HEALTH COMMITTEE

Tuesday 11 January 2005

Session 2

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CONTENTS

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HEALTH COMMITTEE
1st Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (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)
Mr Stewart Maxwell (West of Scotland) (SNP)
*Mrs Nanette Milne (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Carolyn Leckie (Central Scotland) (SSP)

THE FOLLOWING GAVE EVIDENCE:

Mike Baxter (Scottish Executive Health Department)
Jim Brown (Scottish Executive Health Department)
Colin Cook (Scottish Executive Health Department)
Mary Cuthbert (Scottish Executive Health Department)
John Davidson (Scottish Executive Health Department)
Roderick Duncan (Scottish Executive Health Department)
Eric Gray (Scottish Executive Health Department)
Andrew MacLeod (Scottish Executive Health Department)
Richie Malloch (Scottish Executive Health Department)
Patrick McGrail (Scottish Executive Health Department)
Chris Naldrett (Scottish Executive Health Department)
Adam Rennie (Scottish Executive Health Department)
Stephen Sandham (Scottish Executive Development Department)
Sylvia Shearer (Scottish Executive Health Department)
Mike Stevens (Scottish Executive Health Department)
Diane White (Scottish Executive Education Department)
Dr Hamish Wilson (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 11 January 2005

[THE CONVENER *opened the meeting at 14:00*]

Smoking, Health and Social Care (Scotland) Bill: Stage 1

The Convener (Roseanna Cunningham): I welcome everyone back to Parliament and wish them a happy new year. Let us hope that the work of the Health Committee is as successful in 2005 as it was in 2004.

Today, we will receive a briefing on the policy intentions behind the Smoking, Health and Social Care (Scotland) Bill. The bill team leader is Roderick Duncan, who will be accompanied by a variety of colleagues from the different divisions of the Health Department that have a policy interest in the bill. The bill has five main parts and we have arranged this afternoon's session to follow that structure.

I ask Roderick Duncan to make a brief introductory statement. He will remain here throughout the evidence session to address general questions. However, if members have questions on specific subjects, we would be obliged if they would wait until the relevant Executive officials are before the committee. Roderick Duncan is accompanied by Colin Cook, who is the head of the substance misuse division, and Mary Cuthbert, who is the tobacco control division team leader.

Roderick Duncan (Scottish Executive Health Department): Good afternoon, ladies and gentlemen. I thank the committee for giving us this opportunity to present the contents of the Smoking, Health and Social Care (Scotland) Bill. My role as bill team leader is to co-ordinate the Executive's activities as the bill moves through the parliamentary process. I do not have in-depth knowledge of the individual policy areas behind the bill, so I ask members not to ask me too many difficult questions about those.

My colleagues will address the detail of the bill, but I will start by providing a high-level summary of it. The Smoking, Health and Social Care (Scotland) Bill is wide in scope, with a range of provisions that address smoking, health care and social care. The smoking provisions introduce a prohibition on smoking in all wholly enclosed spaces to which the public or a section of the public have access. The health care provisions continue the process of modernisation of the national health service, specifically with respect to the provision of dental and pharmaceutical care services. They also introduce free eye and dental examinations for all. There are measures to update legislation relating to the listing of and disciplinary processes for family health service practitioners.

The bill contains a number of miscellaneous provisions. Among them are a scheme for payments to certain persons who are infected with hepatitis C and amendments to the Regulation of Care (Scotland) Act 2001, including provisions relating to child care agencies and housing and support services. There are amendments to the Adults with Incapacity (Scotland) Act 2000 and provisions to allow Scottish ministers to set up or participate in joint ventures. Finally, the bill contains provisions to end the non-departmental public body status of the Scottish Hospital Endowments Research Trust.

The Convener: I ask Colin Cook to make a short introductory statement on the part of the bill for which he is responsible.

Colin Cook (Scottish Executive Health Department): Part 1 of the bill deals with the prohibition of smoking in certain wholly enclosed public spaces. For some time, we have recognised that smoking is the most important preventable cause of ill health and premature death in Scotland. When the Executive published its tobacco control action plan back in January 2004—the first-ever action plan that was designed for Scotland—it made a commitment to a major public debate on passive smoking. The health evidence about the impact of passive smoking grows all the time. We added to that evidence during the consultation process the estimate of about 865 deaths per annum in Scotland among lifelong non-smokers from the four main diseases related to smoking.

Between June and September 2004, the Executive undertook its consultation, which generated more than 53,000 responses. That was supplemented by opportunities for the public to give ministers their views and discuss the issues on the internet and elsewhere. It was also supplemented by a series of research projects, many of which are covered in the documents that are before the committee. Those projects examined the health and potential economic impacts of introducing the policy.

Part 1 of the bill prohibits smoking in premises that are fully enclosed and to which the public or a section of the public have access. It does so to protect public health. The detailed provisions, including any exemptions that might be considered, will be prescribed in regulations subject to the affirmative procedure. However, given the health evidence that I mentioned briefly,

ministers have made it clear that they want the most comprehensive approach, which will include premises such as transport cafes, restaurants and large-scale public buildings such as hospitals. That takes into account the fact that 70 per cent of Scots do not smoke, that many who smoke want to give up and that evidence suggests that there is no safe level of exposure to tobacco smoke.

The bill provides for a ban on smoking in the premises that are prescribed in regulations as no-smoking premises by creating offences of permitting others to smoke in no-smoking premises; of smoking in such premises; and of failing to display warning notices in no-smoking premises. The bill also sets out powers for enforcement officers to enter no-smoking premises and creates an offence of failing to give a name and address on request by an enforcement officer.

Part 1 makes a significant contribution to the Executive's overall effort to improve health in Scotland. Mary Cuthbert and I hope to answer your detailed questions.

The Convener: Committee members will be aware that we have much to get through this afternoon, so I ask members to keep it in mind that we will ask questions on part 1 until about half past 2. Nanette Milne has joined us. I ask members to indicate whether they have questions; they should not feel obliged to ask questions for the entire time—I am sure that the officials do not mind either way. Does nobody have a question? Somebody must have a question.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): We have questions on other parts of the bill.

The Convener: In fairness to the officials, they will be aware that the committee has taken much evidence that is germane to part 1, so that part will not take up as much time as it would have if we had approached the subject afresh. However, my filibustering has managed to elicit one question.

Mr David Davidson (North East Scotland) (Con): I thought that I would help you out a bit, convener. It may not be competent to ask or to answer this question, but why have many different provisions—each valued in its own right—been incorporated into one bill?

Roderick Duncan: Members may be aware that, in his statement to the Parliament in September 2004, the First Minister outlined the intention to introduce a health service (miscellaneous provisions) bill. When the smoking provisions were brought forward as a health measure, it was thought appropriate to include them in that bill. A large part of the Smoking, Health and Social Care (Scotland) Bill relates to smoking, but it also captures several other important health care and social care matters.

Mr Davidson: I did not receive an answer—that is obviously not appropriate. Do you have any idea why all the provisions have been grouped together rather than introduced as separate pieces of legislation?

Roderick Duncan: Each piece of legislation would be so small on its own that individual bills would not be justified. It was felt that it would be appropriate to bring all the provisions together into a single piece of legislation.

The Convener: I have a question for the two other officials. I was interested in the Scottish Parliament information centre's briefing on the smoking ban, page 12 of which deals with deaths relating to environmental tobacco smoke. I am curious about the fact that three different figures are given for that. NHS Health Scotland and Action on Smoking and Health Scotland estimate that there are around 1,200 deaths a year in Scotland from passive smoking. A University of Glasgow study says that there are

"865 deaths per year in Scotland among lifelong non-smokers from the four main causes listed".

The third source says that,

"including other deaths known to be related to smoking, up to 1000 deaths per year might be attributed to ETS exposure among lifelong non-smokers".

Will the witnesses explain why we have that variety of figures?

Colin Cook: Each of those figures is defined differently. As you said, the figure of 865 deaths, which is probably the most often cited statistic, comes from work done by David Hole at the University of Glasgow. As the briefing states, that study looked at the relevant four main causes of death—ischaemic heart disease, stroke, respiratory problems and lung cancer. We need to bear in mind other smoking-related diseases, but the evidence base for those is less robust; nonetheless, some of the other figures include them. We are looking at those over a long period and, in the case of some diseases, the medical effects might take 20 or 30 years to come through. Different timescales and definitions come into play.

The Convener: There is a bit of rumbling around the table. Can we take from what you said that we have a variety of estimates and that the figures cannot be said to be more than that?

