opposed to guidelines, are you talking about regulations, or are you talking about guidance, which is much looser?

Malcolm Chisholm: That is an important question and I understand why you are interested in it. I believe that we need both statutory guidance and regulations. We want a balance between what must be prescribed and must apply in every CHP, and having a certain amount of local flexibility. The last thing that we want is an inflexible blueprint. Therefore, my present thinking is that we should have a combination of regulations and statutory guidance. However, we want the Health Committee to consider that and comment on it, as it did with the previous bill.

The Convener: That is what I am coming to. Where are the guidance and the regulations in the brewing pot?

Malcolm Chisholm: The guidance is further ahead because we sent out a consultation document that was almost like guidance in its formulation. We have had a lot of feedback on that. We want to take that on board and issue a new document in perhaps a month. It would be good if we could share that with the committee so that it could examine the document and feel part of the process. However, the new document would obviously have to be only draft guidance, because there cannot be any final guidance until the Health Committee and the Parliament have had their say. Therefore, anything that goes out now is only draft guidance. However, members will understand that boards want to get on with the development of their work in that area.

Mr McNeil: We have heard today, again, of Orkney NHS Board's concerns about the dissolution of local health councils. The board feels strongly that it has a particularly active health council, which is regarded as the voice of the community. The RCN has likened the dissolution of health councils to throwing the baby out with the bathwater. Why have you not thought about reforming health councils rather than abolishing them?

Malcolm Chisholm: In a way, what we are doing is reforming. I noticed that you picked out only one bit of the RCN's position. Equally, the RCN supports the creation of the Scottish health council. I believe that we will be getting the best of both worlds. We want a national organisation—the Scottish health council. The RCN and most people who responded to the consultation agree with that. However, we also want a strong local base for the health council. The reality is that some local health councils are excellent but that they work in different ways.

One of the fundamental issues about local health councils is that NHS boards appoint them. I believe that it is important to have a body that oversees public involvement and that is independent of health care providers. We do not have, and never have had, that situation. Health care providers appoint local health councils. We want to set up a body that is independent of health care providers. The fundamental principles for me are independence from health care providers and a strong local base.

Obviously, we will have wider discussions today and in the future about how we make public involvement a lot better than it has been. The creation of the Scottish health council is fundamental to public involvement, because one of the council's key roles will be to monitor and oversee that. The committee often tells me that a particular health board's involvement with the public has not been good. It will be the Scottish health council's role to point out such things and to report on every service change in terms of how public consultation has been conducted. The council will give reports to the minister and if a report said that public consultation had been inadequate, it would have to be done again more appropriately. Therefore, the creation of the Scottish health council will carry forward the public consultation agenda.

I understand people's concerns about the council having a strong local presence and that is why the local advisory councils will be a necessary and key part of the process.

Mr McNeil: Do we not run the risk of demoralising people who have expressed a continuing interest on their community's behalf? That could particularly be the case in a place such as Orkney, which has an active, involved health council. Does your one-size-fits-all proposal not contradict what that local community wants? Is there not a risk that those people will disengage and that your proposed structures will be second best?

Malcolm Chisholm: No, because those people will have an opportunity to be represented on the local advisory councils, which will be the local presence of the Scottish health council. In many cases, they will be the ideal people to fulfil that role. When I spoke recently at the conference of the Scottish Association of Health Councils, I was positive not only about the work that the health councils had done, but about the importance of their members' being involved—if they want to be involved—in the new organisation. We have an implementation group, which fully involves the Scottish Association of Health Councils, that is helping to work up the detail of the proposal.

The other issue that the RCN flagged up is the Scottish health council's place within NHS Quality Improvement Scotland. I do not know whether you will ask about that separately, but I will briefly describe the thinking on that. We want the Scottish health council to have as much clout and leverage as possible, and we think that that will be enhanced by its being part of NHS Quality Improvement Scotland, but it will have special status and safeguards to ensure that it will not in any sense be under NHS Quality Improvement Scotland's thumb; it will have its own existence within that body. It is important that the Scottish health council be tied into the quality agenda because, as I have said on more than one occasion, the starting point for improving quality is the experience of every patient who passes through the health care system. Therefore, if the Scottish health council is part of NHS Quality Improvement Scotland, that adds to the leverage and influence of patient and public involvement.

Mr McNeil: Nevertheless, in Orkney, there is a group of people who complain that they have not

been able to consult their community about the changes and who wish to continue with the present format. If we are saying that communities should be able to decide, why can we not allow them to do so?

Malcolm Chisholm: I do not know—

Mr McNeil: When you talk to centralised bodies, which is the level at which you deal, what sort of dialogue do you find has taken place with those communities in which there is active consultation? I agree that, from the point of view of consultation, not all the health councils operate at the highest level and serve their communities effectively. In Scotland, all the best goalkeepers are dead goalkeepers, and we might be dealing with some mythology about how effective health councils are, but we have repeatedly had evidence of best-practice examples of health council members serving their communities and wishing to continue on that basis. At what appropriate level have we engaged those people to give them the opportunity to continue that service?

Malcolm Chisholm: They will still be able to do that. An important part of what we are saying is that there should be local advisory councils, but the Scottish Association of Health Councils, the RCN and nearly everybody else who responded to the consultation supported the creation of a Scottish health council. It has to have strong local roots and have local advisory councils, but people recognise that, over the years, the fact that the system applies differently in different areas has weakened, rather than strengthened, the system. The proposal gives a bigger prominence to the health council and flags up the importance of public involvement. We cannot have bodies monitoring such involvement if there are different standards in different parts of Scotland. We must have a clear national organisation with national standards, but it must have local councils as well. We are proposing the combination of a national organisation with local roots. I repeat that that was supported overwhelmingly in the consultation and that it was supported by the Scottish Association of Health Councils and the RCN.

