HEALTH COMMITTEE

Tuesday 8 March 2005

Session 2

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CONTENTS

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HEALTH COMMITTEE
7th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*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)

*attended

THE FOLLOWING ALSO ATTENDED:

Carolyn Leckie (Central Scotland) (SSP)

THE FOLLOWING GAVE EVIDENCE:

Susan Aitken (NHS Confederation)
Pat Dawson (Royal College of Nursing)
Howard Forster (E C Harris)
David Fox (Turner & Townsend Management Solutions)
Robert Hamilton (British Dental Association)
Tim Huntingford (Convention of Scottish Local Authorities)
Dr Alan Jacques (Alzheimer Scotland)
Sandra McDougall (Scottish Association for Mental Health)
Alan McKeown (Convention of Scottish Local Authorities)
John Park (Scottish Trades Union Congress)
Hilary Robertson (Scottish NHS Confederation)
Dr Mairi Scott (Royal College of General Practitioners)
Nicola Smith (Enable)
Dave Watson (Unison)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 8 March 2005

[THE CONVENER *opened the meeting at 14:01*]

Items in Private

The Convener (Roseanna Cunningham): We need to get the meeting started. I have apologies from Duncan McNeil, Mike Rumbles and Helen Eadie, who will not be here. Shona Robison will be late, but should arrive at some point during the course of the afternoon.

Item 1 is to consider whether to take items 3 and 5 in private. Under both items, we will discuss evidence received today—effectively, they will be part of the drafting of the stage 1 report. Is the committee content that those items be taken in private?

Members *indicated agreement.*

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

14:02

The Convener: We move to oral evidence on part 5 of the Smoking, Health and Social Care (Scotland) Bill. The first session deals with section 30, on the authorisation of medical treatment for adults with incapacity. The committee papers include background briefings by the Scottish Parliament information centre on part 5, as well as submissions from a number of those who are present today.

I welcome to the committee the first panel of witnesses, which includes: Dr Alan Jacques, convener of Alzheimer Scotland; Nicola Smith, legal adviser of Enable; and Sandra McDougall, legal officer for the Scottish Association for Mental Health. Can I have brief introductory statements of no more than about two minutes each? You are welcome to forgo making a statement if you wish.

Dr Alan Jacques (Alzheimer Scotland): Thank you for inviting us along today. Alzheimer Scotland is the principal organisation for people with dementia and their carers in Scotland. We have had a long-standing interest in the bill, its progress and its success. We have been delighted overall with the success of the Adults with Incapacity (Scotland) Act 2000, but it has been a disappointment that part 5 of the act has been underused throughout the country, although we are aware of some areas in which it is being used and has worked perfectly well.

We are aware of the reasons why the amendments to the 2000 act have been brought forward in the bill, and we are content with them. However, we see them as part of a wider context of making sure that part 5 of the act works effectively, which involves issues about training and awareness and the way in which part 5 is used.

Sandra McDougall (Scottish Association for Mental Health): I thank the committee for the opportunity to give evidence on behalf of the Scottish Association for Mental Health. For members of the committee who might not be familiar with SAMH, it is both a major provider of services to people with mental health and related difficulties and a campaigning organisation.

Our general position is that there must be convincing reasons for any amendments to the Adults with Incapacity (Scotland) Act 2000. Any changes must have a potential benefit for adults with incapacity and must not be aimed simply at reducing the burden on professionals. Although SAMH is not opposed to the amendments that the

bill seeks to make to the 2000 act, there are provisos attached to that position, which have been set out in more detail in our written submission.

Nicola Smith (Enable): I also thank the committee for giving us the opportunity to give evidence. Enable is the largest voluntary organisation in Scotland of and for people with learning disabilities. We are very much a member-based and member-led organisation. We have more than 4,500 members, most of whom are in 65 branches throughout Scotland. Like the other two organisations that are represented on the panel, we were heavily involved in the alliance that campaigned for the introduction of the Adults with Incapacity (Scotland) Act 2000. We have a legal and information service that regularly gives advice and assistance to people in connection with the act. We recognise that, as the act has been implemented, some unanticipated practical issues have arisen, but we feel that any changes to it should be justified and should be made in the interests of adults with incapacity rather than for the convenience of professionals.

The Convener: Thank you. I invite questions from the committee. Jean Turner will lead off.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Good afternoon. It would seem that you welcome the fact that more people than just general practitioners will be able to issue certificates of incapacity. A concern about training is common to all your submissions. The submission from the Scottish Association for Mental Health refers to research that says that some general practitioners

"have expressed a lack of confidence in their skills and abilities to assess capacity".

It is important that whoever assesses capacity knows how to do so and that the necessary training is in place. I would like to get your feedback on that.

Enable commented:

"We have experience of cases where parents or professional carers are still being asked to sign consent forms for adults over the age of 16."

There are still some problems with the system as it stands and we are about to extend responsibility to different people. What do you have to say about training?

Nicola Smith: Enable is regularly asked questions about part 5 of the 2000 act, many of which stem from the fact that doctors are apparently not aware of when it would be appropriate for them to sign a certificate. Quite often, parents and carers are still asked to sign consent forms to allow treatment to take place. That concerns us because the act is no longer new—it has been in force for more than two years. It is a bit disappointing that such problems are still being experienced.

We welcome the idea of more people being able to sign certificates because we think that that will lead to quicker treatment for people with learning disabilities. That measure must be backed up by training and awareness raising among professionals.

Dr Jacques: From the beginning, we have said that there would need to be quite a lot of training in relation to the 2000 act. The idea that someone may be incapable of making highly significant decisions about their life is a major matter on which to make a decision.

At the extremes of capacity and incapacity, the issue may be quite simple but, in between, the concepts get extremely complicated. For example, people can change their degree of capacity; they can be capable of making some types of decision but not others; and there can be difficulties with communication. All sorts of factors have to be taken into account. The assessment of capacity is not a simple process of saying that so-and-so is capable of this and not capable of that. There are large training implications that, as far as we are aware, have never been fully addressed. I understand that the issue is being discussed with NHS Education for Scotland but, as has been said, it is a little late in the day for such consideration. Some of the difficulties that we are addressing today would not have arisen if the issue of training had been covered right at the beginning. A lot of work still has to be done on doctors and the other professions that might become involved.

The Convener: Are you saying that the only discussions that you have had about training were held recently with NHS Education for Scotland?

Dr Jacques: I understand that the Executive has been discussing training with NHS Education for Scotland.

The Convener: But you were not included in those discussions.

Dr Jacques: No.

The Convener: Have any of the organisations that you represent been included?

Sandra McDougall: No.

Nicola Smith: No.

Dr Jacques: No. There was a lot of discussion when the 2000 act first came into force, but the issue was shied away from because it is difficult and complex for medical practitioners.

The Convener: Right. If it is complex and difficult for medical practitioners, the implications

of extending the provision well beyond medical practitioners means that it will be equally complex for all the professions on the list at proposed new section 47(1A)(b) of the 2000 act.

Dr Jacques: Yes, but the issues are the same for all of them. We have to consider how we assess reliably somebody's capacity to make particular types of decision.

Kate Maclean (Dundee West) (Lab): I sat on the previous Justice and Home Affairs Committee when the Adults with Incapacity (Scotland) Act 2000 went through the Parliament. The provisions are complicated, particularly given that people might be capable of taking some decisions but not others. I agree absolutely that training is important, but I wonder what kind of training programmes could be implemented, given the complex nature of the act, and who would be responsible for running them.

Dr Jacques: Those matters would probably be for NHS Education for Scotland. They fall within its remit, and it is well placed to provide training, because it is a multiprofessional organisation that covers all bits of the national health service and can call on specialist expertise from psychiatrists, psychologists and nurses. There is plenty of information around; it is a matter of getting it into a simple, usable form for the wide variety of practitioners involved, which should not be impossible.

The Convener: Would you expect to be consulted about training?

Dr Jacques: Yes.

Nicola Smith: Yes. It is really important that training focuses on the principles of the 2000 act and involves service users. We find that involving service users, such as people with learning disabilities, in delivering training is the best way to get the message across. We feel strongly that they should be involved. We would also like to see training on assessing capacity and on the 2000 act included in the initial training for medical practitioners, nurses, opticians and dentists. For future generations that would mean that the issues were covered at an early stage.

The Convener: If the bill goes through, but the training requirements are addressed no better than they have been, what do you think will happen? Will we be back here in another two years' time with more problems?

Sandra McDougall: The provisions will probably not be used.

The Convener: So without the training you think that the provisions will not be used.

Sandra McDougall: Yes, or we will find ourselves in the position that has been reflected in research to date, in which general practitioners and such like are saying that despite the fact that the 2000 act has been in force for some time, they do not feel confident about assessing capacity.

Dr Turner: What do you think about physiotherapists being included in the list of people who can assess? Many people will need the services of a physiotherapist. I imagine that, like others, they would like training.

Sandra McDougall: The same arguments apply to physiotherapists as to the other professions that are listed in the bill. I am not sure how the Executive arrived at that list, but I was a bit surprised that it does not include clinical psychologists. At one stage, it was suggested that clinical psychologists should be included in the list, but I am not sure why they are not included.

14:15

Dr Turner: If people were not asked about the list, they would not have been able to highlight any apparent anomalies in it.

The Convener: Can we get a quick run around the witnesses to seek their views on whether the power should be extended to physiotherapists and clinical psychologists?

Dr Jacques: As I understand it, the reason for the list is that certain groups of practitioners arguably provide treatments quite separately from doctors. For example, dentists usually carry on their treatments without reference to doctors. The question is whether we should put in an extra loop by requiring the dentist to consult the patient's doctor before treating the patient. A similar question should be asked of any other profession that might be added to the list. Whether it is necessary to include a particular profession is a matter of judgment.

In assessing capacity, the question that is asked is not whether a particular treatment is the right one but whether the person can consent to it. The fact that people have not always been clear about that distinction has sometimes clouded the issue.

The Convener: We need guidance on who should be in the bill. There is a question mark over whether physiotherapists and clinical psychologists should be included in the list at proposed new section 47(1A)(b). You seem to be suggesting that the list of professions at paragraph (b) should remain as it is given that patients will be under the care of those professions because of the doctor's involvement.

Dr Jacques: That may be—

The Convener: You made the suggestion, Dr Jacques—I am just trying to clarify an issue that has been raised with us.

Dr Jacques: I have explained what the issue is, but I could not say whether physiotherapists and clinical psychologists should be included in the list. The issue is whether the profession in question provides a separate treatment or whether the involvement of the doctor is necessary as part of that treatment.

The Convener: We cannot legislate to enable a profession to issue the certificate for one treatment but not for others. The profession must either be totally enabled or not enabled at all.

How do the other two witnesses view the issue?

Nicola Smith: Given that capacity is based on the ability to understand the decision in question, the best person to assess capacity will usually be the person who knows about the treatment and who can explain it. That person should decide whether someone understands the decision. If that person is in any doubt, it would be good practice for them to seek a medical opinion.

A parallel situation exists with powers of attorney. Under a different part of the Adults with Incapacity (Scotland) Act 2000, solicitors can sign a certificate to say that someone is capable of granting a power of attorney. In many cases, it is quite clear whether someone has capacity. In borderline cases, it is good practice for a solicitor to seek a medical opinion.