Colin Cook: Yes, but 865 deaths is the central estimate. Other factors also come into play—for example, deaths among ex-smokers who have continued to be exposed to environmental tobacco smoke over time. The 865 deaths were among lifelong non-smokers, but there are other

categories of people to consider. There are different estimates, but they can all be traced and matched. The evidence report that was produced attempts to do that.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I am not sure whether this is the right point at which to ask this question, which is about the wholly enclosed places. Hospital grounds, which are usually large, wide-open spaces, are non-smoking areas. I am also thinking about the concourses of railway stations, which are reasonably open, although they are roofed. Are they wholly enclosed spaces?

Colin Cook: We can refine the definition of a wholly enclosed space in regulations. We work on the assumption that it is somewhere with four walls and a roof. However, that will be picked up through regulations as the process continues.

Mrs Nanette Milne (North East Scotland) (Con): We have mortality figures for passive smoking, but are there any morbidity figures?

Mary Cuthbert (Scottish Executive Health Department): All the information is gathered on the basis of estimates and there are no available estimates that relate to passive smoking.

The Convener: Following on from Jean Turner's point, I will ask about the kind of spaces that are likely to be covered by the legislation. We know from the Irish experience that some hotels, restaurants, cafes and pubs have devoted external spaces to smoking with the use of marquees, external heaters and what have you. Is it envisaged that that is likely to happen in a number of places in Scotland, where space is available?

Colin Cook: Clearly, the situation will be driven by the market, but one would expect similar things to happen as have happened in Ireland.

14:15

The Convener: There are no more questions. You have got off lightly, but that is because of the enormous amount of work that the committee has already done on the issue, not because there is not a great deal of interest in it. I thank the officials for coming.

As I said, Roderick Duncan will stay with us as we are joined by officials who deal with parts 2 to 4 of the bill. I invite to the table Dr Hamish Wilson, who is the head of the primary care division and who has an interest in all three parts. To deal with part 2, which is on general dental services, general ophthalmic services and personal dental services, we have Eric Gray, who is from the primary care division's dental and ophthalmic services fraud and disciplinary team. To deal with part 3, which is on pharmaceutical care services, we have Chris Naldrett, who is the team leader with the pharmacy issues team in the primary care division. To deal with part 4, which is on discipline, we have Richie Malloch, who is the team leader of the general medical services team in the workforce and policy division, and John Davidson, who is also from the workforce and policy division's general medical services team. I ask Dr Hamish Wilson to make a short introductory statement on parts 2 to 4.

Dr Hamish Wilson (Scottish Executive Health Department): With your agreement, convener, it might be best if I introduced each part separately, because, although the provisions are interconnected, they are also distinct.

The Convener: Okay. We will ask you to make three introductory statements. Perhaps you will deal first with part 2, on general dental services, general ophthalmic services and personal dental services.

Dr Wilson: Thank you. Part 2 deals with three main issues and it would be helpful to consider them in turn. The first is the partnership agreement pledge to introduce free dental and eye checks for all before 2007. Sections 9 and 10 make provision for the introduction of free dental and eye checks for all. The present legislation requires charges to be made for certain people for dental and eye checks, but sections 9 and 10 will remove that requirement.

Part 2 will also provide the potential for more comprehensive free oral health assessments and eye examinations. I will exemplify using the second of those. At present, the specific definition of a sight test involves refraction, which is used when a person needs glasses, whereas the phrase "eye examination" can be a much broader term that allows optometrists, for example, to provide an examination for an individual that may not involve refraction and hence the need for glasses. That is particularly appropriate for certain clinical conditions.

In relation to dental services, the consultation—to which I will return when I refer to section 11—revealed strong support for wider oral health assessment, not just the current dental examination that individuals receive from dental practices. We have used the term "oral health assessment" to describe that broader examination, which will allow dental practitioners to perform something that is much broader and more useful for patients than the current examination is.

The bill will remove the requirement to pay for eye and dental checks and it will provide for a broader range of examinations than are allowed for currently. It might be helpful if I stopped there and took questions on those sections, or would you prefer me to deal with all three issues now?

The Convener: I want to deal with the three parts separately. The first—part 2—deals with general dental services, general ophthalmic services and personal dental services.

Dr Wilson: I will carry on then, if I may, with the other two issues.

The next sections of the bill flow from the consultation that the Executive conducted in the earlier part of last year. The consultation paper "Modernising NHS Dental Services in Scotland" was issued, to which there were a large number of responses, and a number of meetings were held throughout Scotland. As a result of that, the proposals for changing primary legislation are quite limited. The response to the consultation was clear: the changes that professionals and members of the public were looking for could be implemented by methods other than primary legislation—for example, by changes to regulations and changes to the way in which dentists are paid. There is a specific dental remuneration system, which can be changed without amending primary legislation. On the face of it, the changes to primary legislation on dental services seem modest, but they are important. I will deal with them in the order in which they appear in the bill.

First, in section 11, there is a provision to make the dental charging regime simpler and more flexible. At the moment, a patient's dental charge is linked to the dentist's item-of-service fee. If a patient pays, they pay 80 per cent of that fee. That is how the legislation is currently framed; it does not give the detailed percentage but states the way in which the charge is calculated by reference to the item-of-service fee. By breaking that link, which is what the bill does, we will have the opportunity, through regulations, to have a more flexible and transparent system. Ministers have not yet taken a view on what that system should be, but the bill allows for a more flexible system than currently exists.

Section 12 will allow NHS boards to enter into arrangements for general dental services with dental bodies corporate as well as with dental practitioners. Dental bodies corporate are defined in the Dentists Act 1984, which is reserved legislation. It contains provisions for bodies corporate to provide general dental services under the NHS as well as privately. At the moment, arrangements can be made only with individual dentists, but the provision broadens the ability of NHS boards to make arrangements.

Section 13 is on a particularly important matter, which was raised forcefully during the consultation: the ability of health boards to provide financial assistance and support to persons who provide general dental services. That might include, for example, assistance with the cost of premises and information technology support to staff.

Section 14 will allow health boards to make arrangements with dentists for what we describe as co-management schemes—schemes that allow dentists to provide in the community services that might otherwise be provided in, for example, a hospital setting. The bill will allow such services to be contracted with local dental practices in the high street, which will be able to provide them to patients in the community. Indeed, dentists can provide an important service in relation to other treatments—two examples are migraine and snoring treatments, which are not normally associated with dental services.

Sections 15 to 17 are about the listing of those who provide dental or optical services. At the moment, people who are included on health board lists to provide such services are what we call principals—the main providers of service. Those who are not listed are called assistants and they support those professionals in providing services. Assistants are qualified dentists or optometrists but they are not listed. One of the post-Shipman recommendations was that all such individuals ought to be listed, whether the services that they provide are medical, dental, pharmaceutical—we will come to that later—or ophthalmic, so that individual health boards have responsibility for all the individuals on their lists. That is a clinical governance issue.

Mike Rumbles: You make it clear that part 2 of the bill will allow everybody to have free dental examinations and sight tests. When you say that part 2 will also allow the Executive at a future date to establish more comprehensive oral health assessments and eye examinations, do you mean that that could be done by regulations? I just want to be absolutely clear that ministers will be able to come forward with those proposals not through a bill before the Parliament but through laying regulations before the committee. Is that right?

Dr Wilson: Yes.

Shona Robison (Dundee East) (SNP): In the financial memorandum, providing free dental checks has been costed at between £9.1 million and £12.4 million, based on a cost of £6.80 for one check. This exercise is running simultaneously to the awaited response from ministers to the "Modernising NHS Dental Services in Scotland" consultation, so it is quite possible that there will be substantial changes to the fee structure and to the fee level that could be paid to dentists for carrying out those dental checks, particularly as you have said that there is a desire to have wider oral health assessments than just the basic check. There is a likelihood that the figure of £6.80, on which the financial memorandum is based, could quickly become out of date as the fee structure

and fee level change and as what dentists are expected to provide for the check changes. Is not the financial memorandum likely to become way out of date and substantially inaccurate quite quickly?

Dr Wilson: You are absolutely right. Because discussions with the dental profession on the potential for an oral health assessment and what that might mean are on-going, we do not have new figures for the financial memorandum, which was constructed a number of weeks ago. We have simply had to go on the figures that we had available at the time, so you are right to say that the cost could change.

Shona Robison: How will that be managed in terms of the progress of the bill?

Dr Wilson: As soon as we are aware of the changes that might flow from those discussions and from the decisions that ministers will announce, we will have to come back and make an addendum to the financial memorandum.