The Convener: I make no comment. Does Shona Robison want to come in on this topic?

Shona Robison: I will come in now; I did not want to cut across the next question.

I have listened to what you have said, minister, and I do not particularly disagree with any of it, although we could perhaps debate how independent NHS QIS is—we will come to that in a few minutes—but I still do not understand why you feel that it is necessary to remove the key role of patient advocacy from the local health councils. Would it not be possible to have the structure that you suggest but still leave that important role at a local level? I have spoken to some of those who heard your speech at the conference, and they consider patient advocacy to be an important element of their work; it is the interface with patients and the public which, if you like, helps them through the system. I do not understand the thinking behind your belief that it is necessary to remove that role.

16:00

Malcolm Chisholm: You have given an interesting example, because some health councils have that role and others do not. Similarly, some health councils help with complaints and others do not. We have invested more in advocacy over the past two years than has ever been invested by anyone and we are building up independent local advocacy services. The role of the health council will be to monitor such services and to ensure that they are available. In a sense, that represents part of the shift in the role of health councils, which will ensure that processes are in place for public involvement, advocacy and complaints, rather than deliver everything themselves.

We can consider the matter in another way. In the past, you might say that the local health council substituted for the public. We are saying that we do not want a small group of people to speak on behalf of the public; we want much wider public involvement and we want there to be a group that ensures that such involvement happens, monitors it and does something about problems—or draws them to the attention of people who can do something about them.

That is not to say that the local health advisory council cannot speak for patients where that is appropriate—for example, if no other group can do so. I can provide you with a copy of a letter that I wrote to the Glasgow health council to clarify that point when it raised it with me and in the newspapers. We are not saying that local health advisory councils cannot have that role, but we do not want a model in which they do everything for the public; we want there to be wider public involvement, which the councils support and monitor, so that the public involvement agenda is much bigger than it has been in the past.

Shona Robison: I understand the logic of your thinking, but the issues that the Glasgow health council raised are interesting. You have begun to soften your position in relation to advocacy, as it appears that you are saying that if a local health advisory council so wishes, it will be able to continue to perform an advocacy role. That is interesting, because I think that, up to now, the assumption has been that that role will not remain with local councils. However, you are saying that there will be flexibility.

Malcolm Chisholm: That was the position in the original consultation document. I cannot read out the whole letter that I wrote to the Glasgow health council, but I will read out the relevant sentence, which basically repeats what was in the consultation document. The letter says:

"Where the Scottish Health Council identifies an area where public concern or viewpoint is not adequately being considered or where there is not an appropriate patient support group, it will be expected to raise this with the NHS Board or to put forward the views expressed by the public."

So the health council can have that role, although that is not its primary function.

Shona Robison: However, my first response to that is to ask who will define "adequately" and decide whether there has been adequate consultation or an appropriate group to speak for the patient.

Malcolm Chisholm: The Scottish health council will decide, as it says in the letter.

Shona Robison: So the Scottish health council will make that decision, but I can see that there might be problems—

Malcolm Chisholm: It will not be me who makes that decision.

Mike Rumbles: I want to pursue the matter. You have made it clear that the Scottish health council will monitor public involvement. Section 5, on public involvement, says that the health board must ensure that the people who use the services—patients or the people who will become patients—

"are involved in, and consulted on—

(a) the planning and development, and

(b) decisions of the Health Board".

Consultation is quite separate from involvement and I am still unclear as to how you envisage that the health boards will fulfil their obligations under the bill to involve patients—and not just by consultation—in the decisions that are made by health boards.

Malcolm Chisholm: Involvement and consultation are the key words and perhaps they serve to summarise the big change—from consultation to involvement—that we are in the middle of. We all know that in the past, consultation meant end-stage consultation, whereas now we require involvement at a much earlier stage, including consultation during the process of coming up with options as well as consultation on what in the past might well have been a single option that had already been put forward.

Obviously, people are still dissatisfied with how consultation is carried out in many cases. The new draft guidance that was produced last year is still being revised and we need to have final guidance on how boards consult. Along with the guidance, we have run a programme of support for boards, which is what much of the patient focus and public involvement initiative has concentrated on. Some of the money for that initiative has been spent on working with boards to get them to improve consultation. We all, including the boards, accept that a steep learning curve is involved. The aim is to involve people at an early stage and not simply to consult at the end of the process; it is also to involve people on a wider range of issues than has been the case in the past.

Mike Rumbles: I want to pursue the point, although I understand and agree entirely with what you have said. The bill states that people should be

"involved in … decisions of the Health Board",

which means involvement before decisions are made. However, I am trying to get you to tell us your view of how health boards will actually do that.

Malcolm Chisholm: That would require a detailed answer and, if I gave you a blueprint, you might not be happy. The public involvement team has produced a toolkit—a large document with a range of methods that boards can employ to engage with communities in ways in which they have not engaged in the past. That means not only using methods such as big formal public meetings. The document mentions different kinds of opinion panels and groups and a range of other options. The aim is to reach a wider range of people in new ways. We should not prescribe from the centre that boards should do A, B and C; we must be a wee bit more flexible than that.