The Convener: I do not want to get drawn into questions surrounding solicitors. We are trying to pin down whether physiotherapists and clinical psychologists should be included. Basically, you appear not to be fussed whether they are or are not included in the list.

Dr Jacques: I would add only that—like psychiatrists, community psychiatric nurses and trained psychiatric nurses—clinical psychologists would be likely to have the particular skills and interest in the subject of capacity.

The Convener: We will ask all our questions about training before moving on to another subject.

Janis Hughes (Glasgow Rutherglen) (Lab): My question touches on training. The written submission from SAMH states:

"Whilst we can also see an argument for nurses being able to sign incapacity certificates, we believe that this should be restricted to nurses in more senior grades (say grades F and above)."

I assume that SAMH's suggestion does not preclude the requirement that such nurses would have specific training. Just because a nurse is at grade F or above, that does not mean that the nurse will have had specific training. Can you elaborate on that issue further?

Sandra McDougall: We said that about nurses because we were thinking more in terms of numbers. We imagine that there would be many more nurses involved in the care and treatment of adults with incapacity than there would be members of some of the other groups, such as dentists or opticians. One of our suggestions is that people should undergo an accredited training course but that might not be necessary for all nurses, given that the numbers are greater. If the number of nurses was to be restricted, it might make more sense for more senior nurses to be involved. A senior nurse could issue the certificate of incapacity but delegate some of the responsibility for carrying out care functions to other nurses at more junior grades. That would be permissible under the 2000 act, as long as the more junior nurses were acting under the instructions, or with the approval, of the person who issued the certificate.

The reference to grade F came about as a result of our consideration of NHS grading scales. Grade F seemed to be the more senior nursing grade; below that grade were the newly qualified nurses, auxiliaries and assistants. We thought that grade F reflected someone who had a bit more experience.

Janis Hughes: I understand your point.

To pick up on a point that Ms Smith made, in its evidence the Royal College of Nursing states:

"This may be particularly useful for nurses working with people suffering from dementia who may be better placed to see the incremental changes in capacity."

You also talked about the people who work most closely with the patients. I understand what you say about why you picked grade F and above but if a more junior graded nurse was better able to assess the level of need of a patient, perhaps you are being a bit prescriptive.

Sandra McDougall: I can see that argument, but just because a more senior nurse was responsible for issuing the certificate, that would not mean that they could not consult other nurses.

Janis Hughes: Fair enough.

I will move on to a question about extending the duration of certificates of incapacity. All three organisations have agreed in principle to accept the need for extended certificates, but only in the case of people with confirmed long-term incapacity. How should those people be assessed? How do you identify people with long-term incapacity? Who would fit into that category?

Dr Jacques: We are not saying that the proposed changes are necessary; we are saying that we are going along with them, which is a slightly different thing.

Janis Hughes: You agree in principle.

Dr Jacques: We are saying that it is okay to make those changes. However, we are quite concerned about the change to which you refer, because we think that a regular reassessment of people's needs over a long period of time is absolutely central to good care. We would be worried that a provision that makes it okay—or looks as if it is okay—to assess someone only every three years would send out the wrong message. We are saying that we are okay about the proposed change but we are not enthusiastic about it.

We admit and agree that there are people whose mental state—such as severe dementia—might not change and is very unlikely to change for considerable lengths of time, certainly longer than three years. The provision would have to apply to someone whose illness was well established and had been deteriorating over a long period of time already. It would be quite a serious decision to move someone on to assessments every three years. The most important thing is that people who have a long-term illness should be reviewed regularly by a multidisciplinary group that has an interest in their care.

Janis Hughes: Enable's evidence on that is that it would be good practice to carry out an annual review. However, Enable also believes that three years is acceptable. What would be the difference between carrying out an annual review and continuing with the current practice of issuing annual certificates?

Nicola Smith: That is a valid point. Although we do not object in principle to an extension, we feel that it will be difficult to identify the people for whom a three-year certificate would be appropriate. Indeed, it will not be appropriate for an overwhelming majority of people with learning disabilities. However, we cannot speak for other organisations and groups. It is difficult to imagine a person without capacity who will not be under medical supervision or care for three years. As a result, I agree that if an annual review is being carried out a certificate should be issued at the same time.

Janis Hughes: And that is what you prefer.

Nicola Smith: Yes.

Janis Hughes: But you are not opposed to three-year certificates being issued in certain circumstances.

Nicola Smith: That is right, provided that the guidance and codes are clear about when it would be appropriate to issue such certificates. However, as I have said, I think that they are unlikely to be appropriate for most people with learning disabilities. They might be more applicable to other groups, such as people who have dementia.

Mrs Nanette Milne (North East Scotland) (Con): My questions are for Alzheimer Scotland in particular, but the other witnesses might like to comment on them.

In your submission, you express concern about

"continuing reports of inappropriate prescribing of psychotropic medication to people with dementia in care homes",

especially the surreptitious prescribing of such medicine. I, too, have received representations on that matter from an interested person. Will you comment further on your concerns? What should be done to put things right?

Dr Jacques: This is a major issue, and it differs somewhat from the matters that are under discussion today. I am not sure whether the proposed amendments to the 2000 act will improve the situation with regard to excessive use of psychotropic medication and covert medication. If anything, it could be argued that the amendments go slightly in the opposite direction. Indeed, lengthening the period of certification might be seen to encourage very long-term use of medication without review. As far as this issue is concerned, we could take many different steps without necessarily amending the 2000 act.

We must ensure that there is good multidisciplinary assessment and discussion between doctors and nurses about prescribing medicine; assessing the patient's needs; other forms of treatment and help that might be available; and the question whether such drugs are really necessary. The people who are concerned about the person's care must sit down and think seriously about the matter; it is not a matter of simply making out a prescription after a quick in-and-out visit. Before we can move forward, we need a culture change that touches on training matters; the organisation of care among the professions, carers and the people with dementia; the review and supervision of such care; and the approach of the monitoring bodies. As a result, a range of issues must be considered to ensure that there is less overuse of psychotropic medicine and less covert medication.

Mrs Milne: What do you think of the suggestion that the matter should be controlled by regulation rather than by a code of practice?

Dr Jacques: That was discussed right at the beginning of the process. We, among others, suggested that a regulation in respect of the longer-term use of psychotropic medication could be made under section 48 of the 2000 act. A requirement could be made for a second opinion in the same way as happens under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Mrs Milne: Presumably, patients could be monitored in the same way.

Dr Jacques: Yes.

Mrs Milne: Does any other organisation wish to comment?

14:30

Nicola Smith: We do not have a strong view on the issue; we have not discussed it in any detail. From the comments that have been made, however, it sounds as if the issue needs to be looked at a bit more deeply.

Sandra McDougall: We believe that a second opinion would be desirable. The arguments that have just been made were put forward before. I think that the argument against comes down to resource implications. A great many people would be covered by the measure, which means that a large number of second opinions would be required. Resource issues mean that the measure has not been included in the regulations so far.

Dr Jacques: One other related issue, particularly in relation to covert medication, is the interface between the bill and the Mental Health (Care and Treatment) (Scotland) Act 2003. There is considerable need for guidance for practitioners on when the bill will apply and when the 2003 act will apply. That will need to be covered in the codes of practice for the 2003 act.

Mrs Milne: Clearly, there is an overlap.

The Convener: No other member has a question. Shona Robison was late in arriving and I am not sure whether she wants to come in on anything. We have covered most of the key issues that were raised in the submissions.

Shona Robison (Dundee East) (SNP): No.

The Convener: Okay, thanks.

Does any witness want to make a closing statement?

Sandra McDougall: I included the extension of the duration of incapacity certificates in our submission, but perhaps I should emphasise that SAMH does not believe that such extension is appropriate when the sole cause of incapacity is mental illness; someone's capacity can fluctuate greatly over a period of time.

The Convener: Thank you. I thank the three witnesses for coming before the committee and for their written evidence.

I welcome the second panel of witnesses on part 5. Dr Mairi Scott is chair of the Royal College of General Practitioners Scotland; Pat Dawson is head of policy and communications for the Royal College of Nursing; and Robert Hamilton is from the British Dental Association. I ask you to make brief introductory statements of no more than a minute or two, after which we will ask questions.

Dr Mairi Scott (Royal College of General Practitioners): In our written evidence, we stress that we support the level of protection that the Adults with Incapacity (Scotland) Act 2000 gives, and has given, to vulnerable people. Our response is about the practicalities of the act and the need to ensure that it is complied with appropriately and properly. Two of the amendments in the bill will help in that respect.

The extension of the authority to grant a certificate is an appropriate and quite sensible amendment to the 2000 act, given the way in which the health service now works, in multiprofessional and multidisciplinary teams. The extension to the duration of the certificate will help enormously with workload implications. There is a safety net to allow the revoking of the three-year certificate, should a patient's condition change. That is a sensible legislative measure.

Pat Dawson (Royal College of Nursing): Good afternoon. The RCN takes a similar view. We feel that there will be some devil in the detail around the codes relating to implementation, but we are broadly supportive of both the main changes to the Adults with Incapacity (Scotland) Act 2000 that are set out in the bill.

Robert Hamilton (British Dental Association): Our view is very similar. The British Dental Association supports the general principles of the Adults with Incapacity (Scotland) Act 2000. However, in practice, some of its provisions have been unnecessarily disadvantageous to the client, especially with regard to dental treatment. In some instances, delays can be caused in the provision of treatment for pain or appropriate care. We therefore support the provision that will enable suitably trained dentists to authorise certificates.

The Convener: Thank you.

Issues have been raised in respect of the adequacy of training for general practitioners, which will have to be extended to the professional groups that will be included under the new legislation.

Dr Turner: You probably heard the previous witnesses say that training is important, and you have all said that in your written evidence. Where should that training take place? I imagine that there may be a cost to training and workforce planning in the implementation of training.

Robert Hamilton: Some training on the issuing of certificates is included in the undergraduate syllabus for dentistry. There is further training in the general professional training syllabus on graduation, when dentists undergo one or two

years of post-qualification education. I have spoken to the people at NHS Education for Scotland, who are preparing something to cover the necessary training for dentistry; they will introduce that fairly soon.

The Convener: Are you saying that it is sufficient to include the training in the degree courses?

Robert Hamilton: No. It is probably more appropriate to have the training in the general professional training and possibly even further on, once dentists are fully qualified.

Pat Dawson: I am aware that NHS Education for Scotland is considering the preparation of multidisciplinary education in relation to the issue. With colleagues, I have searched for a nursing tool and have been able to provide the committee with an existing tool around assessing capacity. As members may know, legislation on mental health and mental capacity is being considered by the Westminster Parliament, and there might be products of that review down south.

Our regulatory body is looking at both the review of the pre-registration programme and the advanced practice, both of which may be areas in which the preparation and training elements could usefully be put in the context of this extension to the role of the nurse. We are content that, through working in collaboration with NES and others in Scotland, such tools and training can be provided. There is, of course, a cost element, and we have identified that in our evidence.

Dr Scott: I agree that the training should sit with NHS Education for Scotland and that it should be multidisciplinary. I see no reason why it should not be, and the provision of such training would seem to be a sensible use of resources.