Shona Robison: I suppose that the problem is that, in some ways, the timing could not be worse. I have highlighted one aspect where the decisions made by ministers could have an impact on the financial memorandum or indeed on the contents of the bill, but there could be many such aspects. I take it that you are in close liaison with the officials who are working around what the ministers are about to announce.

Dr Wilson: Yes.

Shona Robison: Will you come back and have another session with us on the more realistic figures?

Dr Wilson: Yes. We were able to produce costs only on the basis of the information that we had at the time. In relation to the main service, in addition to the examinations, the bill does not have direct financial consequences other than those that are listed. Clearly, however, if any ministerial announcement includes additional resources for general dental services, that would have to be taken account of as well.

Helen Eadie (Dunfermline East) (Lab): I note from the SPICe briefing that remuneration for dental services across Scotland is set at United Kingdom level. One of my concerns, which I am sure other members will share, is that if there are negotiations going on at the London end of the spectrum, as happened in relation to general practitioners not so long ago, there will be a feeling in Scotland that not enough discussion and negotiation is taking place to reflect Scottish concerns on the issue. What measures are in place to ensure that Scotland is wholly and fully consulted on that point?

14:30

Dr Wilson: There are two aspects to that question. First, the remuneration set by the doctors and dentists remuneration review body for the UK relates to item-of-service fees and, traditionally, we have gone along with that body's recommendations. Secondly, however, we have introduced in addition to the item-of-service fees and outwith the DDRB certain unique allowances and incentives to encourage practitioners to stay and practise in Scotland. In a sense, we have tried to have the best of both worlds by continuing certain aspects that have been introduced on a UK basis while introducing measures on a Scotland-only basis to meet the country's particular circumstances.

One of the basic issues for ministers in considering the future is the extent to which we change the relationship with what happens south of the border. In England, they have already indicated that they will take a contractual route that is different from the one that most people in the consultation wanted us to take. The approaches taken in Scotland and in England and Wales are already diverging.

Helen Eadie: I understand that even as we speak negotiations on this issue are taking place at a UK level. How far have they reached with regard to Scotland?

Dr Wilson: Ministers hope shortly to announce the results of the response to the consultation, which will provide a set of proposals for the future of NHS dental services in Scotland. I am sorry, but I cannot provide a precise timescale.

Kate Maclean (Dundee West) (Lab): How do the bill's provisions for free eye tests compare with those in the general ophthalmic services contract? There has been some criticism that they do not go far enough.

How can we ensure that people such as children who are entitled to free eye tests take them up? For example, it is reckoned that 20 per cent of school pupils have undetected sight problems. Moreover, what provision will there be for people such as those with dementia or learning disabilities who are more difficult to test and need more time for such examinations? I am concerned that, although free eye tests can have a real public health benefit, they have to be carried out properly or there will be no improvement.

Dr Wilson: For that very reason, the wording in the bill has been changed to allow eye examinations, which, subject to discussion with the profession, can be defined in a much broader way than the current sight test. After all, that provision was designed in 1948 for a very specific purpose and has not been altered much since then.

The Convener: Has the wording been changed to take into account Optometry Scotland's concerns that confining the provision to a sight test would miss the point in many respects?

Dr Wilson: Yes. I believe that the SPICe paper specifically mentions Optometry Scotland's view. Indeed, we are discussing with the organisation the potential through the eye care services review group of extending eye examinations to broaden the proposed provision into one that is more of a public health measure than the current provision is.

The other issues that Kate Maclean raised, which are important, are more to do with how we implement the changes. I wonder whether we should simply stick to the bill's content for today. We will take the other matters away and consider them in the context of implementation.

Mr David Davidson: The British Dental Association and Optometry Scotland appear to challenge their members' capacity to deliver the provisions on time. In other words, there are not enough bodies on the park to do that. Moreover, practitioners might be unwilling to participate unless they are forced to. How will you address that matter in the bill?

Dr Wilson: Legislation cannot address that issue in itself; it has to be a matter for discussion and negotiation with the two professions. Let me take them in reverse order. Optometry Scotland has said that opticians across Scotland have the capacity to deal with a policy of free eye tests for all. In comparison with other health care professionals, opticians are reasonably plentiful. I accept that the situation is quite different with regard to dentistry and that, as people around this table know well, there are severe pressures on dentists. We are in discussions with the profession about the content of the scheme, but believe that it must be set in the context of the whole modernisation process rather than being seen as an item on its own. If, through the modernisation process, we can encourage more dentists into the national health service and retain them within the NHS, we have a much better chance of delivering the oral health assessments that are mentioned in the legislation.

Mr David Davidson: Are you saying that Optometry Scotland says that it has enough people to do what it is currently doing and to take on an additional load?

Dr Wilson: Yes. That is what its representatives have been saying in the eye care services review, of which they are part.

Mr David Davidson: Will we be able to read the reports of that review group?

Dr Wilson: The intention is that a preliminary report will be given to ministers in the near future. I am sure that that can be made available to the committee as soon as ministers have seen it.

The Convener: There appear to be no more requests to question this panel of officials with regard to part 2 of the bill, so perhaps Eric Gray is no longer required and—no doubt much to his delight—he can go.

I ask Dr Wilson to make a brief introductory statement on pharmaceutical services, which are dealt with in part 3 of the bill.

Dr Wilson: I stress the fact that the bill is not about the detail of the new pharmacy contract that is being negotiated with the Scottish Pharmaceutical General Council, which is the representative body for community pharmacists in Scotland. However, the bill sets the legislative framework within which the new contract might be delivered.

I emphasise the fact that the legislation, as drafted, substitutes the term "pharmaceutical care services" for "pharmaceutical services". That might seem to be a small change, but care is an important word because part of the negotiations with the profession—because of the requirements placed on the Executive in the partnership agreement—relates to the need to make the best use of the skills of community pharmacists. That issue relates to care, not just dispensing, important though dispensing is. Therefore, the provisions in the bill are meant to underpin a new set of arrangements for the delivery of what we are increasingly going to call pharmaceutical care services rather than pharmaceutical services. In summary, the key provisions in the bill enable the implementation of that new pharmacy contract. The bill underpins the new contract arrangements, the detail of which will be laid out in regulations, as is the case with the current contract.

The bill also introduces a duty on health boards to be much more proactive in identifying and providing or securing the provision of pharmaceutical care services for their respective areas. At the moment, the mechanism for the provision of pharmaceutical services is somewhat reactive. When people apply to come on to a pharmaceutical list, there is a process for considering that application and either accepting or rejecting it, and there is also an appeals mechanism. The intention of the legislation is to turn that process around so that health boards proactively plan the provision of services and secure that provision where it is needed.

The third element is about listing. I mentioned clinical governance in relation to dental and ophthalmic services and the issue is exactly the same in relation to pharmaceutical services.

Currently, lists that are held by health boards do not contain the names of the pharmacists who provide the services, other than those of the superintendent pharmacists who are in charge of particular outlets. The intention—again, a post-Shipman requirement—is to identify all the community pharmacists who provide pharmaceutical care services. They will be on the list and will be responsible for their own acts and omissions, and that will underpin the clinical governance requirements on the NHS board.

The final provisions will ensure that health boards have financial responsibility for the contracts that will be delivered through the contractors who provide pharmaceutical care services, by ensuring that funding is seen as a core part of the health boards' budgets. At the moment, the budget for remuneration for community pharmacies is held centrally, and although health boards are formally accountable for it, they have no direct interest in or control over it. The intention is to change that, so that with the planning of services goes the responsibility for funding them. Having said that, it is important to stress that essential services will continue to be negotiated and defined at national level and that there will therefore be consistency of remuneration for community pharmacies throughout Scotland. The only additions to that will be services that not every community pharmacy will be required to provide, which can be contracted locally. We will still have a national service, albeit that remuneration will be done accountably at health board level.

The Convener: Do members have questions? Why did I guess that David Davidson would be the first member with his hand up?

Mr David Davidson: I am still on the roll of the Royal Pharmaceutical Society of Great Britain, although I do not practise.

Dr Wilson says that there will be national negotiation on the basic fee structure for dispensing purposes and I presume that there will be such negotiation for some form of new establishment contract. Is he saying that health boards will decide which additional services each pharmacy can apply to deliver or will be asked to deliver? How will the funding for that operate?