The role of the Scottish health council is important. It is better to give boards a bit of flexibility and to have an independent body to consider whether the systems are adequate, rather than to over-prescribe from the centre by telling boards to carry out procedures A, B and C. That is our thinking.

The Convener: I want to clarify one point. You said that the Scottish health council will monitor what is done on the ground locally. That is fine because practices are not standardised at the moment. However, the policy memorandum states:

"The role of the Scottish Health Council will be to provide leadership in securing greater public involvement".

That is a top-down role rather than simply a monitoring role. My concern is that the flexibility that ought to exist locally, given that standards must be met, will not exist and that systems will be imposed from above. Let us leave aside Quality Improvement Scotland at present. My problem with the language is that monitoring is perfectly laudable, but the top-down role is not.

Malcolm Chisholm: Which section of the policy memorandum was the quote from?

The Convener: Please excuse me, I have a sore throat. I have a legitimate lozenge in my mouth, not a Smartie. I am at paragraph 42 on page 10 of the memorandum.

Malcolm Chisholm: Right. The issue of the balance between national standards and local flexibility comes across in many topics. I do not have a problem with a body that is independent of me, and which has expertise in public involvement, providing leadership in securing greater public involvement. The council will not impose a blueprint, but it will ensure that the kind of failures of which the committee is aware will not happen any more. It is admirable that there should be a body that provides leadership and supports boards and others to carry out consultation better, which monitors the way in which they do so and which ensures that feedback from patients and the public, which is important, is received. I do not have a problem with that kind of leadership.

The Convener: With respect, minister, you used and continue to use the word "monitor", but the policy memorandum does not say anything about monitoring. I do not have a difficulty with monitoring.

Malcolm Chisholm: Monitoring is part of the role. You flagged up the word "leadership", which I do not have a problem with. Monitoring is part of a wider role that can be described generally as providing leadership and ensuring that things are done better than they have been done in the past. Monitoring is one way of describing the role, but it is not an exhaustive definition of what the Scottish health council will do; it is the bit that was relevant to what we were talking about a moment ago. A national body that provides leadership is a good thing, as long as it has local presence and flexibility, which are important.

Mr McNeil: I want to pursue the point made by Mike Rumbles. We should welcome the ambition to involve and consult people at health board level. That is really important. However, it will also be a long-term objective. Some of the bad communication and consultation that have taken place have done serious harm to the relationship between health boards and communities. I welcome the attempt to get things back on track.

We have discussed with others who have given evidence the expectation that involvement and consultation give to communities. In the longer-term planning of health boards—their priorities over a five or 10-year period—it is very important to get that right. Is there a case for suspending consultation programmes and ideas when services are facing radical change or are in crisis? My experience—which is shared by many—is that when we say that we will hold a consultation about a radical change to a service we create a false expectation in a community. We are being less than honest with that community. If radical change to a service in an area is necessary, is there not a case for being honest with the community and presenting proposals to it for debate, rather than giving the notion that consultation is taking place on two, three or four options? Honesty is vital in this process.

Malcolm Chisholm: That is an interesting suggestion. If we could produce an example of a situation in which there was genuinely no alternative, we could make a case for the approach that you suggest. However, there is usually more than one option, even when radical change is thought to be necessary. I do not see why the public should not be involved not only in giving a view on the options but in formulating those options in the first place. I understand the point that you are making, if there is genuinely thought to be no alternative to one course of action. However, even in that situation there would be a strong duty on boards to ensure that they explained the issues in a far better way than they have in the past and I would not be driven to the conclusion that public involvement should be suspended.

Mr McNeil: Perhaps I did not communicate my point effectively. I was not saying that the involvement of the public should not be welcomed. However, as the minister knows, in certain health board areas across the country there are situations in which a consultation process can take one, two or three years. During that process, the services on which the health board is consulting are collapsing along the road—irrespective of the consultation. In that situation, the consultation becomes meaningless. That is different from longer-term planning. We have created an expectation in the public. If the objective of involving and consulting communities is to be successful, we need to build up from the current very low point. How can we do that if we allow situations to develop in which, week by week, consultations are seen to become meaningless and people disengage from the process as a result?

Malcolm Chisholm: From your comments, one might draw some conclusions about the length of consultations. If they are taking place over the sort of time scales that you suggest, it would seem to be appropriate for them to be held more quickly. That point can be taken on board. The other conclusion that we can draw is that we should try to deal with issues before the crisis point is reached. Argyll and Clyde NHS Board may be mentioned in other contexts today. One of the problems with the board's previous management was that it failed for too long to address some of

the issues in the area. That situation is to be avoided. There are many lessons to be learned from the situation that you describe, but I do not think—and you are not suggesting—that that should lead to a suspension of public involvement.

Mike Rumbles: I want to ensure that my understanding of what is before us is the same as yours. You should correct me if I am wrong, as I may be guilty of wishful thinking. The bill says that health boards must ensure that patients are "involved in" and "consulted on" the development of services. Those are two quite separate things, although they are part of the same process. The policy memorandum makes it clear that the Scottish health council will not only provide leadership but

"support the development of good practice in public involvement".

That implies that the Scottish health council will have a monitoring role. Obviously, if good practice is to be spread across Scotland, the council will need to monitor what is happening.