The training would take place during basic specialty training. In reality, unless the young doctor had had experience in psychiatry during that time, it would take place during the year that they spent attached to the practice. As you know, we have said before that that training period is too short. We are well aware of the difficulties and have been looking to extend the training period for some time, but we need support from the Scottish Executive to do that. That training is additional, and to do more of it would require more time.

The Convener: Do you recognise the issues that were raised by the previous witnesses in respect of parents or professional carers being asked to sign consent forms for people over the age of 16? Do you recognise that the training has perhaps, so far, not been sufficient for the purposes of the 2000 act?

Dr Scott: It would be interesting to know where the examples came from—whether or not they came from general practice. I am not sure about that.

The Convener: I assume that they must have come from general practice—that is where the power lies at the moment. Is that not correct?

Dr Scott: They might have come from other areas of the health service. Other practitioners can sign under parts of the 2000 act. Having said all that, if what you say is the case, that is a training issue. You are absolutely right: it could simply be a matter of confusion, which could be sorted out quite straightforwardly.

Shona Robison: I note from the RCN's evidence the point about the key role of the nurse consultant. Could you say a little more about the barriers that exist in that area?

Pat Dawson: Towards the end of the committee's discussion with the previous witness panel, I heard some comment about the potential grade or competency of staff who might be asked to take up the new power. We would point out that the provision is not set out in any restrictive way. I understand where the previous witnesses were coming from, but the provision will apply to nurses in specific roles with specific expertise; they have quite an expert skill. At this stage, we would not necessarily want the provision to apply to all pre-registration education. The power would be used by those nurses who work with the particular client groups for whom the 2000 act applies.

Our organisation's ambitions for the further development of nurse consultants are quite right. However, I draw the committee's attention to the appendix that the Scottish Executive has supplied by way of further evidence, which says:

"in general, it is envisaged that nurse practitioners, practice nurses and nurse consultants are the groups most likely to use these powers."

We accept that nurse practitioners and nurse consultants have a degree of autonomy—the new role of nurse consultants emphasises that—but we suspect that other areas of practice will be relevant. Those areas will concern not necessarily practice nurses but, more important, nurses who work with people with learning disabilities, psychiatric nurses, nurses who work in palliative care and the range of specialist nurses who work in clinical practice with degenerative diseases. Although the provision might promote the role of nurse consultants, we do not see it as a route to restrict the application of the role concerned to those with certain job titles.

Dr Turner: Are any difficulties being experienced with how things work in practice at present, with respect to feedback being given to the general practitioner—the family doctor—of the patient who requires the certificate? There is a requirement to have information on the patient's

medical history, and there is a need for continuing communication with the GP, so that they are aware of everything that is going on with the patient.

Robert Hamilton: Having asked around the country, I am aware that there are a number of difficulties in dentistry in that respect. When a certificate or authority is asked for, the general medical practitioner will sometimes not sign it, for some reason. There have been problems in obtaining certificates to enable treatment to be given. I could not really say what the reasons for that are. Perhaps the doctors do not feel competent about authorising dental treatment.

We envisage that most of the dentists who would be concerned by the provisions would be community dental officers and senior dental officers, who have a specific remit for the treatment of people with learning disabilities or dementia. I have spoken to general dental practitioners, who feel that they would have a lesser role in this area. I reiterate that, in community dental services, the communication with general medical practitioners and the situation with obtaining medical histories is fairly good in the main.

Kate Maclean: Can you clarify that? Surely the GP is being asked to decide about a person's capacity, not about any dental treatment that is required. I cannot understand why doctors would be reluctant to make such decisions.

Robert Hamilton: In certain areas, the certificates that we request are not forthcoming, and we do not always get feedback on why that has been the case. That delays treatment, and it means that a further phone call to the medical practitioner is required.

The Convener: Perhaps Dr Scott should be brought in on that point.

14:45

Dr Scott: There is an issue about consent and understanding procedures. If the GP felt that they could not adequately explain the procedure and that they could not respond to questions from the patient to ensure that they had understood it, they would have difficulty in being the person who signed the certificate. That is why we support the suggestion that the dentist—or whoever delivers the treatment—should explain the treatment appropriately to the patient. Proper explanation requires the person who is doing the explaining to check that the explanation has been understood and to respond to any questions that the patient might have. The process is complex and the legislation would ensure that that problem area was covered.

Janis Hughes: The Royal College of General Practitioners says:

"Currently the Adults with Incapacity Act limits responsibility for assessment of incapacity to medical practitioners only. The RCGP believes this is inappropriate as it includes all registered medical practitioners regardless of the nature of their professional experience and training, while excluding others such as appropriately trained specialists, clinicians and clinical psychologists."

Is the suggestion, therefore, that there should be extra training for medical practitioners who do not have experience in the area of incapacity?

Dr Scott: There are medical practitioners who have no need of such training. For example, laboratory specialists will not be called on to make the kind of decisions that we are talking about unless they are delivering specific care to patients or are investigating them in some way. However, there are other professional groups—such as community psychiatric nurses—for whom such training would be extremely appropriate.

Janis Hughes: I believe that the Royal College of General Practitioners, unlike the previous witnesses, strongly supports the extension of the certificates' duration to three years. Could you comment on some of the evidence that we have heard on annual assessments and the other downsides to having three-year certificates?

Dr Scott: The issue concerned linking regular review to the provision of a certificate. Clearly, the cases of patients who are incapacitated at that level for three years will need to be reviewed regularly—probably more frequently than annually, in terms of their clinical care. That review should be multidisciplinary, because those patients have complex needs.

Completing a certificate is quite time consuming because there is a legal requirement to check certain things—it would take between 45 minutes and an hour to do it properly, or a shorter time if the practitioner knew the patient. Remembering, each June, for example, that it was time to redo the certificate and completing all the associated work would, in some ways, distort the flow of care because it would be an additional thing that people had to do. However, I agree totally that regular review of such patients is good clinical practice and I hope that that is being done.

Janis Hughes: Do you have any concerns about extending the duration to three years?

Dr Scott: No. The extension has the caveat that, if the patient's condition changes, the certificate can be withdrawn.

Mrs Milne: I wanted to probe with Dr Scott the issue of the use of psychotropic drugs in care homes. I presume that that issue concerns GPs more than anyone else. The witness from Alzheimer Scotland suggested that it would be

appropriate to have two medical opinions before such drugs were prescribed. Do you have any comment to make on the general principles of prescribing such drugs in care homes and on who should make the decision to prescribe them?

Dr Scott: That is not part of the issue on which we were asked to give evidence. Therefore, my response is tempered by the fact that I would like to see the evidence that Alzheimer Scotland and others have before making an informed comment.

In general terms, we do not want inappropriate prescription of powerful medicines to take place. It should not be encouraged in any way and part of proper professional care would be to ensure that that does not happen.

The Convener: That covers most of the issues that members wanted to be raised. Since all three witnesses are pretty much in agreement with the proposals, I will give them the opportunity to talk about any specific experience that they have of the existing system not working and why they think that it should be changed.

Robert Hamilton: There have been instances in which care home staff have drawn our attention to a resident who has an abscess and we have been concerned about the individual's capacity to consent to the treatment. However, when we have asked for a certificate to enable us to deal with the matter, there has been a delay. It can take up to two weeks to get a certificate from a doctor, and that is not appropriate for someone who is in pain, especially as the procedure is fairly straightforward.

Loss of dentures is also a problem, as there can be delays. If someone with Alzheimer's disease loses dentures, that can be significant, because the ability to wear dentures is learned and they can lose the concept of wearing dentures. The delay can be important, so we should at least make a quick start on replacing the dentures.

The Convener: Is Pat Dawson aware of any examples from the nursing profession?

Pat Dawson: When we rooted around for evidence for the consultation before the bill was introduced, a large number of issues came to us on the flu vaccinations. However, I will comment on paragraph 15 of annex A of the Scottish Executive's supplementary evidence. I am a little concerned that it says:

> "the Code of Practice will set out the circumstances in which it would be appropriate for nurses and other proposed signatories to issue certificates."

I hope that that is not a signal that the Executive wants to implement a restrictive practice with lists of people and named individuals who can issue certificates. We have all tried to put forward the expanding and emerging new ways of working in the health service. We have autonomy and regulatory practice that protect the patient in addition to what is proposed in the bill. The changes should be more enabling than restrictive.

Dr Scott: The flu vaccination is probably the best example in which the workload implications were considerable. There are practices that have a much higher burden of the elderly because of the number of nursing homes in the area, so the impact can be quite disproportionate. As Pat Dawson and Robert Hamilton said, we need to try to ensure that patients get good care in a reasonable timeframe and that that is not prohibited by a legal process that, by its nature, can be slower than we would want it to be.

The Convener: That deals with everything. I thank the witnesses for coming to the committee.

We have a gap while we wait for the next sets of witnesses, so the meeting will continue in private for item 3. I advise all members of the public that the meeting will resume in public at approximately 10 minutes to 4.

14:53

Meeting continued in private.

15:51

Meeting continued in public.

The Convener: We reconvene the meeting to discuss sections 31 and 32 of the bill. The first panel of witnesses comprises David Fox from Turner & Townsend Management Solutions and Howard Forster from E C Harris. I understand that Alex Macleod of Skanska is ill and is unlikely to arrive. I ask for brief introductory statements of just a minute or two from each witness before we ask questions.

David Fox (Turner & Townsend Management Solutions): I am happy to kick off—I will give the story so far. After an initial bedding-down period of the procurement route in England, the local improvement finance trust joint venture model has developed from being a purely health-focused model to one that delivers other services on a best-value basis, including social care and care for the elderly, and libraries and sports facilities. It also creates third-party opportunities.

With political will, the model has encouraged joint thinking throughout public sector departments, which has resulted in multiple use of space and allows the public sector pound to work harder. Many projects are in their early stages, so value for money is being assessed continually because many benefits follow the establishment of improved facilities and delivery of services after the settling-in period.

That said, we believe that room for improvement exists. Despite the apparent success, there is certainly room for improvement in Scotland, especially because Scotland is upstream of implementation in England and is ideally placed to benefit from that. Partnerships for health have highlighted many aspects for improvement that have been incorporated in their later projects, but the new market in Scotland offers the opportunity to do more than just to tinker around the edges.

In developing a Scottish model, we would consider simplification of what is a complex model for relatively simple facilities, provision of assurance of continuing opportunities that will encourage the private sector to invest for the long term and design of individual schemes so that scheme sizes are attractive to bidders but will also deliver value for money. We support the development in Scotland of joint ventures that would be delivered in a manner that reflects Scotland's needs and which also benefits from the lessons of England.

Howard Forster (E C Harris): I am a partner at E C Harris, which has been involved in more than 17 schemes in the south and therefore has practical hands-on experience of NHS local improvement finance trusts in operation.

We ran a session in Scotland last year with a cross-section of the market, and from experience we believe that the proposed joint ventures model will bring significant opportunities and benefits, particularly in urban regeneration. To support those comments, I state that from practical experience we observe that, in particular, the planning structure that supports NHS LIFT has enabled local authorities and health service organisations to come together—in many instances for the first time—to consider joint planning of their estates. In doing so, greater impact has been made than would be achieved by simply replacing primary care accommodation.