Dr Wilson: Additional services will be defined. There are four essential services in the proposed new national contract: acute dispensing, which is what most people think of as a pharmacy service; a minor ailments service; a public health service; and a chronic medication service. Those will be national services and the tariffs, capitation fees and so on will be laid down centrally. Examples of additional services include services to residential homes and oxygen therapy services. As I said, additional services will be defined and, just as happened with primary medical services, there will be a national specification and a benchmark tariff. Health boards will be able to use those, but at the same time they will be able to flex them to fit particular local circumstances. It is likely that specific pharmacy contractors will provide those additional services; not every pharmacy will provide them, just as at the moment not every pharmacy contractor needs to provide oxygen therapy services. They are distributed around an area to make sure that there is sufficient coverage.

Mr David Davidson: Are you saying that from the patient's perspective, which is where we need to come from, people who currently enjoy additional services will continue to do so and the health boards will not be able unreasonably to withdraw services from any particular area of Scotland?

Dr Wilson: We expect the pharmaceutical plan, which is mentioned in the bill, to cover the full spectrum of services so that people can be satisfied that the full range of services is available to the whole population, albeit that additional services will not necessarily be available from every community pharmacy.

The Convener: No other member has indicated that they wish to ask a question on part 3 of the bill, so that is good news for Chris Naldrett, who can now head off, perhaps wondering why he came along in the first place. I thank him anyway, and I ask Dr Wilson to make a brief introductory statement on part 4 of the bill, on discipline.

14:45

Dr Wilson: I have mentioned the post-Shipman recommendations more than once this afternoon, and a number of measures in part 4 of the bill flow from them—not necessarily the most recent recommendations, which have just appeared, but those that appeared not long after the events.

In Scotland, we have an NHS tribunal, which is the national disciplinary body for family health service practitioners—that is, doctors, dentists, pharmacists and opticians. Following consultation, a number of measures to strengthen the protection of patients throughout Scotland are proposed in the bill.

The first of those is the removal of the tribunal's sanction of local disqualification. At the moment, an NHS tribunal can, in theory, disqualify someone nationally—that is, throughout Scotland—or only in the area or areas in which they provide services. It seems inappropriate that someone should be disqualified in one part of Scotland only to be allowed to practise in another part of the country. The consultation was clear that that should no longer be the case and, in fact, the NHS tribunal has not used the provision for many years.

The second measure is to add a third ground for disqualification to those that currently exist. That third ground is unsuitability by reason of "professional or personal conduct". There have been circumstances in which the requirements that are currently placed on the NHS tribunal have not allowed it to consider the disqualification of individuals whose disqualification members of the public would, I suspect, think that the tribunal ought at least to consider. In common with our colleagues south of the border, we are introducing that third ground for potential disqualification.

The third measure is the introduction of an additional ground for suspension. The tribunal can already suspend individuals from practice—that is, not disqualify them, but suspend them for a period of time—and the agreement from the consultation is that we should add:

"that it is otherwise in the public interest to do so."

There are circumstances in which, to protect patients, it is appropriate to extend the current grounds for suspension. I add that, as mentioned in the SPICe note, we will, through regulations, provide for NHS boards to be able to suspend someone locally, as it might be appropriate to take action quickly in specific local circumstances. However, national suspension is reserved to the NHS tribunal.

The fourth measure is to bring within the NHS tribunal's jurisdiction all the additional categories of staff that I mentioned in connection with listing. As I mentioned, assistants who support the provision of, for instance, dental or pharmacy services are not covered by the NHS tribunal because they are not on a list. However, because we seek to list them through the bill, they ought to be covered by the NHS tribunal, and provision is made for that.

Finally, there are provisions that will ensure that the Scottish ministers can, through regulations, require that decisions that are made in other parts of the UK also apply to Scotland. It is important that, if someone is disqualified in England, Wales or Northern Ireland, they are also able to be disqualified north of the border, and regulations will allow that to happen.

The Convener: Thank you. I have a question about the Shipman inquiry, which has recently published a report. Does the Executive intend to introduce further measures in part 4 if that seems sensible as the weeks go by?

Dr Wilson: Part 4 would be the appropriate part of the bill in which to do that. As you know, the Shipman inquiry's "Fifth Report—Safeguarding Patients: Lessons from the Past—Proposals for the Future" has become available only very recently. It is the most recent report and deals with issues that are not dissimilar to those covered in the bill. In fact, the direction in which the bill is moving is consonant with the fifth report's recommendations, but if there are specific issues, we would bring them back to the committee.

The Convener: Do you anticipate anything additional coming up or do you think that, at the moment, you have gone as far as you can go with post-Shipman recommendations?

Dr Wilson: We are still in discussion with the other health departments about what measures might need to be introduced, but we could come back at stage 2 or stage 3 if we felt that there were significant issues that it was important to include in the bill, because that would be the opportunity to capture anything that comes out of the Shipman inquiry's fifth report.

The Convener: I will have to demit the chair to my deputy convener for a few minutes, because I have a television interview that I have to do. I ask the committee and witnesses to accept my apologies.

Mike Rumbles: I welcome the more comprehensive nature of the bill's provisions on disqualification by the NHS tribunal, but to put the matter into perspective, I ask the Executive officials to tell me approximately how many individuals have been disqualified by the system in the past five or 10 years.

John Davidson (Scottish Executive Health Department): There is about one case per year, but there has recently been an increase. There are two cases running at present, but we anticipate that the workload will increase, especially in relation to fraud cases.

Mr David Davidson: I ask the officials to clarify the situation with respect to suspension and disqualification. What is the relationship that the various health departments have agreed or are negotiating with the professions that have registration and statutory disciplinary systems of their own? In some cases, a professional body might not support the NHS view but, in others, the professional body might wish to suggest to the health service that it take action. Such bodies could do so simply by disqualifying somebody from practising. What is the new arrangement under all the changes that have been made in the past year?

Dr Wilson: That arrangement is closely tied up with the recommendations from the Shipman inquiry and what might happen as a result of the inquiry's fifth report. It is largely focused on the General Medical Council, but will inevitably have implications for the other councils. The intent has always been to make the procedures as consistent as possible while recognising that the NHS and the professional bodies have distinct roles. The NHS has a specific role in relation to the safety of

NHS patients, while the registration bodies have a broader role. However, the health departments have always tried to make those roles as consistent as possible. As the committee knows, the structures north and south of the border are different, so the bodies that deal with the issues in different parts of the UK might be different, but the principles are still the same. Discussions have continued with the professional registration bodies to ensure that they do not envisage any difficulty with the arrangements, and they have been consulted as part of the process.

Mr David Davidson: Will a standard system apply over the four health departments in the UK to a professional body that covers the whole UK?

Dr Wilson: Yes. The process by which that happens might be different because of the different bodies that are involved, but the principles will be the same.

The Deputy Convener (Janis Hughes): That concludes the questions on part 4 of the bill. For questions on part 5, we will move on to a new panel of witnesses, apart from Mr Duncan. We are a little ahead of schedule due to the discipline of members and their short questions, so I suggest that we have a short break and reconvene at 3 o'clock.

14:52

Meeting suspended.

15:01

On resuming—

The Deputy Convener: We will now deal with part 5 of the bill, which contains miscellaneous provisions.

I welcome our next panel, which comprises a host of miscellaneous officials. Mr Duncan is still with us. Stephen Sandham is from the regeneration, fuel poverty and supporting people division of the Scottish Executive Development Department and Sylvia Shearer is from the blood transfusion services and rehabilitation equipment branch of the Scottish Executive Health Department's health planning and quality division. Andrew MacLeod is head of the Scottish Executive Health Department's health planning and quality division and Adam Rennie is head of community care division 2 of the Scottish Executive Health Department. Diane White is from the Scottish Executive Education Department's social work services policy division training and development team and Jim Brown is head of the public health division of the Scottish Executive Health Department.

I invite Sylvia Shearer to make some opening remarks on section 24.

Sylvia Shearer (Scottish Executive Health Department): The Skipton fund commenced business in July 2004, following an expert group's report. The scheme aims to make ex gratia payments to people who became infected with hepatitis C as a result of receiving blood tissue or blood products as part of their NHS treatment prior to 1 September 1991 and who meet certain criteria.

In order to minimise any payment delays to individuals, the payments have been made using common-law powers. To allow payments to be made over the longer term, it is necessary for our ministers to be given legal vires for establishing and being involved with the ex gratia scheme. The bill that is before members therefore makes statutory provision for those payments. To date, the fund has paid out just over £8 million to Scottish claimants and a total of 400 Scottish claims have been processed.

David Davidson asked originally why there are so many parts to the bill, and I think that that partly answers his question. This is our first opportunity to propose such legislation to the committee.

Mr David Davidson: My original question was not so much why there are so many parts to the bill, but why some parts of it are not stand-alone pieces of legislation.