16:15

I think that there is a second part to that process, which I want to check with you. As well as monitoring whether health boards throughout Scotland show good practice in public involvement, will the Scottish health council have a role in following up that monitoring and identification of good practice? What power will the Scottish health council have to ensure good practice in public involvement? Would the Scottish health council go back to you so that you could use your powers of intervention, or would it go directly to health boards? What process would the Scottish health council use and what power would it have?

Malcolm Chisholm: You are right that monitoring, which I flagged up in a particular context, is not the Scottish health council's exclusive role. Monitoring is part of its role, but supporting development is another part, which you have emphasised. Ensuring that feedback from patients and the public not only takes place but is taken account of is perhaps the Scottish health council's other key role.

It depends on the situation, but the Scottish health council will have a role in the most prominent controversial service changes that come into the Scottish Executive and its advice will be taken on board. It will have real teeth. As you know, at the moment consideration of whether the consultation on different service changes has been adequate has to be done by the health minister. Perhaps the most topical example of that is the questions that are being asked about the secure care unit in the west of Scotland.

Once it is set up, the Scottish health council will be the body that gives a view on all the processes that have taken place. If the Scottish health council says that the process has not been adequate, it will then be up to the minister and the Executive to take action to ensure that something is done about that. Such proposals would not be accepted if they did not get a green light from the Scottish health council.

Dr Turner: Will you provide us with clarification on patient advocacy and the complaint-handling role? It is important that it is easy for the person who has a problem to raise it. Will you clarify how the NHS boards will deal with that, given this flexibility? Will boards perhaps commission separately for that advocacy and complaint-handling role, as we have heard it suggested?

Malcolm Chisholm: Boards have already been commissioning independent advocacy services. I think that everyone would agree that there has been a big expansion of such services over the past two years. A lot of money has certainly gone into such services. That is the model that is being proposed for complaints as well.

I know that some concerns have been expressed about boards commissioning those services but the reality is that they have already been doing so for advocacy. We have taken a strong line with boards that they must commission independent advocacy organisations. Sometimes we have got into trouble because we have said that a body could not provide the service because it is not independent enough from the providers of services. If you look at the model for advocacy, you can have confidence that complaints will be handled by independent bodies.

We are saying that boards should ensure that that support is available to people. The role of the Scottish health council and the local health council bodies will be to ensure that those arrangements are working effectively. I repeat that not all health councils currently provide such support for complaints. Some do, but some do not. That is the way that the system works at the moment.

Dr Turner: From the health boards that use that process at present, are there any figures for the cost-effectiveness of that in comparison with the way that things were done before?

Malcolm Chisholm: I am not sure that cost-effectiveness is uppermost in our mind so much as the independence of the organisations and the level of the service that they provide to patients. We have put a considerable amount of money into advocacy, but the key thing is whether those bodies are independent and whether they are delivering a service to patients and service users more generally who need them. That should be the key criterion.

Dr Turner: Have you any evidence on how speedily the services operate? The patient sincerely wishes to have a result quite quickly. Does commissioning mean that cases are dealt with faster?

Malcolm Chisholm: We are in the middle of a process. I am not saying that we have all the services that we need. I am simply stating the fact that there has been a big increase in the number of independent advocacy services in the past two years. We have a lot more to do and we are saying that complaints are a new matter that has to be taken on board.

Mr Davidson: I will press you for more of a definition. You said that the advisory parts of the new Scottish health council may or may not deal with the advocacy role. You have talked a lot about establishing independent advocacy bodies, but you have not told us today or put in writing the definition of advocacy services and how that could be applied.

You suggest that the new health council will monitor those services, so I presume that what it monitors must be defined, or will it be left to develop models for use? You might recommend, or give a health board the right to establish, an advocacy service. For the sake of argument, I will mention a mental health advocacy service in Grampian that is in difficulty because of a lack of funding, of decision making and of patient expectation. I do not pick that out as a particular difficulty, but a difficulty does exist. Will we have clarity from the Health Department about what will be monitored?

Malcolm Chisholm: A range of services is involved. Advocacy is the service that is being picked out, and advocacy services basically support vulnerable people in dealing with health and social services and, in some cases, other bodies. Much work is being undertaken on advocacy. Two years ago, we produced a guide for commissioners in which we covered all the issues. Advocacy is one strand, but it might be different from the complaints procedure, although the matters could overlap. Some people with complaints might need the support of advocacy services, but others might not.

A key aspect of the patient focus and public involvement agenda is the analysis of different strands. I introduced the debate in the chamber in June partly to achieve clarity about that. Other strands are the patient agenda, patient experience, patient involvement and support for patients through advocacy and complaints procedures. The wider public involvement agenda is a citizens' agenda and does not involve only those who are using health services. Advocacy is an important part of that, but it is by no means the only part.

Mr Davidson: I agree that the complaints procedure is slightly different, although some overlap exists. I do not argue about that. However, the Executive will give to a body that has not yet been created a role that it cannot define. That body will have to operate under some guidance. Will we have that eventually?

Malcolm Chisholm: I did not flag up advocacy services, so I am not sure how they entered the debate. To complicate matters, we have the Advocacy Safeguards Agency, which fulfils the role that has been described. Advocacy is probably the last of the matters that I would have flagged up as involving a central role for the Scottish health council, because we already have a body that monitors advocacy services. The Scottish health council will be concerned with wider public involvement, the complaints procedure and other matters. We already have a body that deals with advocacy services.

Mr Davidson: That is fine, but you suggested—we can check the *Official Report*—that local health councils or the new bodies could be involved in advocacy services. Will that be on a commissioning or agency basis? Who will decide?