We have seen a number of significant examples of that in Merseyside and farther afield, which have contributed to wider urban regeneration agenda and supported sustainable communities. From practical experience, we support the introduction of a model that would encourage wider discussion among public sector organisations and which would enable them to enter into joint planning and delivery of physical assets.

Shona Robison: I have questions on two aspects of the contracts, relating to risk and cost increases during contract negotiations. On the first issue, can you outline where the bulk of the risk lies, should a joint venture company fail? Who picks up the cost burden?

David Fox: In terms of a joint venture company, many of the principles are similar to those of private finance initiative projects, in that the contracts are designed to ensure that the public sector stays whole and that the impact is, at worst, a delay in implementing the project through a retendering process, either for the LIFT partner or perhaps for a contractor. There are examples from the PFI industry in which the provisions within PFI contracts, which are reflected in the LIFT contract, have been used successfully in such circumstances. In fact, close to here, in East Lothian, and in Tower Hamlets in London, the provisions of the contract have been used to replace a failing contractor who was providing the construction service, in a situation where the works were carried out in parallel with step-in by the public sector. The provisions were such that the public sector was compensated and a new contractor was put in place.

Shona Robison: Who compensated the public sector?

David Fox: The public sector was compensated through the clawback mechanism.

Shona Robison: Was clawback from the failing contractor?

David Fox: It was, in effect, from the funders. The funders provide the capital and also a degree of equity support. In the case to which I referred, an SPV—a special purpose vehicle—was involved. The provisions in the contract in that case allowed the public sector to step in, maintain the construction process and retender. Effectively, the value of retendering and construction works was handed over to the new successful contractor, net of any costs. Such provisions are normally in place within a PFI-type contract. Howard Forster may want to enhance that answer—or otherwise, given his intimate knowledge.

Howard Forster: In the NHS LIFT structure, design and construction risks are distributed through subcontracts. The cost of any delay in construction is borne by the subcontractor building partner, and is passed down through the subcontracts.

Similarly, the risks that are associated with life-cycle maintenance and provision of facilities management are passed down through an FM contract; the risks are borne by the FM supplier. As in a PFI contract, the joint venture vehicle is protected from any of the risks' coming back to it by the provisions of those two contracts.

16:00

Shona Robison: What is your view of the contracts, given that public money is involved in them? Do you think that they should be made

public so that everyone can see the provisions in them in advance of any problems that arise?

David Fox: It is fair to say that the model contract is a public document, which is available on the websites of Partnerships UK and, I believe, the Parliament, although I may be corrected on that. However, contracts for individual projects reflect many of the bespoke items that are specific to those projects and there is some commercial confidentiality attached to them. I noticed smiles when I mentioned commercial confidentiality—the base provisions are public knowledge, but the specifics about particular sites are kept confidential.

Howard Forster: NHS LIFT adopts the same standard for PFI contracts, with some minor modifications. The provisions are now widely understood and are—

The Convener: That may be the problem, of course.

Howard Forster: I accept that.

Shona Robison: Unison Scotland has given evidence to the committee in writing and will appear before us later today. In its evidence, it says:

"the cost of using PFI has tended to escalate during contract negotiations. The risk of such cost increases in a joint venture will be borne by the … public sector".

Do you have a view on that?

Howard Forster: In the LIFT market, the average time between the placing of an advert in the *Official Journal of the European Communities* and the financial close is about 17 months. That period is relatively short compared with the periods that have traditionally been borne in similar PFI negotiations. To my knowledge, the cost escalation in the schemes in which we have been involved has been relatively limited. In the mainstream PFI market, cost escalations are mainly due to delays in projects and inflationary pressures during those delays. That has not been apparent in the LIFT market; on the whole, the first 42 schemes that have been bid on have been straightforward. Although they represent a spectrum of schemes, most are relatively small and have been well thought through by the public sector before they come to the market. Because the client has a clear grasp of what it wants, the risk of its changing the brief is relatively small, according to my experience of 17 or so LIFT schemes.

David Fox: The experience to which Unison referred certainly matches our experience of early PFI-type schemes. At that time, there was perhaps not much understanding of the balance to be struck between obtaining a price from the market in the tenders and ascertaining for how long that price should be maintained, be it six months, a year, 18 months or whatever. If we want a price to be maintained for at least a year, interest will be built into it. As the industry matures, there is greater understanding of that balance and—which is probably more important—of the fact that the scope of projects must be more comprehensively and robustly developed, thought out and reflected in the specification. The specifications of many of the original PFI and LIFT projects—dare I say it—left a bit to be desired. Many of the cost escalations, apart from inflation, reflected things that had been missed out of contracts.

Shona Robison: Do you regard the contract for the new Edinburgh royal infirmary as an example of that?

David Fox: It was one of the first projects in Scotland to be carried out under PFI. I am sure that lessons have been learned from that contract and reflected in subsequent contracts. However, I do not have intimate knowledge of the contract and therefore cannot comment on it.

Shona Robison: You will appreciate the public unease about that contract, given some of the difficulties that were experienced with the model of PFI that was used. There might be some scepticism about what improvements have been made in respect of PFI.

David Fox: In order to alleviate such scepticism and to give comfort to elected representatives such as yourselves and to the industry in general, the Scottish Executive must be complimented for implementing what it calls the key stage review process, which is closely modelled on the gateway process that the Office of the Deputy Prime Minister and the Office of Government Commerce—the OGC—have implemented. At key stages in the development of a contract—before the issue of tender documents, before the naming of the preferred bidder and before the close of the contract—an independent review of the documentation and work to date is carried out. In the Executive's case, that has been done by Partnerships UK.

That review throws up issues that are associated with previous problems and it ensures that promoters of projects get it right. Problems must be revisited before a project goes out to tender or before a preferred bidder is appointed. That represents the spreading of best practice by experts in the field to promoters who might be less experienced and it is one of the means by which we in the industry intend to avoid repeating the problems of previous years.

Shona Robison: What is the percentage of profit that a company could expect to make under the new model of contract?

David Fox: I cannot comment specifically on LIFT, although Howard Forster might be able to do so. For a typical PFI project, the level of return, as it would be termed, would commonly be between 12 per cent and 13 per cent. I stress, however, that that is over 30 years—that does not refer to a one-year contract. 13 per cent over 30 years might not sound like an awful lot, but that is attractive to the marketplace. There is a long-term opportunity and there are opportunities to establish partnerships in the event of expansions of a project, through change mechanisms. That is effectively a win-win situation for both parties.

I ask Howard Forster to comment on LIFT.

Howard Forster: The experience of LIFT to date has been broadly similar to that.

The Convener: I invite any other specific questions on the subject of cost increases and risk.

Dr Turner: I have a question relating to something that Shona Robison said.

The Convener: Is it to do with cost increases and risks?

Dr Turner: It is to do with outline business cases not being perfect. Does business cases' not being perfect have anything to do with the fact that you might get only one contractor bidding? The idea is that a project should be cost effective. As many bidders as possible would be wanted, but it costs companies a lot of money to bid. If an outline business case were not up to standard, would the UK organisation—I have forgotten the name of the company.

David Fox: Partnerships UK.

Dr Turner: Does Partnerships UK sort out business cases that are perhaps not perfect? As you said, costs would escalate if a project was to go ahead despite the business case's not being complete at the beginning, in which case the builders would find out that they would have to add in this, that and the next thing.

David Fox: I will start; Howard Forster can perhaps add to what I will say. Every outline business case in the UK is now reviewed independently. In England, cases go through what is called the projects review group; in Scotland, they go through the Scottish Executive.

Each business case is rigorously analysed by independent bodies, predominantly Partnerships UK, which is the body in which the general expertise in the United Kingdom market is most concentrated. That process highlights gaps or aspects that should be in place but are not—for example, not all the land might have been acquired or not all the planning permissions be in place—and gives bidders much more confidence that when a project comes to the marketplace it is robust, comprehensive and well developed, and that there will be a relatively smooth run through the procurement process. In other words, the risk of abortive bid costs is much reduced.

Howard Forster: Mature design is now expected at the outline business-case stage. It is expected that, before an advert is placed to invite tenders, the scheme will have been developed to the extent that departmental layouts and sample room layouts are in the design. One would go to the marketplace when one arrives at an outline business case that has that degree of certainty of design. That is expected in NHS LIFT in England and throughout the PFI market in healthcare.

Dr Turner touched on the number of bidders for a project. The LIFT market is different, because the nature of the projects is different and has attracted a much wider market than traditionally bids for the major PFI health projects. To my knowledge, it is something in the order of 19 bidders. In addition to the more traditional firms that bid for PFI contracts, many have come out of what is described as the third-party development market; some are property-led companies and some have been housing associations, such as Bradford and Northern Housing Association, which has rebranded and is now called the Accent Group. An interesting range of different types of proposal has come from the market. To my knowledge, there was a minimum of two bidders on the 42 projects in the LIFT market. I think that the last project to come to market attracted the fewest bids, but in all the earlier waves the lists were eight bidders or more long. The market has been attractive to bidders.

Dr Turner: Is that because the projects are smaller than hospitals?

Howard Forster: I think so. Relatively speaking, the initial bid costs are less against a reasonable deal volume.

David Fox: I suspect that you are thinking about the more limited tender lists that we have had in Scotland over recent years. The capital value of construction works within a LIFT project is attractive to a much wider range of contractors because of the type of relationship and the fact that the contract is spread over a number of years. Perhaps only a limited number of contractors could carry some of the recent education projects that have had a capital cost value of £90 million to £100 million, whereas the smaller year-by-year value in a LIFT-type project makes such projects more attractive to a much wider range of contractors, which increases the number of contractors that bid and, hence, the competitive pressure that creates value for money.

Carolyn Leckie (Central Scotland) (SSP): Three aspects of the consultation document that you submitted to the committee make me worried about the risk to the public sector. I should say that I am a member of Unison and have direct experience of the impact of privatisation on the health services. In the document, you refer to facilities management's not being included in LIFT projects, which indicates that it is perceived as being too much of a risk to the private partners. Will you expand a wee bit on that?

Another paragraph mentions

"the critical mass required to make the LIFT model viable and hence attractive to private sector investors."

That is obviously about diminishing the risk to the private sector. Could you give detail on what you mean by that? What is the impact on local services? How much makes a "critical mass"? Does that mean that there will be reductions in access to local services?

You also say:

"Each phase should ideally be profitable as a stand-alone venture".

Obviously, that again relates to concerns about minimising risk to private sector profits. Could you expand on that and on what its impact would be on the public sector?

16:15

Rather than give us a projection over 30 years, could you tell us what has been the impact so far of LIFT schemes, with which you have been involved in England, on the growth of profits for the companies involved? Similarly, what has been the impact on the public sector in respect of terms and conditions, service provision and so on?

The Convener: It would be helpful if you left jobs until we have dealt with cost increases and risks.

Howard Forster: I believe that the first question was about FM. I did not think that Carolyn Leckie's other questions were all related to cost increases and risks, but that they were all different.

The Convener: Indeed. If you could confine your answers to the questions that relate specifically to cost increases and risks, we will mop up some of the other issues later.

Howard Forster: I am not sure that any of the questions directly relate to cost increases. I can respond to each question in turn, however.

The Convener: That would keep us moving.

Howard Forster: FM content in NHS LIFT schemes is limited to hard facilities management, such as building services. It has not so far been extended to soft facilities management.