The Deputy Convener: Members may now ask questions on section 24.

Mike Rumbles: I want to consider the necessity for section 24. Payments for what is, basically, no-fault compensation are being made under common law. I heard what you said about ministers thinking that it would be better to firm things up in statute, but I am concerned that if cases arise on other subjects that relate to the health service, people may be concerned about no-fault compensation for victims who have an issue through no fault of their own or the health service and the bill might be used to block any future extension of no-fault compensation.

We already have no-fault compensation for AIDS and hepatitis C victims. No immediate pressure is building for compensation for any other category of victims, but that could happen in the future. I do not want the provision to be used as an excuse for not providing such compensation. You confirmed that ministers are allowed to provide no-fault compensation under common law, so why is the provision necessary?

Sylvia Shearer: The bill is not intended to pave the way for other schemes. We see hepatitis C as a special case, as with AIDS and other particular circumstances. We do not wish to set a precedent.

Mike Rumbles: That does not answer my question. I understand that point of view, but if the common law allows the payment to the Skipton fund—as it does—why is the provision being introduced?

Andrew MacLeod (Scottish Executive Health Department): We are using common-law powers to make the payments under the budget resolution because that is allowable as a temporary measure. However, the legal advice is that we cannot make hepatitis C payments in the long term without a statutory provision to do so.

Mike Rumbles: You have had specific legal advice.

Andrew MacLeod: We have legal advice that that is necessary.

The Deputy Convener: Members have no more questions on the provisions on hepatitis C compensation, so we will move to the next sections. I invite Adam Rennie, Diane White and Stephen Sandham each to give a brief introduction on their interests, particularly in relation to amending the Regulation of Care (Scotland) Act 2001 and the registration of child care agencies and housing support services.

Adam Rennie (Scottish Executive Health Department): We deal with several distinct provisions. Section 25 concerns independent health care services and is a fairly technical measure. The Regulation of Care (Scotland) Act 2001 lists various care services that are to be regulated by the Scottish Commission for the Regulation of Care, which include an independent health care service as defined in section 2(5) of the 2001 act.

The scope of the 2001 act goes further than the original policy intention. For instance, if regulation were commenced under the definition in section 2(5) as it stands, that would make the care commission responsible for regulating services from a doctor or dentist that are provided under arrangements for a third party and private services of any description that NHS general practitioners provide.

Section 25 will give ministers the power to except services from the overall definition by regulations. That is in line with many other service definitions in the 2001 act, such as the definitions of a school care accommodation service, a nurse agency or a child care agency, all of which provide for ministers to make regulations to narrow the scope of regulation if that is thought appropriate. Consultation would take place on any proposed use of the power and the regulations would have to be laid before Parliament in the usual way.

If section 25 was technical, section 26 is extremely technical. Section 26 will rectify drafting of the 2001 act. Strictly speaking, section 16 of the 2001 act requires the care commission to proceed with action such as serving an improvement notice on a provider regardless of representations that the provider may make. That was clearly not the intention. The care commission should consider any representations from people who have been notified of its intention to do something, then decide whether to do what the person was consulted on. Section 26 will amend the 2001 act to ensure that the commission considers representations then decides whether to proceed. The same change will be made to provisions on the Scottish Social Services Council, for which my colleague Diane White is responsible. She will also speak on section 27.

Diane White (Scottish Executive Education Department): The change is the same for the Scottish Social Services Council, which maintains registers of all social service workers. As is the case with the care commission, if the council intends to impose a condition on registration, it will issue a proposal notice to the person involved. Even if that person makes representations, the 2001 act is drafted so as not to take those representations into account. Section 26 will make a technical amendment to ensure that any representation is taken into account before any final decision is made. The final amendment in section 26, which also relates to the Scottish Social Services Council, is a technical amendment to the drafting to ensure that it is clear that a potential registrant has a right to appeal to the sheriff against all decisions and proposals.

Section 27 will make a technical amendment relating to the codes of practice that are issued by the Scottish Social Services Council with the consent of Scottish ministers. The 2001 act makes it clear that any employer must take the codes of practice into account when they deal with a conduct issue regarding a social services worker. Section 27 aims to clarify exactly the circumstances and what information should be provided to the council when any registration matters are being dealt with. It also makes it clear that employers are expected to contribute to any registration process and any investigations that the council may undertake.

Adam Rennie: Section 28 deals with the registration of child care agencies and housing support services. As members can see, it is a fairly complex-looking provision. The proposed amendment is necessary to rectify a problem that we identified last year. I will give the committee some background information about how that arose.

When services that were not previously regulated by the care commission are brought within regulation, a procedure has to be set up to

phase that in. Regulation cannot simply be introduced overnight; if that were to be done, suddenly everybody would find themselves breaking the law. All services that are in operation at a particular date are deemed to be registered with the care commission for a specified period. During that period, service providers may apply for registration with the commission. Provided that they apply by the deadline at the end of that period, the deemed registration then continues for a further period, during which the commission determines the application. That procedure has been used for the commencement of various services. In particular, it was used for the commencement of the regulation of housing support services and child care agencies from 1 April 2003.

Due to the complexity of the services concerned, discussions between the care commission and the providers about the application arrangements took much longer than was anticipated. An especially difficult question was what precisely constituted a branch for the purposes of registration with the commission. During those discussions, the deemed registration period ran out, by which time very few providers had applied for registration. As a consequence, many providers were inadvertently acting illegally under the terms of the 2001 act. I hasten to add that everybody was acting in good faith—at the time, very few people realised that the change was taking place. That did not come to light in the Executive until it was too late to take action to extend the deemed registration period. Once the deemed registration period had finished, it was not possible to breathe life back into it.

In July, once we had discovered that and had worked out what to do about it, the Scottish Executive issued a news release urging providers to apply by the end of September 2004 and stating that the Executive would take steps at the earliest legislative opportunity to ensure that the registration status of the services concerned was brought within the law. At the same time, the Lord Advocate granted the providers who were affected an amnesty against prosecution for providing unregistered services, provided that they submitted an application for registration with the care commission before 30 September last year.

The provision in the bill implements the Executive's commitment to bring the registration status of the providers within the law. The provision looks quite complicated, but basically it will ensure that, if a person was deemed to be registered from 1 April 2003 as a provider of child care agencies or housing support services, that deemed registration will not cease until 1 April 2006, provided that applications for registration were made before 30 September 2004. In effect, it puts something right.

My colleague Stephen Sandham, who is responsible for housing support services in the development department, will talk about section 29, which is related to what I have just spoken about.

15:15

Stephen Sandham (Scottish Executive Development Department): Grants are made by the Scottish Executive to local authorities, under the Housing (Scotland) Act 2001, towards the cost of housing support services for vulnerable people. Local authorities in turn pay grant to providers of those services. One of the grant conditions was that those providers who required to be registered with the care commission were indeed registered. The lapsing of the deemed registration due to the complexity of the registration process—which Adam Rennie discussed in relation to section 28—meant that payments were, in fact, made by local authorities after 1 October 2003 to providers who were not registered, in contravention of the grant conditions. When the problem came to light, action was taken by the Executive on 19 August 2004 to remove temporarily the requirement for providers to be registered with the care commission. That enabled us to continue grant payments to providers to ensure that crucial services continued.

The provisions in section 29 seek to correct the unlawfulness of the payments that were made between 1 October 2003 and 19 August 2004—recognising, as Adam Rennie said, that throughout that period providers were acting in good faith and in ways that, in every other respect, entirely met the grant conditions.

The Deputy Convener: Do members have any questions? No? The evidence was either too complicated or very comprehensive. I therefore thank Mr Sandham, Mr Rennie and Ms White for their contribution.

Jim Brown will make a short statement on the authorisation of medical treatment for adults with incapacity.

Jim Brown (Scottish Executive Health Department): Section 30 proposes changes to part 5 of the Adults with Incapacity (Scotland) Act 2000. Part 5 of that act gives a general authority to medical practitioners to treat patients who are incapable of consenting to the treatment in question. That is done through the issue of a certificate of incapacity. At the moment, only registered medical practitioners can issue certificates of incapacity.

Prior to the 2000 act, to treat a patient without consent, unless in an emergency, could be considered an assault. The general authority to treat that is conferred by the certificate of

incapacity does not extend to particular treatments specified in regulations—treatments such as electroconvulsive therapy or abortion, for which special arrangements apply. It also does not extend to emergency treatment to preserve life or to prevent serious deterioration in a person's condition.