Malcolm Chisholm: It will be interesting to check the record. I do not want to labour the point, but in the extract from the letter that I quoted, I did not use the word "advocacy". The phrase that I used was

"put forward the views expressed by the public."

When members of the public express concern about a particular service, the local advisory council can put those views to the board. Advocacy is a slightly different concept, which refers to giving support to vulnerable people.

The Convener: We do not have the letter, but I understand that the minister has undertaken to provide the committee with a copy of it.

Mr Davidson: I am happy to wait for that clarification.

Helen Eadie: The evidence that the committee has heard indicates that there is great concern about the independence of the Scottish health council. Although the establishment of the council is welcomed, we are concerned about its inclusion within NHS QIS. Why was it decided to establish the Scottish health council in that way, as opposed to establishing it as a separate statutory body?

Malcolm Chisholm: Well—

The Convener: That was a heavy sigh, minister.

Malcolm Chisholm: That is partly because I have covered some of that question already—I got a bit ahead of myself. I am wondering how much to repeat.

As I said, it is important that the Scottish health council should be independent from health care providers—that is one reason to move away from the system of appointment by health boards. A contrary proposal, which might be the one that you put forward, is that we should set up the Scottish health council as a non-departmental public body that stands on its own. The first point is that, compared to other NDPBs, the health council will be a relatively small unit. There are certain logistical advantages in sharing support services with another body.

The more important reasons, which I have already touched on, are that we want to give the body as much clout and leverage as possible and that we see patient and public involvement as centrally connected to the quality agenda. The starting point for improving quality is the experience of every patient who goes through the health care system, so there is an intrinsic connection. In the consultation, the majority of people, although not all, welcomed that connection in principle.

The corollary of that is that we must ensure that the Scottish health council has a special status within NHS QIS and that there are safeguards for its independence within that body. We are working up the details of that with the Scottish Association of Health Councils; it is one of the key issues that the implementation group is considering.

You present an alternative scenario, in which the health council is set up as a relatively small NDPB, but we think that it is better for it to be connected to NHS QIS. As Martyn Evans said in his evidence, the reality is that NHS QIS operates as an independent body and, in that sense, I do not think that there is a problem with its independence from me. People have concerns—the RCN was concerned about how independent the health council would be within the organisation. We must ensure in the way in which we set up the council that it has its own existence within the umbrella organisation.

The Convener: My response to that is, "Why bother?" If you will have to build firewalls or moats around the council, why not just set it up separately?

Malcolm Chisholm: I always knew that that would be a major point of debate on the bill. Size is one practical reason why it would be difficult to make the council a separate body but, for me, the intrinsic connection between the patient and public agenda and quality is an important reason for connecting the council to NHS QIS. My perception is that the proposed structure will help to give the body greater clout and leverage, but I accept that there will be an interesting debate on the issue during the next few weeks.

Helen Eadie: The question is whether there will be management lines of accountability to NHS QIS; the answer to that will signal whether the body is independent. If the Scottish health council is accountable to the chief executive of NHS QIS, that will raise an issue.

Malcolm Chisholm: Most organisations have accountabilities. NHS QIS has accountabilities to the Scottish Executive, but in my view that does not mean that it does not operate independently. The relationship between NHS QIS and me might be the same as that between the Scottish health council and NHS QIS. Such a relationship does not mean that an organisation does not have the same space, as it were, and independence within the arrangements. No doubt if we set up a Scottish health council in the way that you suggest, someone might question its independence because it was accountable to me. The same arguments might well apply in a different form. That does not mean that the council will not be independent; it means that we have to set it up in such a way that it is given its own space.

16:30

Helen Eadie: I inferred from what you said—I cannot remember the precise words that you used—that the Scottish health council is to be included in NHS QIS because of its scale and because of accommodation issues, for example. Is that what you were driving at?

Malcolm Chisholm: That was the first reason that I gave. I said that that was not the most important reason, but that it was a factor. The Scottish health council will be a relatively small body in comparison to some NDPBs. In other situations we are attacked in the Parliament for having too many NDPBs, so it will be interesting if the Health Committee proposes a new one, but that is your right if that is what you want to do.

The Convener: I do not think that threatening us with that gets you out of it.

Perception is also an issue. You have rightly talked about the reality of the management line, but perception is often more important than reality. The perception seems to be that the new Scottish health council will not be independent.

Malcolm Chisholm: I am not sure which bit of the perception you are talking about. I have not read all the evidence that the committee has received, but Martyn Evans said that, although that is the perception, it is not the reality.

What are people frightened about? Is it such a bad thing in principle for the Scottish health council to be part of the body that is spearheading all the new work that is being done on the quality agenda, which is one of the most significant

advances in health care in recent times? Is it a problem that the Scottish health council will be part of such an organisation or is it a problem that it will be part of an organisation that has "NHS" in its title? To be honest, I do not know what the problem is.

The Convener: If you read the evidence that the committee has heard, that will give you guidance on that point. Many witnesses have raised the issue with us.

Helen Eadie: The issue has been raised by all the witnesses. People in informed circles have told me that they distinguish between quangos that have a budget to spend on front-line service delivery on behalf of the public, using public money, and other quangos. The issue is the extent to which an organisation should be an independent body. That sets hares running because one encounters issues of accountability—to whom should the independent body be accountable? The debate is bigger than can be covered by the quick response that we have received today.

The Convener: Yes, I think that it is.

I am conscious of time, so we will move on to questions from David Davidson.