It is probably worth saying that limited services have been delivered to general practice facilities in primary care over the period. You should bear it in mind that the market is already mixed. A number of general practice premises are in private sector ownership and are run by GPs; they might not have any facilities management services. To some extent, the services are being newly provided to the primary care market.

On whether the absence of FM in the marketplace would be an issue, the answer is—on the whole—no. For some of the batched primary care schemes that are coming onto the market and which are not LIFT schemes—such as in Stockport in south Manchester—there would be a market for working with private sector organisations on design, construction and replacement of facilities and the associated financing outwith FM contracts. There would be a market if FM provision were not included, although FM is relatively new in the primary care market. In saying that, I am setting aside any concerns relating to off-balance sheet issues and so on. I am not an accountant, so I would not want to comment on what that would do to a risk profile. Regardless of whether FM was excluded from NHS LIFT schemes or not, the market would be attractive. The market is different to the one relating to major health care private-finance initiatives.

The second question related to critical mass. It is fair to say that there is a minimum bid cost associated with LIFT schemes, which has so far been of the order of £500,000 to £1 million. Certainly, before a preferred bid is arrived at, individual schemes will have cost the private sector between £250,000 and £500,000. Clearly, if a bidder is about to make that sort of investment and can expect to win only one in three bids, the bidder would want to ensure that the overall value of the projects that would be secured in that market is reasonable.

The 42 LIFT projects that are currently on the market vary enormously in terms of value. For example, in the Manchester, Salford and Trafford LIFT scheme, many primary care trusts have come together to procure jointly, whereas Dudley South Primary Care Trust might have only three to five schemes. I come back to my earlier point; such schemes are still attractive to the marketplace and the marketplace still responds.

Because of the geography of Scotland, different scales and types of procurement would be needed. My expectation, based on experience, is that there would still be good competition and at least two bidders if the value of the deal were more than £10 million to £15 million overall. That might represent three or four primary care premises; the cost of building a typical primary

care facility is between £3 million and £5 million for the scale on which they are built these days.

The third question was about profitability and how it looks currently. It is impossible to say. The first schemes have just been completed, so it is too early to offer a view and certainly too early to make observations. The first built projects are just being completed now within NHS LIFT in England. The only figures are those that have been modelled; they are broadly comparable to PFI marketing.

I am not quite sure what the point about growth in profits was about.

Carolyn Leckie: What have the benefits been so far?

Howard Forster: There have been very few because construction has just started and the facilities are not finished. Even the comparison between the estimate of how much a building will cost versus its actual cost, which is a risk borne by the private sector, is yet to be evidenced and understood. It is probably just a little bit too early to be asking those questions.

Carolyn Leckie: Are the share prices increasing?

David Fox: I cannot comment in detail on NHS LIFT, but I can give you a typical example of a PFI project. I stated earlier that, over a 30-year period, a PFI project would provide a return of something like 13 per cent. It is important to note that until year 20 to year 22 of a 30-year contract, the special purpose vehicle of the successful company is in the red; it is making a loss and it goes into profit only in the final few years of the contract. I would be surprised if the LIFT projects were any different, although I could be proved wrong as I do not have intimate knowledge of that particular vehicle.

Carolyn Leckie: You did not answer the question about guarantees and pipeline workload in each phase being profitable as a stand-alone venture. How do you envisage that working? Is that to take account of the worries that the project would not be profitable?

Howard Forster: No. The nature of a LIFT procurement is that a partner is appointed—by way of competition—for two or three projects out of a batch of projects. A batch might contain as few as five projects or as many as 30. Each individual project within the overall project will be a contract in its own right. Each contract needs to be bankable and able to secure external funding, and it must go through the same due diligence tests as any PFI contract. The contracts must be robust in the way that they respond to public sector governance and value for money tests; they must also respond robustly to private sector tests such as cash flow protections and ensuring that the contracts distribute risk appropriately. Each tranche of the overall LIFT relationship has to be robust. That goes without saying.

Private sector involvement is partly about profit, but it also has wider objectives. I refer to what was known as the Bradford and Northern Housing Association—now the Accent Group—which distributed its profits to its other objectives. It was not about return for individuals, companies or share value.

David Fox: To provide a bit of comfort on your first point about FM and FM services, the evidence from the Scottish Trades Union Congress identified that Scotland has the staffing protocol. That is not a feature to the same extent in the English market and it is one example of how NHS LIFT, as developed in England, would have to be adapted for the Scottish marketplace. There will be other issues, because we are considering a Scottish solution, not just the importation of an English solution that may or may not be appropriate.

The Convener: You talked about staffing protocols. Kate Maclean has a question on jobs.

Kate Maclean: Your report mentions that the employment protocol will probably affect the pricing model. The small paragraph about staff-side issues states that the staff side is stronger in Scotland and that that might create difficulties. People are concerned that job losses may occur as a result of the use of joint ventures and that two-tier workforces would be created in certain premises. Has that happened in England? Will you expand on that? I could find no other references to staffing or job issues in the report.

Howard Forster: To be clear, that document comes from the observations of the 70 people who attended the seminar, who were from public and private sector organisations, including staff-side organisations. We tried to give a representative view. The document represents a range of views and does not necessarily contain my personal observations of the market.

So far, NHS LIFT has not had the impact that you describe. As I said, we need to understand the nature of the premises and the existing services that support them. We are talking about GP practices extending into much wider functions because, as things stand, many premises do not have facilities management services at all. New services would be introduced under the proposals.

On a separate issue, one of the affordability constraints for primary care organisations in using the lease plus arrangements within the LIFT scheme, rather than the previous arrangements, is that new services are being introduced. Facilities management, guaranteed replacement and

grounds maintenance are relatively new services. Where they existed previously, they were generally managed by individual practices, which made their own arrangements. Most of the LIFT companies with which I have dealt are interested in using local suppliers to manage existing services, but on the whole the services are absolutely new.

One can see that from the state of primary care facilities in the UK. The 2,500 GP practices throughout the UK are not being regularly repaired or maintained and no life-cycle replacement is taking place. As a result, we have a huge backlog of maintenance and buildings that are decaying and not fit for purpose. However, the situation will improve, because we are securing some of the required services through the new contracts, and on the whole that is for the first time in the primary care market. Therefore, the changes will not have an adverse effect on existing staff because there are no existing staff.

Kate Maclean: So existing public sector workers will not be transferred to joint-venture companies.

Howard Forster: That may happen for limited numbers of staff. I do not know the profile for primary care in Scotland so I cannot provide specifics, but, if that happened, the same provisions as for any transfer of undertakings would apply. However, from my experience, such cases will be limited. So far, I have not observed that as an issue in any of the 42 schemes in the NHS LIFT marketplace.

Carolyn Leckie: You did not quite answer my earlier question. The scheme has obviously had impacts. The issue is not just about terms and conditions and the employment protocol, because that does not relate to final salary pension schemes. What has the impact been on such schemes in England? Another issue is staffing levels and ratios. Historically, the contracting out of cleaning services has resulted in staffing ratios plummeting. Since the introduction of the LIFT schemes in England what has happened to the numbers in various staff groups compared to patient turnover?

Howard Forster: As far as NHS LIFTs are concerned, the answer to the latter part of your question is fairly straightforward: as there are no soft facilities management services, none of the contracts includes any cleaning or catering services. For the reason that I have just given, those services are in many cases brand new. I have to say that I have not come across that issue in the public or private sector.

16:30

Carolyn Leckie: Have you compared the terms and conditions of new staff involved in new services with those of the NHS or local government workforce? Studies into PFI and overall staffing levels carried out by Allyson Pollock and others have highlighted that, although the scheme might not directly employ people, there are indirect impacts because of the costs to the authority of funding the contract. Have you considered the impact on overall staffing levels in public authorities?

Howard Forster: As none of these facilities is operational—one might be operational in south-east London—it is too early to make such observations.

Carolyn Leckie: Do you think that there will be an impact and, if so, have you taken any steps to avoid it? Do you think that a reduction in overall staffing levels would be a bad thing?

Howard Forster: What I said is that, so far, there has been no such impact. It has not presented itself as an issue. It is still too early to make those comparisons. The private sector has to go to an employment marketplace and attract an appropriately skilled staff to deliver what are on the whole new services to facilities that, historically, have not had those services delivered.

Carolyn Leckie: On what terms and conditions are those staff being recruited, and how do they compare with those of staff in public bodies?

Howard Forster: I do not know the detail of the terms and conditions.

The Convener: Would they vary from project to project?

David Fox: As far as staffing levels, pensions, wage rates and so on are concerned, we have the staffing protocol, which came into being a short while ago and which the Executive has implemented on all relevant PFI projects. No doubt your good selves will make your views known to the Executive on the question whether the protocol should be similarly applied to any LIFT joint ventures that might come along. Certainly, since the creation of the staffing protocol, one of the key themes in the projects in which I have been involved has centred on staffing levels, the protection of pensions either through admitted body status or through broadly comparable schemes and the avoidance of a two-tier workforce. Indeed, that has been reflected in the project documentation issued to the various contractors. I would be surprised if this situation were any different.

Janis Hughes: You said that no soft FM services are included in English LIFT models. Have there been any discussions about doing that in Scotland?

Howard Forster: Not that I am aware of. However, to my knowledge—I have worked on 17

deals—only hard FM services have been included in NHS LIFT market deals. I cannot say that absolutely and would need to test it out, but I think that that statement is correct.

Carolyn Leckie: The E C Harris report says that most people agreed that soft FM services should be included, so that is something that you are obviously aspiring to.

You also said that public bodies were involved in the consultation. However, when I counted them, I found that 14 out of 58 consultees were public bodies and the rest were involved in private finance, construction and so on. As a result, the document will reflect those interests.

I have to say that I am not sure about the accuracy of the report. The veracity of your argument is brought into question by the comment:

"Overall it was believed that there was not as much deprivation in Scotland and so they are starting from a better position".

How on earth did you reach that conclusion?

Howard Forster: Clearly, any audience that discusses such a matter will have a bias. The audience was not perfectly balanced because we sent out an open invitation for the session and those who wanted to attend came along. We certainly did not exclude anyone and, as we have said, we extended the invitation specifically to staff-side organisations, which did not attend.

Returning to the first point, I welcome the idea of providing soft FM services in primary care premises where they do not exist at the moment. The member referred to a marketplace, but, as I said, I am talking in general not about the Scottish health care market, but about what that looks like in the primary care setting and in the provision of primary care facilities.

Currently in primary care provision in the UK, buildings are not being maintained and are not receiving the soft and hard FM services that are typically received in other markets in other parts of the health care sector. The issue is one of levelling-up. On the whole, I would welcome the introduction of new services to facilities that have not benefited and also to primary care services that have not benefited from that sort of provision in the past.

The Convener: I call Shona Robison for a last brief question.

Shona Robison: In your report, under the heading "Political Climate", you say—no doubt you are stating a fact—that

"The Scots are generally more hostile to PFI/PPP than their southern counterparts."

You go on to say:

"However, the fact that the public sector stands to benefit from potential profits through participation in the joint venture vehicle may prove a selling point."

Are there any examples of the public sector making such a profit?

Howard Forster: As I said, it is too early to be drawing conclusions—

Shona Robison: How likely is it?