Guidance on the operation of part 5 of the 2000 act was set out in a code of practice. The operation of part 5, which started on 1 July 2002, gave rise to concerns, among general practitioners in particular, that the procedures and requirements that it set out were onerous and time consuming and that some streamlining was necessary. In addition, other professionals—in particular, dentists—were concerned that they were unable to treat patients attending their surgery, sometimes in pain, because a certificate was not already in place to allow treatment to take place. In consequence, those professionals had to seek out a doctor to issue a certificate.

Accordingly, a two-part consultation process was launched in 2003. The first part of the process sought views on a range of changes or improvements that might be made to the code of practice on part 5 of the 2000 act; the second part of the process took the shape of qualitative research, which was designed to examine the experience of the operation of part 5.

In the light of responses to the consultations—which were complemented last year by a meeting with key stakeholders—it was decided that two changes to the 2000 act should be proposed. First, it is proposed that, as well as medical practitioners, other health practitioners should be permitted to issue certificates of incapacity that are relevant to their specialism. The bill will therefore amend section 47 of the 2000 act to allow dentists, ophthalmic opticians and registered nurses to issue certificates of incapacity. There is also provision to extend the authority to sign certificates to other professional groups. That would be done by regulations, which, of course, would be the subject of consultation and would be laid before the Parliament. It is important to stress that the issue of a certificate will apply only to the particular specialism of the health professional group concerned. For example, a dentist could authorise only dental treatment.

The second proposed amendment to the 2000 act aims to extend the maximum duration of a certificate of incapacity from one year to three years in certain circumstances. The circumstances in which the extended period could be applied will be set in regulations to be the subject of consultation. It is envisaged that the longer-lasting certificates will be dependent on the nature of the illness from which the patient suffers. For example, if a patient were suffering from a progressive degenerative condition with no chance of improvement, it would be open to the certificate issuer to extend the certificate beyond one year.

In proposing the amendments to the 2000 act, the aim has been to help improve the operation of that important legislation while at the same time maintaining its principles and ensuring the continuing benefits and protection that it provides for that vulnerable group of adults.

The Convener: Thank you, and I am sorry that I was not here for the start of your statement.

Mike Rumbles: Jim Brown is right, the amendments to the 2000 act are extremely important for a vulnerable section of the community.

You propose to replace the words,

"the medical practitioner primarily responsible for the medical treatment of an adult"

with the words

"any of the persons mentioned in subsection (1A)".

You stressed the fact that health professionals will be able to issue certificates that are relevant to their specialism. However, the person responsible for anybody's general health and treatment is their GP, so the GP should and does take an overall look at the individual.

I am a little concerned that we might be removing that responsibility and giving it to an awful lot of other people. The list of health professionals in the SPICe briefing includes GPs, other doctors, consultants and dentists—which is obvious if dental work is required. However, the list also includes hospital trusts, nurses, people in social work and the voluntary sector, health care providers, health care associations and academics.

Jim Brown: First of all, the ability of a general medical practitioner to issue the certificate remains. The other categories described in the bill—for example, dentists, ophthalmic opticians or registered nurses—are additions.

We are aware that concerns were raised in the consultation process about the ability of those health professionals to assess capacity. In other words, there was concern that what is needed before treatment can proceed and before a certificate can be issued is a rounded assessment of the patient's capacity to respond or not respond to a particular treatment.

We are in touch with NHS Education for Scotland with a view to developing protocols and guidance for health professionals who are affected by the new legislation to ensure that they are equipped in every way to assess capacity to the maximum extent.

Mike Rumbles: We—rightly—recognise the expertise of registered nurses, in giving them more authority for example. However, does the legislation represent a move away from allowing the GP to make the overall assessment of capacity?

Jim Brown: I hope not. The provisions in the 2000 act on the assessment of capacity and what is said in the code of practice will still apply to those groups of professionals, so there is no dilution of the absolute requirement for a thorough assessment process to take place. All that is happening is that we are extending the range of professionals who are able to issue the certificate of incapacity, based on a thorough assessment of a patient's ability to consent to treatment or otherwise.

Mike Rumbles: Can you give me an example of a situation in which it would be more appropriate for a registered nurse to make the assessment than the person's GP?

Jim Brown: Nurses have a range of duties—applying dressings to a wound, for example. If a patient were to present at a doctor's surgery and be incapable of consenting to any kind of treatment—even to having a dressing applied to remedy the situation—and if a certificate of incapacity were not ready, the nurse would have to seek the authority of the general practitioner to carry out the treatment based on a certificate issued by the GP. The change is really an attempt to improve the service rendered to the patient.

The Convener: I see that Mike Rumbles is hesitating. I shall allow David Davidson to ask a question now and we can return to Mike once he has had a think.

Mr David Davidson: Jim Brown talked about the development of protocols with NHS Education for Scotland. New breeds of prescribers—supplementary and independent—are beginning to come through. I am not convinced that they yet have the right training within the existing schemes. Will they be dealt with through the protocols or will they be included in the wording of any eventual regulations?

Jim Brown: Extending the provision would be a matter for consultation. The provision in the bill makes it clear that regulations would apply to

"a person who falls within such description of persons as may be prescribed by the Scottish Ministers, who satisfies such requirements as may be so prescribed".

Those could include having certain qualifications, for example in the assessment of incapacity.

Mr David Davidson: So they could be covered by the legislation without much change?

Jim Brown: The idea is that, initially, additional groups would be given authority to issue certificates of incapacity, and that would be complemented by guidance on the assessment of incapacity, issued by the department and enshrined in and incorporated into a revised code of practice.

Mr David Davidson: I take as an example a supplementary prescribing registered pharmacist who goes into a care home to assess medication. Within certain protocols, such pharmacists can represcribe and change doses, which is treatment. Would they be included on the basis of a protocol or as of right? Currently, their training does not cover the situation.

Jim Brown: We would need to take that up with NHS Education for Scotland to determine what guidance should be issued to the field in that respect.

Carolyn Leckie (Central Scotland) (SSP): I think that what Mike Rumbles was getting at is similar to the concerns that I have. There is concern that there should continue to be holistic assessment of a patient to take into account all their circumstances and their background. I would be worried about inconsistencies in the assessment of incapacity, depending on which health professional happens to see a patient and in what circumstances they are assessed for incapacity related to mental illness. A patient might go into a maternity hospital because she is pregnant. What level of incapacity is to be assessed? I can see that there might be inconsistencies depending on who approaches the issue. Someone could be assessed as having an incapacity in relation to one aspect of health care, but in relation to another aspect, they might not.

There is a need for an holistic assessment. I am just a wee bit worried, because that kind of holistic assessment and individualised care takes time. In the care home situation that David Davidson referred to, it is quicker to mass prescribe than it is to take time with an individual patient. There are legitimate concerns about opening up the process and about patients being compartmentalised according to different conditions.

Jim Brown: I take that point keenly. That is one of the reasons why we seek to develop guidance that will assist in setting the parameters for the assessment of capacity—or incapacity, as the case may be.

Shona Robison: I thought that I knew where you were going until you used an example to highlight your point to Mike Rumbles. Unless I have picked you up wrong, I am now quite concerned that we could have a situation in which people who have not necessarily gone through specific training in assessing capacity find

themselves in the position of issuing certificates and making judgments. Will the protocol allow only people who have been through a clear training programme to carry out such assessments?

Jim Brown: It is certainly our intention that issuers of certificates should have that experience. The same issue arose in the consultation in relation to general medical practitioners—sometimes even doctors did not fully understand the assessment process. We are anxious to address that.

15:30

Shona Robison: Would there be a register of people who have completed the appropriate training and who are therefore qualified to carry out such work—with the appropriate support and with the requirement that they update their training and so on?

Jim Brown: Those are issues that we are considering at the moment.

Mike Rumbles: Pursuing that point, I can see where the Executive is coming from, and I can see the purpose of the proposal. My concern is that no system is perfect and that things will go wrong. I am worried that the proposal might open the door to more things going wrong than might otherwise have been the case. The proposals are as a result of the consultation that took place, and I notice that the SPICe briefing on the miscellaneous provisions says that most of the respondents in the consultation

"were health professionals and medical and health organisations, rather than patient interest groups concerned with adult incapacity."

How many responses did you get from patient interest groups or groups concerned with adult incapacity? I want to know what sort of balance we had. I can understand the medical profession—in the widest possible sense of that phrase—wanting the changes; I am concerned about the other side of the coin.

Jim Brown: The written consultation attracted 148 responses, notwithstanding the fact that more than 1,000 consultation documents were issued. Responses were received from 28 GPs; 10 other doctors; 17 dentists; 10 hospital trusts; seven nurses; 11 social work respondents; nine voluntary sector respondents; and 56 others, representing a diverse cross-section of organisations and individuals, including health care providers, health care associations, national representative organisations for health care providers, interest groups, academics, medical protection societies and individuals.