Mr Davidson: I will try to be helpful to the minister and ask some fairly simple questions.

This afternoon, minister, you have told us about new roles that the Scottish health council will have. You have talked about communications to the new advisory councils and you have talked about leadership, which has not yet been defined. You have also talked about monitoring and consultation. Those are all serious roles. When the Scottish Association of Health Councils gave evidence, it said that delivery was impossible—the word "impossible" is probably mine, before anybody criticises me—for the currently proposed £2.1 million because of the new roles that are being given to the health council and the need for the council to become a much more cohesive and professional organisation. Do you agree that the Scottish health council can do the job that you want it to do for £2.1 million? If not, what sum of money should it get?

Malcolm Chisholm: The implementation group is discussing many of those issues. I am sure that you agree that £2.1 million is a lot of money. Obviously, over time no wall is drawn around the sum of £2.1 million, but it is more than enough to set up the body and to get the show on the road. We must be mindful of the fact that that figure is not the sum total of the money that goes into the work on patient focus and public involvement—the figure of £14 million has been mentioned before for the work that has gone specifically into that initiative. It may well be that some of that money can supplement the £2.1 million. No one is saying that that is necessarily the end of the road, but I think that the sum is quite sufficient to set up the body.

Mr Davidson: Before the bill goes through the Parliament, could you give us a hint about what you think the budget that the Scottish health council needs to work to should be? It would not necessarily be able to deliver on that in the first year, while it is growing, as there may be front-end costs.

Malcolm Chisholm: I am quite happy with the figure of £2.1 million at the moment. We have adopted an inclusive approach and, given that the Scottish Association of Health Councils is central to the implementation group, I would be happy to listen to its views and those of others who think that that sum will not be adequate. I do not see any reason to believe that that is the case at the moment, but my mind is not absolutely closed on the subject.

Mr Davidson: I want to move to another question on money. Will you outline any work that the Executive has done to reach the conclusion that the bill will not result in any net additional expenditure? Has the Executive made separate calculations of the savings and additional costs that the bill will produce in each of the affected departments?

Malcolm Chisholm: In general terms, we recognise that there will be costs and savings. The fundamental point that the financial memorandum makes is that the bill will not result in any expenditure beyond that which has been announced. For example, there is a new duty to improve health, but of course we have already announced the provision of large sums of money to increase the health improvement budget. The point of that is to spend the existing money more effectively.

There are some methodological difficulties, because it is not possible to be precise about the financial effect of the abolition of trusts, for example. We have used the figure from Dumfries and Galloway NHS Board, which I know has been used in committee, because that process has happened there—that has given the concrete figure of £500,000 over three years. Given that most boards have not been through that process yet, it is difficult to arrive at such concrete figures. However, we can say with confidence that abolishing trusts will certainly not cost more and will save some money, because of the rationalisation of various functions.

The situation is different in each case. On community health partnerships, there will be two main expenditures—those related to the provision of services and those associated with the

management of CHPs. Although most of the management costs already exist within the LHCCs and primary care trusts, the provision of service costs are subject to the much wider budgets relating to boards and service development.

We could go on to consider each of the different areas. I suppose that the power of intervention has been the most controversial in previous evidence-taking sessions. We were asked specifically to give a figure for that, but we did not think that that would be easy to do, as the situation would be different in each case. We used the example of Tayside NHS Board—that is how the figure of £85,000 was arrived at—but, if one were to base the calculation on the intervention in Argyll and Clyde last year, the figure would be higher than that. On the other hand, if one was to imagine what would have happened if the scenario that arose at the Beatson oncology centre two years ago had been dealt with under the power of intervention, the figure would have been less than £85,000. The figure is different in different cases.

As I said, there are some methodological difficulties with estimating the bill's costs and savings, but we can go on doing the work and developing the figures as more information becomes available.

Mr Davidson: Will you share with us the financial assumptions that your department worked on and that resulted in the present state of the financial memorandum?

Malcolm Chisholm: As I have said, the financial memorandum was basically saying that the bill would not result in any expenditure beyond what had already been announced. It said that reprioritisation might be required in certain areas, so it was not ruling out the possibility that more money would be spent on particular areas, but its fundamental point was that the bill would not result in any expenditure beyond what had already been announced.

Mr Davidson: That is a net conclusion. Can we have the assumptions on which you have calculated where the savings and costs will come from?

Malcolm Chisholm: I accept that there is more work to be done on that issue, partly because new information on trusts and other areas becomes available all the time. That is something that we must keep working on. I am not claiming that the financial memorandum was ideal, but I think that some of the difficulties were the result of circumstances rather than of failings in the Health Department.

Shona Robison: You have already touched on the issue of additional resources for public consultation and said that £14 million was available for public involvement measures. Presumably that money is already in the system. However, will additional resources be required to meet the new duty, particularly given the staff time that will be needed to ensure that public involvement is adequate?

Malcolm Chisholm: We are talking about different budgets. The £14 million that you have mentioned is from the patient focus and public involvement initiative and is not included in health boards' budgets. Instead, that money supports boards' work, the advocacy work that we have already referred to and the fair for all initiative, which relates to ethnic minority health and is relevant to the equal opportunities provisions that we are proposing to add to the bill. Furthermore, there is the health council budget of £2.1 million that has been mentioned. Of course, as we will no doubt discuss in a moment, most of the money is with the boards—in other words, the money for the boards' work on public involvement will be taken from their budgets, not from the budgets that I have just described.