Howard Forster: In NHS LIFT, the public sector has 40 per cent of the shareholding of the joint venture vehicle, which means that it has a 40 per cent share in any benefits that accrue in that arrangement. That is different to anything that has gone before in terms of other PPP models. It gives the public sector a stake and a share in that and gives it influence over the distribution and use of the profit.

I refer to the Bradford and Northern Housing Association and its objectives. The committee might like to engage in a conversation with Bradford and Northern Housing about its operation. Certainly, its motives are neither share value nor profit in the sense that those are understood, but of redistributing value into the wider regeneration objectives of the organisation. Although the benefit of LIFT is beginning to prove itself, it is too early to offer specific numbers or observations.

The Convener: Although Nanette Milne is interested in examples south of the border, they have been discussed consistently throughout the questioning. We have quite limited time. Is there anything further that you wish to raise on the subject, Nanette?

Mrs Milne: I have a question that leads on from what was just said. You spoke about differences of scale and so forth. I notice that under the "Consultation Point Conclusions" heading on page 11 that you say that

"It may be appropriate to implement 1 or 2 pilots in geographically distinct areas".

Perhaps lessons from England could be learned for the pilots. Will you elaborate on that?

Howard Forster: In the main, the first 42 LIFT schemes in England were directed at the major towns or inner city conurbations. I think that it is fair to say that, although it was not universally the case. The next nine schemes, which come under what is described as the fourth wave, cover Kent, for example. Possibly the schemes in the fourth wave are more comparable to some of the geographies in Scotland.

I apologise for the fact that some of the comments in the report are naive. As I said, the report represents the views of those who were in

the room. I apologise if I am coming across as being naive about the geography of Scotland. That said, the observations of the people in the room and of the private sector, are that it would be very different to bid, let us say, for a Glasgow or greater Glasgow scheme than it would be to look at one in a more rural community where general practice was distributed over a much wider geography. It is likely and sensible to suppose that the planning and approach to that scheme would be different.

I think that the group was saying, "Would it not be sensible to try that out." The suggestion was for some pathfinder schemes that could explore the two extremes to see what they would look like and how Scottish planning partnerships could be involved in the process. That is part of the recommendations. It is likely that the way in which Scotland would engage other wider public sector stakeholders within the process would be different, and sensibly so.

I imagine that the issues that arose in Kent, such as the need to involve the ambulance service more formally within the partnership, are more relevant in wider rural settings than in city settings where adjacency issues are easier—albeit not easy—to overcome and where access to facilities is less of an issue. Those points are reflected in the observations in our submission.

David Fox: In the Scottish context, there are a couple of linked points that we have already discussed. First, we can learn from the recent wave of education PPP projects, in which the interest of bidders varied depending on the value of the projects and their geographical complexity. We need to consider the right balance between bidder interest—bigger tender lists help to drive value for money—and the ability of bidders to deliver projects.

At the moment, we are perhaps at the starting point for the next stage that the Executive team will need to consider. Taking account of those experiences, they will need to consider which trusts—

Mrs Milne: I must interrupt you. When you say "trusts", do you mean health boards?

Howard Forster: Yes, he means health boards.

David Fox: Sorry. People will need to take account of the experience of education projects and of the consultation process that has already taken place. They will need to assess what is the ideal combination of project value and geographical spread that will maximise interest from potential bidders and thereby drive the competitive pressure that will deliver value for money.

Some health boards might opt for a combined project similar to the Manchester, Salford and Trafford LIFT. Although those are substantial conurbations, it was felt that a combined project would be better at driving value for money. Such an exercise needs to happen, but it would need to be consulted on and tested before it goes ahead.

Mrs Milne: What was included in the Manchester, Salford and Trafford project? What did the project comprise—

The Convener: Nanette, please speak more clearly into your microphone; the rest of us cannot hear a word that you are saying.

Mrs Milne: Sorry. What facilities were produced by the Manchester, Salford and Trafford project?

David Fox: The Manchester, Salford and Trafford LIFT is a large-scale but reasonably typical LIFT project that will provide facilities in which primary care trust services can be delivered in the Manchester and Salford areas. The facilities include GP surgeries. Because our company was involved in assisting the successful bidder for that project, I know that that LIFT has presented an excellent opportunity to combine health and many other related public sector services, so that the space is multi-used and works harder for the public purse. That is a successful example of how a LIFT can drive efficiencies so that there is more cash to put elsewhere.

Janis Hughes: My questions are on community planning. In his introduction, Mr Forster said that the LIFT model would be more beneficial than more orthodox methods in providing primary care services. Will he elaborate on why the LIFT model is more beneficial?

Howard Forster: There are two aspects to that.

First, the model fills a gap in the planning process for primary care accommodation by replacing the current mix of different approaches by which GPs might replace their accommodation. For example, GPs might previously have rented accommodation that was designed and built for them by a private sector organisation, or they might have worked with the public sector health organisation—the health board in Scotland or primary care trust in England—or, alternatively, they might have held their general practice surgeries in part of their own house. In many cases, the accommodation needs of GP practices would be considered in the light of their practice population, but in the absence of wider considerations pertaining to the whole town or area. However, the NHS LIFT model has accelerated the process whereby primary care providers—principally, general practitioners but also optometrists, pharmacists and other providers within primary care—are brought together in the planning process. They are surrounded with the capacity and skills to help them to think about their

future needs for their premises. Historically, that did not really happen.

16:45

The other aspect of that is the point that was just made about mass. In St Helens, a primary school—Ravenscroft Community Primary School in Knowsley, which is well worth a visit and is being constructed as we speak—came together with the primary care trust and the two sites were combined. The primary care site that was up the road has now been moved to the primary school site, and a common access has been created. A community centre has been put in the middle of that. Maximum use is being made of the land, and those community functions are being brought together. The local community is engaged in the school and there is no vandalism of the school—there never was, but the old GP practice was vandalised every week. There have been benefits to bringing the community closer to primary care provision.

Another example in St Helens involves the church. The Archdiocese of Liverpool has given over one of its sites for a GP practice. That has attracted other investment—residential and retail investment—and is having an impact on the overall regeneration of Duke Street, west of the town centre. Those are two examples of where wider planning has occurred and where the deficit in planning, even within the health care sector, has been dealt with.

Janis Hughes: I hear what you are saying. Both the examples that you have given are in England, but you say in your report that the framework is different in Scotland. That is why we have devolution—because we have different ways of dealing with things here and different issues to address. I was a bit concerned about your comment that

"There is a need to develop the link between local and strategic planning, which was perceived to be missing from the current LIFT process."

The committee knows only too well from previous experience about the lack of strategic planning in the NHS and how vital it is that things are planned strategically. It concerns me to hear you acknowledge that there are gaps and that strategic planning has perhaps not been addressed properly in this process.

Howard Forster: Some people who attended the consultation observed that. My personal experience is that the process has been more joined up than I have seen historically within a primary care setting. I think that you have an approach to infrastructure that gives you an advantage over some parts of England. I agree with that. I have observed that and that was mentioned in the conversation that we had at the consultation. Your strategic partnerships are perhaps stronger here and better suited to this model, and you already have experience of joint venture structures.

In many parts of England, it was new for organisations to come together in that way. Even within primary care, as I say, there was a deficit in planning. Historical structural changes had perhaps led to the loss of some of the skills around that; nevertheless, we have seen the benefit of joint planning with local authorities, local education authorities, education providers generally, the faith school sector and the church sector. It has been very practical to do that, and I have offered those practical experiences. The schemes that I have been involved in have been better than I have seen previously, but there is a long way to go. We are trying to ensure that those opportunities are considered systematically in every scheme that is developed; however, realistically, that is probably not where we are now.

The Convener: How old is the oldest of the schemes in England to which you refer?

Howard Forster: The schemes that I am involved in—

The Convener: I mean the ones with which you are familiar. You have referred to schemes south of the border, but you have also said that it is too soon for us to look to them for examples. How far down the line is the oldest model of this kind in England?

Howard Forster: The first financial close was 18 months ago, and the facility is now complete in London. The schemes that I have been involved in are under construction and are not yet complete; however, it is early. The LIFT market in England is roughly three to four years old. The process for bidding is 17 months to financial close and it takes 12 months to construct the larger schemes. It is not likely that, over the past three to four years, there have been a huge number of such schemes.

The Convener: Is it true that only a handful of schemes have been completed in England?

Howard Forster: That is correct.

The Convener: Under this model, the public sector provides the shareholders and directors. In the handful of LIFT schemes that have been completed, have issues of accountability and conflicts of interest been raised, especially in relation to the public sector directors?

Howard Forster: It has been a major issue regarding how the primary care trusts and other public sector organisations have set up the LIFTs. The governance arrangements for strategic partnering boards, what the shareholder

agreement does and how it affects individuals have been much discussed. We should bear in mind the fact that Partnerships UK has been closely involved in the procurement and setting up of LIFT companies. That means that a Government body has supported the process and considered the issues.

The Convener: Have there been any subsequent controversies or arguments? Have any concerns been expressed?

Howard Forster: I imagine that concerns will be expressed at some point, but to my knowledge that has not yet happened in the marketplace.

The Convener: Thank you for your attendance. You are welcome to take a seat at the back of the room and to listen to the evidence that is given by the next panel of witnesses. If you want to leave, you may do so.

David Fox: I would like to clarify some evidence that I gave earlier. When talking about risk, I gave the example of East Lothian. East Lothian was not an example of there being a step-in on the SPV. The SPV was still in place—it re-tendered and carried the cost associated with that. The project arrangements in the example that I gave applied south of the border.

The Convener: I welcome our next panel of witnesses. They are Alan McKeown, health and social care team leader for the Convention of Scottish Local Authorities; Tim Huntingford, chief executive of West Dunbartonshire Council and joint chair of the joint premises project board of COSLA; Hilary Robertson, director of the Scottish NHS Confederation; and Susan Aitken, policy manager of the Scottish NHS Confederation. I invite one representative of each organisation to make a brief introductory statement. It should not be longer than a minute or two.

Tim Huntingford (Convention of Scottish Local Authorities): COSLA is strongly committed to partnership working. We have demonstrated that through the involvement of local authorities in joint future work and community planning. We are in favour in principle of joint ventures and recognise the advantages of shared premises for health and local authorities. That approach offers the potential for regeneration, the provision of state-of-the-art premises and, most important, improved seamless services for the public.

However, local authorities need to be full partners and to be fully involved. We are concerned that in previous initiatives, such as the health improvement programmes and, more recently, community health partnerships, local authorities have felt that they are on the margins, while health services and the Health Department have led.

We are in favour of the provisions in the bill, but wish to ensure full local authority buy-in to produce developments that are flexible and responsive to local needs and circumstances. LIFT may be one model but it is not the only one. COSLA feels that it is for local partnerships to determine their strategies and approaches to the issue.

Hilary Robertson (Scottish NHS Confederation): From discussions with our members, we are confident that there is general support for the principle of joint ventures as outlined in the bill. Joint ventures would give boards another option for the development of premises and facilities, without removing any of the existing options. That would result in a welcome increase in flexibility. The application of joint ventures to the exploitation of intellectual property is very welcome. That is currently an untapped resource.