Mike Rumbles: We can pursue that as the bill goes through.

The Convener: Yes. I can see exactly where you are going with that.

Dr Turner: I can understand why, if somebody who needs to see a dentist because they have a terrible abscess has to wait for a GP to give them a certificate, they would want to get that sorted out. However, I can see problems arising with continuity of care. If a patient has other health problems and is on other medication, that complicates the issue a bit. Dentists and ophthalmic opticians have quite a bit of training. In health centres or private companies who carry out procedures, there is more throughput, because we do not have the work force. We are considering a whole lot of different ways of providing service. Not everybody will have the same standard of assessment. We agree that the process is even difficult for GPs.

I am more worried about the proposal now than I was when I first read it. We should be safeguarding the patient and safeguarding GPs, who should be at the hub of the wheel—everything should come back to them. One begins to wonder whether this is the beginning of a dilution of the service to patients. The GP might not know everything that is going on, and that is a worry.

The Convener: There are a range of concerns among committee members about section 30. I appreciate that it might not be easy for the Executive officials to respond to all those concerns at the moment. However, they might want to flag up back at the office the possibility that the proposals will run into trouble if some of the issues are not resolved—at least to the committee's satisfaction—before we get to the more vital parts of the bill.

Jim Brown: We will do that.

The Convener: Is that a fair assessment of the situation?

Members *indicated agreement*.

The Convener: I thank the officials for their evidence; they are free to leave.

We move on to evidence on the final sections of part 5, for which Roderick Duncan continues to sit on the sidelines. The officials who have been invited will deal with joint ventures for facilities and services. They are Mike Baxter, who is the property and capital planning division team leader; Dr Hamish Wilson, who is back again; and Patrick McGrail, who is from the joint future team in community care division 2. Mike Stevens, who is the deputy director of the chief scientist office, will deal separately with joint ventures, intellectual property and the Scottish Hospital Endowments Research Trust.

I invite Dr Hamish Wilson to give a short introduction on joint ventures for facilities and services.

Dr Wilson: I will keep my comments brief. I introduce the provisions from a primary care perspective because they flow from several national reviews of the various methods by which improved facilities—particularly premises—can be secured to support better delivery of primary and community care services, especially when several agencies are involved, such as health services, local authorities and GPs.

Methods exist to secure premises in the community—for example, through public capital, third-party investment in property that is leased to occupants or investment by practitioners—but following a review, it was felt that there was a gap in opportunities in Scotland. That was reinforced by experience from south of the border, where provisions were introduced a short time ago to allow Scottish ministers' counterparts and the equivalent NHS bodies to form or participate in joint venture companies to provide such facilities and services.

The bill is intended to add to the armoury of organisations in Scotland to support the delivery of better facilities in the community. It also allows us to learn from the experience of the approach in England. We will not necessarily follow slavishly the precise methods that have been used south of the border, but we can at least gain from the experience there in the past couple of years.

The provisions are fairly straightforward. They allow the Scottish ministers and, hence, NHS bodies to form or participate in joint venture companies to provide facilities and services in the same way as can local authorities, which already have such a power.

Helen Eadie: The proposals are interesting. The SPICe briefing on the miscellaneous provisions refers to

"the proposed structure of joint ventures as companies limited by share capital".

You will be aware that a key policy objective of the Scottish Executive is to develop co-operatives and a co-operative development agency. Will that aspiration be considered so that joint ventures could be not only companies limited by share capital, but companies limited by guarantee? That would encourage mutual development throughout Scotland.

Mike Baxter (Scottish Executive Health Department): In producing the proposals, we undertook much research into the different vehicles that could fulfil what we are trying to achieve, which is a co-ordinated and strategic approach to premises development, rather than the individual approach that the techniques that are available to most organisations have developed.

Given the scale of possible development, we need to recognise that the development of new and different models would incur cost and have time implications. There might also be an effect on market acceptance by funders and private sector partners and on their willingness to engage in untried and untested models.

The proposals do not take a one-size-fits-all approach. A range of opportunities is available to the NHS and local government to develop premises and we do not suggest that we want to stifle that. We want to provide something that acts as a conduit to bringing the organisations together. If the NHS or local government made proposals, we would be happy to consider them, but no specific alternative models were proposed in the responses to the consultation that we undertook.

Shona Robison: How would the model differ from the public-private partnership model that is already in operation for joint ventures? The SPICe briefing on the bill's miscellaneous provisions says:

"Section 31 of the Bill proposes to allow Scottish Ministers to"

do a number of things, one of which is to

"invest in, provide loans to or provide guarantees to companies providing … facilities and services"

for those who provide health and care services. How would that work? Will you give us an example?

Mike Baxter: On the first point, the powers that we seek are a consequence of the fact that ministers do not have powers to enter joint ventures for provision of health services. That is the vires issue that brings us here. The public finance initiative model that we have is simply a contractual vehicle between the private and public sectors; the joint venture approach differs from that significantly in that there is a long-term investment for the public and private sectors in the joint venture as a vehicle to deliver premises. That is quite a departure from what has happened previously—

Shona Robison: I am sorry to interrupt, but local authorities already have the powers to enter joint ventures. Would the bill bring health boards into line with them?

Mike Baxter: Yes, it would. Although public-private partnerships are the easiest model to look to, the power would also provide the opportunity for public bodies to work together and to form joint ventures. Therefore, the health service and local government could work together to form joint ventures, which they cannot currently do. Local

authorities have had the powers for some time and have used them in different ways.

On the second point, there are a number of ways under the bill in which ministers and NHS boards could invest and take a financial interest in the joint venture company, such as by providing financial guarantees—the investment of cash and share capital—or by putting land into the deal as a capital investment. The drafting of the bill is reflective of the different types and methods of investment in the joint venture company.

Shona Robison: Where would the risk lie?

Mike Baxter: Because it is a joint venture, the risk would be shared, which is the real dynamic in the joint venture. With the traditional acute services PFI schemes, a large amount of the risk is in the construction, whereas in the joint venture models that we are considering the risk will be spread more over the longer term in the residual value of the property after 15 or 20 years. It is a different animal altogether.

Carolyn Leckie: I am interested in the risk, so will you be more specific about that? You made a comment about making the joint venture more attractive to private participants, which obviously means less risk, increased chances of profit and more secure income for them. I would be interested to hear you expand on the detail of that. What are the calculations and the attractions for the private sector?

What you said about no specific alternatives having been proposed by respondents to the consultation contradicts the SPICe briefing on the bill's miscellaneous provisions, which says that

"A number of alternatives … were suggested".

Will you comment on that and tell us more specifically what the alternatives were?

On the consultation, the briefing says that the majority of respondents were positive and about 10 per cent were negative. However, some respondents were from the private sector and some were from, for example, trade unions. Will you tell us what the balance was? Of the positive comments, how many were made by the private sector and the employers' side? Were the negative comments from all the trade unions?

Mike Baxter: I will take your last question first. The answer is yes, and the trade unions' objection is essentially a philosophical one to the involvement of the private sector in provision of health care.

15:45

I turn to the first question about risk. The risk to which I referred was the development of a model that is untried and untested. Given the size of the joint ventures that we are talking about, we are not talking about the creation of many such companies throughout Scotland. A necessary critical mass is required to make such a venture commercially viable and attractive. Therefore, we have limited bites at the cherry in trying to propose something that is novel or different.

According to the consultation responses, the alternative models that were proposed are currently available to local authorities and other parties. The point was that those models were not available to the NHS.

Carolyn Leckie: I will follow up on the risk question because I would like you to be more specific about the positive conclusions of respondents to the consultation, which came primarily from the private sector. The private sector is motivated by profit and I imagine that the attraction for that sector comes from what it expects the returns will be. Will you be specific about why the private sector likes the proposal?

Mike Baxter: It likes it because it proposes a long-term partnership. We are not reinventing the wheel with individual procurement; we are trying to establish something that has long-term flow as regards premises development. We are not looking at any measures in isolation.

The proposal has attractions for both the private and public sectors. From a financial planning point of view, it allows us to consider our infrastructure, how we replenish and develop it in conjunction with other public sector partners and the availability of private capital.

At the moment, the vast majority of primary care and GP premises are privately owned and developed. It is a question of how we can actually bring those kinds of developments together with other NHS and local authority developments, look at services more strategically, reduce the risk of duplication and increase efficiency in use of public resources. At the end of the day, whether we are paying for leases on such premises or investing in companies, we are talking about public money.