The reality is that people are already working on those areas; the key thing is to get them to carry out that work better. Indeed, as I said earlier, much of the patient focus and public involvement initiative is about supporting boards in that respect. In most cases, the initiative is not about employing lots of new people, but about getting the people who are currently doing the work to do it better. As a result, I do not think that a fundamentally big increase in public expenditure will flow from the duty on public involvement.

Shona Robison: Do you accept that doing the work well might involve a wider range of staff than is currently involved? Given that the thrust behind the measure is that public involvement is everyone's duty—not just the duty of the public involvement officer—such work might require more members of staff to become involved. Surely that will impact on available staff time. Will you monitor that situation? Moreover, given that we have all received feedback from boards about their tight budgets and the fact that they are strapped for cash, will you look at the matter again if it is proving difficult for boards to carry out the work without additional resources to free up staff time?

Malcolm Chisholm: I am always happy to look at things again, if necessary. However, the issue highlights the different strands of the agenda. The aspect of the agenda that will impact more on every member of health care staff is what I would describe as patient focus. Indeed, I spent most of the debate in June outlining that part of the agenda because, with the culture change in the NHS, staff are engaging with patients every day. The requirement to relate differently to patients and to take on board patients' experiences will impact on every member of the health care team.

However, I do not think that every member of the health care team will routinely engage with the wider public as citizens. That activity will be more discrete.

As I said, patient focus is about people doing their existing jobs differently, whereas public involvement is probably more tied to specific members of staff who engage with the wider public. As those staff already exist, the issue is about ensuring that they do their job more effectively than they have in the past.

Kate Maclean: I have a couple of questions about the powers of intervention, the first of which is why such powers are needed and when and how they will be used. My second question centres on who will pay for those powers.

According to the evidence that we have received, everyone accepts that Scottish ministers should have the power to intervene if things go wrong, because they are accountable for the NHS in Scotland. However, people are concerned that the bill does not make it clear what is meant by intervention. Evidence that we have heard has suggested that some organisations would like intervention to be defined more clearly in the bill and we heard evidence today that other organisations would be satisfied with a definition in regulations. Can you clarify for the committee on the record when and how the powers of intervention would be used?

There seems to be no clarity about who would bear the cost of the powers of intervention. Earlier, you referred to previous evidence and to the estimate by the Scottish Executive of £85,000, which was based on ministerial intervention in Tayside NHS Board. However, we also heard that the cost of intervention in Argyll and Clyde NHS Board was £300,000. You said that the cost of intervention at the Beatson was less than £85,000, but if memory serves me correctly the Beatson had to close, which would save money.

Intervention has taken place mainly, although not solely, when a board runs into financial difficulties, as that is likely to be the first indication that there is a problem. It does not seem to be particularly fair that the board should bear the cost of that intervention. Evidence that we have heard suggests that some health boards are under the impression that the Scottish Executive will pick up the tab for intervention, whereas other boards are under the impression that they will have to do so. Can you clarify that issue?

16:45

Malcolm Chisholm: Intervention is envisaged very much as a last resort. There are many earlier steps that can be taken. Proposed new section 78A(2) states:

> "The Scottish Ministers may, where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable, direct that specified functions of the body or person under or by virtue of this Act be performed".

That is important, as it leaves open the possibility of challenge. A board could challenge a decision to intervene and there could be a judicial review, if intervention were thought not to be necessary. It is thought to be necessary only as a last resort.

On the first question, it would be very difficult in principle for us to describe in some way, either in the bill or in regulations, the situations in which intervention would arise. The bill states that intervention may take place when a body or person is failing to provide a service to a standard that is acceptable. I accept that that appears to be subjective, although any decision to intervene remains subject to challenge. I do not know how we could translate that into a description in the bill or in regulations. It would be interesting to hear suggestions, but I cannot imagine how we would do that.

Proceeding by examples is a good approach. In some ways, it is easier to use the concrete examples that we have. We were able to intervene at the Beatson and in Argyll and Clyde NHS Board because, ultimately, we secured the agreement of the relevant governing bodies to do so. Under the powers that we currently have, we could not have intervened without their agreement. That is why we need the new power. At some point, a board may say that it will not co-operate with us and that it wants to continue to provide a service itself.

I have given the examples of difficulties in the running of a cancer service and more wide-ranging difficulties in Argyll and Clyde. How would we describe those in the bill? That question defeats me. The basic idea is that intervention can take place when a service is judged to be failing. That is the right general description, because it relates to the issue about which the public are concerned. If there is a service failure in an area, under the new political arrangements in Scotland people want the centre—in the first instance, the Scottish Executive, but the Scottish Parliament could also call for intervention—to intervene. The general criterion of service failure is right, but it escapes me how we would write the details of that into the bill.

Kate Maclean: The second part of my question was about the cost of intervention.

Malcolm Chisholm: My understanding—this may need to be spelled out if it is not clear—is that boards will have to bear that cost. That does not mean that there should not be flexibility. If a board is in financial difficulties and there are particular circumstances that need to be taken into account, there is nothing to prevent the Executive from

deciding to fund intervention either fully or in part. However, it would cause considerable concern in all the other boards in Scotland if one board that had been failing were seen to get extra money. At the end of the day, extra money from the Executive is top-sliced from the budgets of all other health providers. The sums involved may be small, but it would cause considerable difficulties for other boards if a board that was perceived to be failing received extra money.