Much detail has still to be worked out. We are talking about a power that boards do not have at the moment, so there is no practical experience in the NHS. We would welcome the NHS being closely involved in developing the proposals.

The Convener: The session will not work if all four panellists answer every question, so I would be grateful if the witnesses could do what they did with their introductions. I will ensure that each organisation gets a fair crack of the whip. If committee members want to ask a specific question of an individual, please make that clear.

Shona Robison: The panellists heard the previous discussions about risk and increasing cost. I want to ask both the Scottish NHS Confederation and COSLA how, as guardians of the public purse, they can ensure that the public sector does not, in LIFT contracts, take more responsibility for risk than it should do. When things go wrong, how can we guarantee that the public purse will not bear the brunt?

Tim Huntingford: I cannot give any guarantees. That is the kind of detail that will need to be carefully worked out. When local authorities, the health service and the private sector work together, the devil will be in the detail. Local authorities are gaining experience of that through the huge upsurge in PPP contracts for the regeneration of schools. Lessons can be learned and I hope that they will be applied.

Shona Robison: You say that lessons can be learned. Obviously, delays and quality issues have arisen in some areas with the schools programme. Have lessons been learned?

Tim Huntingford: I think so, yes. We are becoming much more skilled as more and more people become knowledgeable. As several previous witnesses have said, a considerable body of knowledge is developing elsewhere in the

United Kingdom. We can build on that to try to ensure that lessons are learned and mistakes avoided.

Susan Aitken (Scottish NHS Confederation): We would agree with that, and with the point that the devil will be in the detail. Governance arrangements, and arrangements concerning the balance and sharing of risk and reward among the range of partners, will require a lot of work.

The NHS came rather late in the day to joint ventures, which gives us some advantages. We can learn lessons that Scottish local authorities have already learned from being involved in joint ventures. Through the LIFT scheme in England, we have learned that we can use the best bits of models and discard the bits that have not worked. We can get the best of both of worlds.

A lot of work remains to be done. Our members—the NHS boards—are enthusiastic and see a lot of potential in the joint ventures model, but at the moment it is just potential. A lot of detail has still to be worked out.

The Convener: Are there particular things from south of the border that you have already decided are not appropriate for Scotland?

17:00

Tim Huntingford: I have limited knowledge in that area. In the early days in England, one of the problems was that the LIFT model was heavily health oriented. The sort of developments that have been referred to started in later phases. Local authorities and other partners have joined in to make truly joint ventures—as previous witnesses have said, developments in the early days were mainly to do with primary care premises. People have talked the talk about partnership down south, but they have only latterly started to implement partnerships in reality. That is an important lesson for us in Scotland.

Susan Aitken: So far, there is nothing specific that we absolutely must actively avoid, but there are certainly things that cannot be transferred wholesale. Obviously, there are different structures in Scotland. Previous witnesses have alluded to the very different geography here, and NHS LIFT projects have tended to be in inner city areas. One of the main issues in Scotland is primary care premises in remote and rural areas, so we will develop our own model and start from scratch in many ways.

I echo what COSLA said about partnership. Some later LIFT projects have involved a much wider range of services, including library services. There have been local authority environmental and leisure services and a much wider range of things on board; we would look to emulate that. That has already started in Scotland in projects that have been developed through more traditional funding routes—the committee may have heard of the Dalmellington area centre in East Ayshire, for example, which was a joint NHS-local authority project. NHS and local authority services and other community services come under a one-stop shop premises. There are other projects in West Lothian and other parts of the country. Therefore, there are already partnership models with a wide range of services to benefit the community that we can consider.

Kate Maclean: I want to ask the same question about jobs that I asked the previous panel. Do you have any concerns about workforce issues? In particular, I want to ask COSLA about having premises in which there are staff who are employed by a joint venture company and staff who are employed by a local authority. In the Scottish Commission for the Regulation of Care, for example, difficulties were caused by two sets of public sector employees coming together. Do you foresee any such difficulties with the proposals that we are considering?

Alan McKeown (Convention of Scottish Local Authorities): We have experience of such issues in the joint future work that has been done between local authorities and NHS bodies on matters such as terms and conditions, pay and holidays. That has proved to be a bit of a stumbling block, but we have managed to work our way through it. We would want to consider where the differences lie in our work and how we would overcome them. We would not want there to be dramatically different terms and conditions and rights and responsibilities for employees. We would try to even things out as much as we possibly could.

Kate Maclean: Local authorities are still trying to work through single status. The proposals in the bill seem to add another dimension that might create even more difficulties.

Alan McKeown: I do not think that we will rush into LIFT or LIFT-type schemes. As we pointed out, the potential is there, but there is a long way to go in our discussions, which are currently at the officer level. Our submission says that we have not yet had political discussions. We need to go through a level of detail honestly and openly, but that is yet to happen. You are right to say that single status is being worked through. Tim Huntingford can talk more about that than I can, but there are many issues to be worked through.

Carolyn Leckie: I do not know whether you heard the previous evidence session, during which questions and concerns about jobs were referred to. The E C Harris consultation document says that, as a result of links with local authorities,

"LIFT in Scotland will be even more flexible with more exciting outputs."

Do you know what it means by that, and does that statement cause you any concern?

The companies have expressed a wish that soft facilities management be included. Will you rule that out? I have experience of the joint future initiative from an NHS point of view, and I know fine well that lines of accountability have not been sorted out; there are vast differences in terms and conditions between occupational therapists in local authority employment and occupational therapists in NHS employment. Will all those issues be negotiated and resolved with the trade unions before any contracts are entered into?

In the evidence that we have heard today from all sides, the response to a number of questions has been, "The jury's still out. There isn't enough evidence." If we cannot assess the impact on staffing levels, service provision, terms and conditions, and lines of accountability, does that not indicate that the bill is premature? We have been unable to work out what the problems are, because there is not enough evidence or experience.

On the specific question—

The Convener: Carolyn, could you focus your questions? I am worried that they are not being followed.

Carolyn Leckie: I am worried that I will not get back in.

Will you rule out facilities management? What detailed discussions have you had on the impact on terms and conditions and service provision? Is there any evidence of the efficacy of the schemes?

The Convener: Can you get to a set of questions that the witnesses can answer? If you simply go on and on, that will ensure that you will not get back in.

Carolyn Leckie: The questions are quite specific.

The Convener: If the witnesses can unpick the questions from that speech, could they try to answer them?

Carolyn Leckie: In addition, will you rule out facilities management?

The Convener: Carolyn, enough.

Alan McKeown: I will try my best.

First, on the legislation, if the bill is enabling, that is fine and that is the end of it. Secondly, on facilities management, staffing, and terms and conditions, of course we will talk to the unions; we always seek to do that. We have a good relationship with the unions through the joint future work. We have sought to build up that relationship and we will continue to do so. It is too early to say what the situation will look like, but there is an absolute guarantee that discussions will take place.

The third point is the opportunities that joint working will bring. It is true that our geographies are different, our governance arrangements are slightly different, and with community health partnerships we have a completely different local feeling, but CHPs are very new. The ink is not even dry on half of the schemes. We have yet to determine whether CHPs will add value, but there is a framework for better working. Through our joint future work, we have the scope to do innovative things in rural, urban and mixed areas. We could look at the full range of services that could be provided from one-stop shops, for example, which would provide exciting opportunities for our communities.

You are right—the job is big. That is because we are at an early stage in the process, and we need detailed discussion at every level to ensure that our governors, who make the decisions on investment, know exactly what they are dealing with. Right now it is too early for that, but that is why groups are being established and why we are giving evidence.

Carolyn Leckie: I have one specific question—

The Convener: Can the NHS Confederation answer the question as well?

Susan Aitken: I concur with Alan McKeown. On trade union involvement, the NHS in Scotland operates on a partnership basis. Without question, the Scottish partnership forum and all the local partnership forums on the staff side and NHS board side will be involved in any discussion about this major development. That goes without saying. It also goes without saying that the staff protocol that will be adopted for joint ventures will be the one that was adopted for PFI. It had not occurred to us that that would not continue. The protocol has been adopted and is accepted across the NHS, so I do not see that being an issue.

I see nothing sinister in there being exciting opportunities for doing even more between the NHS and local authorities. Much potential and enthusiasm exists and there are many ideas out there about partnership working, which we have started in Scotland. The joint future initiative is one element of that and community health partnerships will be another. In some ways, many of the issues are not new. As Alan McKeown said, we are addressing differentials in pay and conditions. That matter has not been resolved, but people know about it. That aspect of the process will continue for joint ventures.

Apart from that, everything is up for discussion, as Alan McKeown said. The bill is certainly not premature; without it, nothing can be considered, because the NHS does not have the power. Local authorities already have the power, but we cannot consider extending partnerships under the proposed model without the bill. The bill is enabling and will compel nobody to participate in joint ventures—for example, it does not assume that all NHS boards will enter into joint ventures. However, without the bill, there would not be much point in discussing the other details, because the NHS would be unable to participate in such projects.

The Convener: Does Carolyn Leckie still have a specific question?

Carolyn Leckie: My question is very specific. Concern was expressed in the consultation report that E C Harris presented to us about the need to achieve critical mass for any projects that people become involved in. A question arises about the antagonism between achieving critical mass and providing rural services, for example. Have you examined that? Do you have concerns? What do you expect to happen? Are rural services in danger?

Susan Aitken: We have not examined that specifically, but my response to the question whether rural services will be in danger is no, because the aim is to provide new services. Existing services are unlikely to be withdrawn—"downgraded" is the common term these days—as a result of such an initiative. In fact, they will be extended and enhanced. If NHS boards enter into joint ventures, they will do so to enhance and develop existing services and to build on what exists.

The Convener: You said that the bill was enabling legislation, and Carolyn Leckie was right to refer to it as all being quite vague. If the bill is passed this year, what is a ballpark figure for when you expect a brick to be laid?

Tim Huntingford: The joint premises project board that I co-chair with a health service chief executive has considered the tension between critical mass and local determination, which needs to be worked through. The evidence suggests that the timescales for developing LIFT schemes in England are reducing. The previous panel said that the first scheme took 18 months to develop, but we are receiving evidence that that period can be reduced to a bit over a year. If the bill were to be passed, the detailed guidance issued and LIFT models adopted, work would probably begin a bit over a year after that.

The Convener: We could be talking about 2007.

Tim Huntingford: Yes.

The Convener: Nanette Milne is interested in what is happening south of the border.

Mrs Milne: Have you noted from schemes south of the border any good or bad examples for what we will do up here?

The Convener: I think that we have asked about that.

Mrs Milne: I suppose that we have.

Susan Aitken: I do not know much about the LIFT projects that have been completed in England, but I know that some of them are expected to make significant contributions to community regeneration by bringing not only services, but new and often well designed user-friendly state-of-the-art buildings into communities that have had no such services before. There seems to be a lot of enthusiasm for that, and I see no reason why we should not seek to emulate that kind of result.

17:15

Tim Huntingford: The partnership needs to be genuine. One of the concerns in Scotland has been that a driving force behind the initiative is the problems that we have in our urban areas, such as Glasgow. Nobody has mentioned it yet, but dentists' premises are a major problem in Glasgow, because most of them are up a close in tenement buildings.

The Convener: At least Glasgow has dentists.