Carolyn Leckie: It is an ambitious claim that your proposal would be more efficient for the public purse. Is there evidence to support that? What calculations have been made and can they be made available?

Mike Baxter: We still have detailed work to do on the financial structure of the companies and our possible options. We looked at the experience of the joint venture development model south of the border and the results are certainly encouraging in terms of value for money and how different strands of public resources can be brought together and made to work more effectively.

When we looked at joint ventures and how they developed in England initially, there was a primary care and health focus. That has evolved substantially over the past couple of years and we now have projects that have taken on a focus on regeneration or on education and training. That is all about bringing different strands of money together to deliver more effective services.

Carolyn Leckie: I am interested in the English examples, so I would appreciate your being specific about those you mention. Are you talking about diagnostic and treatment centres?

Mike Baxter: No. I am talking about NHS local improvement finance trusts; the regeneration example that I quoted is the NHS LIFT project in St Helens, in respect of which there has been a significant impact on urban regeneration in deprived areas. There are also examples in Liverpool.

The Convener: If some of that information is available on paper, I invite you to let the committee clerk have a copy and we will make sure that everybody gets hold of it for comparison.

Dr Turner: The matter of joint ventures has provoked most thought—there are so many questions because we did not have enough examples. Would you consider a joint venture like some of the initiatives that occurred after the sale of hospital land? NHS or public money could go into a venture with that of other companies.

A private company can be formed and registered at Companies House. It is quite cheap to do that and it makes it difficult for the public to ascertain what is going on: I have had difficulty finding minutes for such a company. Eventually, after about a year, I discovered that minutes are produced, but that they are not verbatim—they are précised for public view. I was told that minutes are not necessarily kept in a library. I worry about accountability for how money is spent.

Flexibility is another issue. I worked in a health centre that was built in 1982, but by 1990 it was not fit for purpose under a new contract because it was not big enough. To enter long-term contracts is probably comfortable for businesses, but how does that maintain the flexibility that the NHS needs? We do not know where we will be 20 years from now. Different techniques and ways of working will apply because medicine is always changing. I would like examples of how entering a joint venture will deal with that.

In my area, the local authority does not seem to have control over one initiative, although it does over another. Ministers probably have more control over the private company. The situation is extremely difficult to understand. Could I have some answers? If you cannot provide them now, perhaps you could provide them in writing.

The Convener: That was an open-ended question.

Mike Baxter: There are two sides to accountability. For financial accountability, any flows into or out of an NHS board or local authority must be accounted for. Interaction with a joint venture company will take two forms. The share capital investment that we envisage will be recorded on an NHS board's balance sheet. Lease payments to rent parts of or whole premises will be identified as lease expenditure. The accounting regulations provide a basis for identifying the financial flows into and out of an NHS board in relation to a joint venture company.

As for the flexibility argument, I agree that—as with all capital or infrastructure developments in the health sector—change and how we plan for it are huge issues. Bodies can engage in the joint venture model at different levels. One way to engage is as a shareholder in the joint venture. Another is by being the lessee of part of a building or buildings. The model that we are examining is a lease plus agreement, which would run for 15 years or less with opportunities for break points. Some flexibility is built into the model, but I accept that flexibility is a huge issue across the board for the NHS.

Dr Turner: I take it that the purpose is profit for the NHS.

Mike Baxter: The profits of a joint venture company are shared among shareholders.

Dr Turner: Are the share proportions clear?

Mike Baxter: Yes.

Dr Turner: We should be able to access such information easily.

Mike Baxter: Yes.

The Convener: Members have no more questions for Mr Baxter, whom I thank for appearing.

I invite Dr Wilson to give a brief introduction—I am sorry; I am repeating myself. I invite Mike Stevens to give an introduction on joint ventures, intellectual property and the Scottish Hospital Endowments Research Trust.

Mike Stevens (Scottish Executive Health Department): Section 31(2) also deals with companies, but for the purpose of income generation. Ministers have a range of powers to generate income for the NHS. Those powers were extended to NHS bodies through a power of direction in 1989 and include developing and exploiting ideas and exploiting intellectual property. However, ministers are not empowered to establish or participate in companies in exercising those income-generation powers. That can be a limitation on exploiting intellectual

property when the creation of a small spin-off company to attract external finance is the most appropriate and—sometimes—the only way to exploit ideas.

In addition, the Executive's growth and innovation grants are available only to businesses that have a base in Scotland. They are not available to public sector bodies such as the NHS or universities, but many of the companies that they support have emerged from the university science base. Section 31 will extend the powers that are available to ministers by allowing them to create companies and participate in their running, but solely for the purpose of generating income. Ministers intend to extend the power to NHS bodies and, in order to ensure that it is used only when appropriate, they propose to prescribe and regulate carefully the circumstances in which it may be used through a power of direction.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The SPICe briefing note on the bill's miscellaneous provisions says that NHS bodies in England and Wales have been able to gain additional income as a result of their intellectual property. Will you give some examples of how intellectual property has boosted their income?

Mike Stevens: The big benefit is the ability to exploit a particular innovation by collaborating with a private company. It could be that a particular device has been invented in the NHS in Scotland, but if no private company can share in its ownership, the device will sit on the shelf. However, if a device is invented in the NHS in England or Wales, where the power was introduced in 2001, a private company can be set up. The private finance would pay for development of the device and ownership would remain joint with the NHS.

Mr McNeil: That is the potential, which we are trying to understand. Are there any clear examples in which the NHS has been able to maximise the benefit or gain from intellectual property?

Mike Stevens: There have been no approvals yet of the establishment of companies in England, but the Department of Health's commercial directorate is considering one proposal. I referred earlier to the power of direction; in England, that power calls into the Department of Health all such proposals, which are carefully scrutinised.

Carolyn Leckie: I have some technical questions to ensure that I understand what section 31 means. At the moment, if a technique is developed in the NHS, the fact that it has been developed there means that it is owned and shared by the NHS, which can—as a public body and if it is given the investment—choose to develop the technique further and spread it across the NHS. Section 31 seems to me to say that that is not an option because there is not enough funding and that, therefore, if the NHS can collaborate with a private company to develop an idea, the intellectual property will be shared between the part of the NHS that is participating—which might be an individual hospital, GP surgery or laboratory—and the private sector company. That intellectual property could then be sold within the NHS as a whole, which I would have difficulty with. Is that what section 31 means?

Mike Stevens: Yes. At present, if the innovation is a device, the NHS purchases it anyway. We are saying that if the NHS has the capacity to share in ownership and to profit from the development of a device, it will be able to do so through section 31.

Carolyn Leckie: My point is that there are ideas within the NHS that do not attract NHS funding but which nevertheless belong to the NHS. However, you are talking about such ideas being part-owned by the private sector, which has not developed them but is involved because you want its money because no public money is available. The ownership of such ideas might be transferred from the NHS to the private sector and then sold back to the NHS.

Mike Stevens: The proposal is that the intellectual property would be shared, but only if there was no NHS investment. If the NHS was prepared to invest, it would own the intellectual property outright.

Carolyn Leckie: That is my understanding of section 31.

Helen Eadie: The SPICe briefing note on the miscellaneous provisions states:

"Future financial benefits as a result of the power are difficult to predict, but nonetheless are expected."

Can anyone give us any ballpark figures of what we might expect in a year?

16:00

Mike Stevens: In a year, we could expect very little, based on the English experience. I can give you some figures for the number of innovations that have been looked at in England and Scotland. In England each year, the NHS considers approximately 500 innovations that might be worthy of further exploration and selects 100 for further development. It is pursuing 24 licensing deals in total. In Scotland, 200 new ideas have been looked at. They have been refined to 35 that are suitable for potential further development, subject to funds being available. Scottish Health Innovations Ltd, which has been set up to manage NHS intellectual property, holds equity in one company, and nine further exploitation proposals are under consideration. Any one of those proposals could generate £20,000 or £200,000, but at this point it is very much a guess.

The Convener: Were there any objections to the proposal to make the Scottish Hospitals Endowment Research Trust stand alone?

Mike Stevens: No.

The Convener: I just wanted to clarify that that proposal is not controversial.

I thank all the officials for coming along. I thank Roderick Duncan in particular for sticking it out, although perhaps it was not too onerous.

I remind committee members that next week's committee meeting will take place in Stonehaven, albeit without my presence. The meeting will be under the capable convenership of my deputy convener, Janis Hughes. I will see committee members in the last week in January.

Meeting closed at 16:01.

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