Kate Maclean: I suspect that boards would not be envious of another board in which ministers were intervening, even if the cost of intervention were borne by the Scottish Executive.

Just for clarity, are you saying that the definition of intervention will not be in the bill or in regulations and that the cost of intervention—even if it is necessary because of severe financial problems caused by mismanagement—must still be borne by the health board, even if it amounts to £300,000 or more?

Malcolm Chisholm: We may need to clarify that, but that would have to be the formal position. As you know, we made a contribution in the case of Argyll and Clyde and I would not want to rule out that degree of flexibility. In my judgment, if we write into the bill that the costs will be borne by the Scottish Executive, that will cause more of a negative reaction, because although we might not be perceived as rewarding failure we would be seen as helping a board where there is failure. I think that that would create a negative reaction from boards that would ultimately have to bear the cost of such intervention.

The Convener: I do not know whether you intend to put that into regulations or guidance, but it would be helpful to have further thoughts from you on the costs of intervention. You seem to be saying that you will need to exercise discretion.

Malcolm Chisholm: There will have to be an amendment to make that clear. We cannot have that kind of doubt about the issue, so we will probably have to say that the cost will be borne by boards. However, putting it that way does not rule out the possibility of the Executive contributing at its discretion. That is what we intend to do.

Kate Maclean: If a board is to operate without knowing when the Executive is likely to intervene, that seems to create some difficulty. I can accept that there perhaps should not be a definition in the bill, because that would not allow enough flexibility, but I cannot understand why the definition of intervention cannot be in guidance for boards. Without such definitions, how are they to know at what stage and for what reasons there will be an intervention?

Malcolm Chisholm: If members can come up with a form of words that would somehow capture what service failure is, I would be interested in hearing from them. The point is that intervention will not come like a bolt from the blue. It will happen very rarely, because a whole ladder of interventions would be used before the sort of intervention that we are now discussing would be made. Boards would know a long time before that happened, because the problems would have been flagged up.

Kate Maclean: Will that be in guidance, then? Will the stages that are reached before intervention be set out in guidance?

Malcolm Chisholm: The boards already know what the stages are, because when they get into difficulties the Executive intervenes in management support or in other areas. I do not imagine that that is something that boards do not know about already. I shall look further into the issue of guidance. Perhaps, for all I know, there is already some formal guidance. There has been a lot of guidance from the Scottish Executive Health Department over the years and I cannot say that I have read every single piece of it. However, I can certainly be confident in saying that boards know what the procedures are. As to whether those procedures are currently written down in guidance, I will have to get back to you.

Kate Maclean: Is that something that we could explore further through correspondence?

Malcolm Chisholm: We shall write to the convener.

The Convener: The policy memorandum refers to what happens at the end of the road, once you have sacked—to use a rather brutal word—a chair or other board members. The memorandum says:

"These are very much powers of last resort and have rarely, if ever, been used."

It would be quite useful to know in what circumstances they have been used. That would give us some idea of the ultimate sanction in cases where you have had to intervene because the situation has been so bad that people have almost been suspended on the spot. I do not know about the other committee members, but that would certainly be useful for me.

Malcolm Chisholm: We can incorporate that information in our letter. It is now 26 years since the National Health Service (Scotland) Act 1978, but I am told that the most draconian power in that act—to hold an inquiry and then sack the board—has not been used.

The Convener: So, do you have to have a judicial inquiry?

Malcolm Chisholm: Part of the problem may be that the procedure is very cumbersome. That may be why it has never been used.

Mike Rumbles: I would like to pursue that point. My observation is that the definition is quite clear; it is wide and gives the minister a huge amount of power. You have just said that the power would be used as a last resort and that such interventions would happen very rarely. I take that on board and I am sure that that is the case.

However, the bill states that Scottish ministers may intervene

"where they consider it necessary for the purpose of ensuring the provision of the service in question to a standard which they regard as acceptable".

That can be read in two ways. One way of reading it would be that intervention can take place if the minister—not anybody else—feels that it is necessary. That appears to be the objective test, according to my reading of the bill. Would not it be better to have said that Scottish ministers may intervene "where they consider it essential for the purpose of ensuring the provision of the service in question", changing "necessary" to "essential" and leaving out

"to a standard which they regard as acceptable"?

If intervention is to be a last resort and a rare event, the provision does not need to be so all-encompassing.

Malcolm Chisholm: That is an interesting suggestion and it could give rise to an interesting amendment. I would not like to make a snap reaction to it, but I shall certainly reflect on what you have said.

The Convener: Thank you, minister. We have another short item before we go on to our private budget briefing and I know that you are coming back for that.

Subordinate Legislation

Honey (Scotland) Regulations 2003 (SSI 2003/569)

Regulation of Care (Scotland) Act 2001 (Transitional Provisions and Revocation) Order 2003 (SSI 2003/587)

16:55

The Convener: The final item on the agenda is the consideration of two instruments under the negative procedure: the Honey (Scotland) Regulations 2003 and the Regulation of Care (Scotland) Act 2001 (Transitional Provisions and Revocation) Order 2003. The Subordinate Legislation Committee has made minor comments in relation to the Honey (Scotland) Regulations 2003 but no comments on the other instrument.

Members have had the opportunity to see both instruments, but no comments have been received from members and no motions to annul the instruments have been lodged. Does the committee agree to make no recommendations in relation to the instruments?

Members *indicated agreement*.

The Convener: That completes our business for today, so I conclude the meeting.

Meeting closed at 16:56.

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