Tim Huntingford: Yes. Trying to deal with the problem of single-practitioner GPs has been a driving force for the Health Department. From a local authority perspective, we are much more interested in regenerative activities that will bring services together, such as the kind of things that you heard described as happening in St Helens. I am talking about not only local authority social work services, but environmental health, leisure services and other local authority services. We must free up our thinking about what the initiative could deliver, rather than thinking that it is mainly about trying to overcome the backlog of inappropriate primary care premises.

The Convener: I will make an observation about something that puzzles me and on which you might wish to comment. The provisions on joint ventures are obviously significant for COSLA and the Scottish NHS Confederation, but in your evidence so far, you have said repeatedly that you do not know much about what is going on down south. That surprises me. Why do you not know much about it? If that is where some of our evidence should come from, why do you not know more about what is happening there?

Susan Aitken: We know what is happening in that we know about the kind of projects that are being developed—the examples about which your previous witnesses spoke and we have just spoken—and the impact that they can have on community regeneration, for example, but we do not know about the long-term financial impact because there has not yet been a long term. In addition, we are wary of assuming that the LIFT model could be transferred wholesale. It shows potential and is an example of what could be achieved, but there is no assumption that LIFT as it operates in England will be the model that we use in Scotland.

Alan McKeown: In our written submission, we said that a number of issues have been internalised in the NHS system and that external partners have been brought in late in the process if at all. Joint ventures are coming in only at the bill stage, in the same way that the CHPs came in late, and we are playing catch up. Tim Huntingford has been the chair of the joint premises project board only in the past two months; I am now joining the board and we are seeking additional representatives for it. There must be an earlier process and, as Tim Huntingford said, the partnership needs to be genuine. We are concerned that we will be brought into the process late, as has been our experience, and that we will not feel that the partnership is genuine.

The Convener: So you have concerns about that.

Alan McKeown: Yes. We are concerned about late involvement. We accept some responsibility, as we could have done a bit more, but there has been no political engagement at this stage, just as there was limited engagement on the CHP debate. If joint ventures are to be truly successful, that political engagement must happen quickly and openly. An area-by-area strategic approach is fine, but if critical mass is a key issue and we are to have regional boards around Scotland, that is a different ball-game and we need to have an honest discussion about it if it is going to work. We need to get it on the table and discuss the issues that come with it.

The Convener: Are you saying that you have not yet discussed those issues with Government?

Tim Huntingford: There has been some discussion. There has been a very steep learning curve for me, because I have been involved with the joint premises project board only for the past couple of weeks. If I had been asked to give evidence to the committee in three weeks' time, I would by then have been to England to see LIFT schemes for myself. It was interesting that when the Deputy Minister for Health and Community Care spoke to COSLA leaders about a month ago, primarily about the bill, 99.9 per cent of the discussion was about smoking issues—that was unsurprising—and only fleeting reference was made to the joint ventures provisions. However, those provisions are important for local politicians. We have not yet done enough to alert local politicians to the matter, but the Executive has not done enough, either.

The Convener: The timing of this meeting is not particularly good, given that you have not yet visited the schemes in England. However, if you have observations to make after your visits, please put them in writing to us, if you have the time to do so.

Shona Robison: Would it have been more appropriate for the provisions on joint ventures to have stood alone, rather than be included in a bill that addresses other matters that will dominate discussions? The danger of tagging the provisions on joint ventures on to the bill is that important issues could get lost among other elements of the bill.

Tim Huntingford: That is a fair comment. I do not like the fact that the provisions are included in a health bill that is promoted by the Health Department and discussed in the Health Committee. Where is local government in all that? The proposals should have been sponsored jointly and should not have been tagged on to the bill. I understand why that happened: there was a wish to get on with things. However, the experience of the discussion at the COSLA leaders' meeting was typical; a vast majority of people do not know that the bill contains the important element that we are discussing.

Hilary Robertson: I will make a brief point. The bill would give powers to the health service that it does not already have, whereas local government already has those powers.

Janis Hughes: The E C Harris consultation concluded that

"There is a concern that Community Planning Partnerships could create tensions as they have limited involvement and experience of the planning process for creating physical assets."

What are COSLA's views on that and, specifically, on how the community planning process can work with the LIFT model?

Tim Huntingford: The experience of working together is growing and I do not agree that it would be inappropriate for community planning partnerships to consider planning. Community planning partnerships represent the table around which all the agencies can gather and they can facilitate more imaginative buy-in, not only from local authorities and the health service but from many partners. For example, the police might be obvious partners in certain locations.

There is an issue about the size of planning units in relation to developments such as those about which we are talking; that creates another tension. In many ways, community planning partnerships represent the right model and the right forum, but whether CPPs in fairly small local authority areas are the right size in relation to the—dare I say it—critical-mass element of LIFT-type initiatives, is another matter. For example, in my area—West Dunbartonshire—the partnership is split between Greater Glasgow NHS Board and Argyll and Clyde NHS Board, both of which cover other vast territories, so there are questions about whether the community planning partnership would be the right size in relation to the planning considerations of the boards.

Janis Hughes: I expressed concerns to the previous witnesses about the consideration that would be given to strategic planning in the LIFT model. The fact that the local authority that you represent covers an area that is spanned by two health boards means that there would be a greater need for strategic planning, which might perhaps be worked into the process. Could that be beneficial in the longer term?

Tim Huntingford: Strategic planning is very important, but we have not had a great deal of strategic planning to date. A critical part of the joint premises project board's role in considering proposals will be to consider how the different areas—whatever areas are determined—can be involved in joint asset-management planning to meet current and future needs. That needs to happen in a way that has not happened previously.

The Convener: We have five minutes left before the current panel of witnesses must leave. Jean Turner has a final question.

Dr Turner: Are there any concerns about the possible loss of flexibility that might arise if joint ventures for new health centres involve increased numbers of partners such as schools, libraries, optometrists or any private organisations that one might care to name? I worked in a health centre that became too small within eight years of being built, so I know that things can change within the health service and that, like schools, health centres can be required to do different things. Might we lose flexibility by being joined to other partners in what might be a long-term contract with payments?

Susan Aitken: Although independent primary care practitioners could be partners in such ventures, they would not have to be partners because they could lease the premises from the NHS board or from the other partners. In fact, such an arrangement could give more flexibility not only to practitioners—such as GPs, dentists, podiatrists and optometrists—but to the NHS board.

That is where planning comes in. As I said earlier, NHS boards will use such projects to fill identified gaps in services by, for example, providing services where none currently exists, or by improving inadequate and inaccessible services and addressing other problems. In identifying needs and gaps, the planning process would very much inform the design of premises and facilities. The aim would be that, at the design stage, flexibility would be built in for future health care needs so that independent practitioners and other services could still be brought in. All the partners in the venture would be involved in that process.

There are other potential benefits for practitioners. In deprived urban areas and in remote rural areas that are currently experiencing a shortage of dentists, one disincentive that practitioners face is that, if there are no premises currently available, they may need to make a big investment by entering a long-term lease for premises or by purchasing new premises. Joint venture arrangements could provide flexibility for such practitioners by allowing them to lease facilities for shorter periods without their having to commit to long-term investment. For example, in parts of the Highlands that currently have no dental premises, the dentist might otherwise need to build new premises. Some practitioners have found themselves in that position.

Hilary Robertson: The principle behind the proposal is about long-term partnerships. Our expectation is that partnerships will grow and develop. From day one, they will be flexible partnerships rather than the static arrangements that were perhaps first conceived.

The Convener: We will hear no more questions because we are running out of time.

I want to make a point about mobile phones in the committee room. Regardless of whether they are set on mute or vibrate, mobile phones still interfere with the sound system. Members' phones have been going off for about the past half an hour. Please switch them off rather than simply to mute. Kate Maclean is attempting to look innocent, but it is not working.

Kate Maclean: I have just switched it off.

The Convener: It is not working. Shona Robison was also one of the guilty parties.

Kate Maclean: Bad Dundee girls.

The Convener: Yes—clearly it is an issue with Dundee.

I thank the witnesses for coming along. As I said, if you would like to make any follow-up

comments in writing, please do so, and they will be circulated to all members.

17:30

I welcome the third panel, which is John Park, assistant secretary of the Scottish Trades Union Congress, and Dave Watson, who is head of policy information for Unison Scotland. I will not ask either of you to make brief introductory statements; my experience thus far has been that such statements have not been brief. You can take it as read that we have seen your evidence. I hope that you have heard from the questions that we have asked that we have taken on board a number of the points that were raised in your evidence. We will go straight to questions. We have been beginning with Shona Robison on cost increases and risk, so we will stick with that.

Shona Robison: You have heard the responses to questions, in particular the response from the private companies on where they see risk and cost increases. Will you respond to what you heard? Have you been reassured that joint venture companies will not carry the same risk or have the same problems that were associated with PFI schemes?

Dave Watson (Unison): You will not be surprised to hear us say that the answer, to be frank, is that we have not been so reassured. The essence of a LIFT scheme is the same as that of a PFI scheme. The economics are no different and the problems are the same. They are driven by the same desire to get expenditure off the balance sheet—what we describe as Enron economics—which is a particular problem for Scotland because of the way the block grant is calculated. The risks still exist.

A number of colleagues have spotted the phrase "critical mass" being used. It means that the banks like to finance big deals—ideally, nothing less than £50 million. They will finance smaller schemes under LIFT, but "critical mass" means that local priorities become distorted, because to achieve critical mass with a number of small health centres, it is necessary to group together a range of schemes. It may be that a health board has five schemes that are fairly high on its list of capital priorities but, with LIFT, the banks and the companies—you will have gathered that the process is very much market driven—can say, "Oh no, we need nine or 10 schemes." Therefore, the critical mass overrides the local priorities for capital expenditure.

The value-for-money analysis that is allegedly used in PFI schemes is exactly the same as that which is used in LIFT schemes. We all know from vast experience of a range of PFI schemes how those value-for-money exercises have been skewed. The reality is that the additional costs of PFI will simply be replicated in LIFT schemes.

Shona Robison: The NHS Confederation mentioned dental practitioners leasing back premises that a health board private partnership built in the first place. Do you view that in the same way as other potential service developments, or is it more acceptable to Unison?

Dave Watson: No it is not. A LIFT scheme is still a 20-year contract. Somebody must at the end of the day pick up the bill and guarantee the financing. Whatever happens, the public sector picks up the bill—we have seen that time and again. Every scheme has a clause that is usually buried in the annex that states that if the whole scheme goes pear shaped the public sector will pick up the bill. The only guarantee in PFI is that the bankers always get their money.

Kate Maclean: I will ask the same question about jobs as I asked the previous two panels. The first panel does not perceive any difficulty regarding loss of jobs or a two-tier workforce. COSLA, however, acknowledged the difficulties that can arise when trying to operate two sets of terms and conditions in one workplace. Can you expand on the fears that you have in respect of jobs and workforces when efforts are made to harmonise conditions in one set of premises?

Dave Watson: We raised the question of the STUC-Scottish Executive PPP staffing protocol in our response to the initial consultation on LIFT and joint ventures. It is interesting that in none of the Executive responses and summaries has anybody yet confirmed that the protocol would apply to LIFT schemes and similar joint ventures. Our view, having considered the Treasury definition of a PPP scheme, is that it clearly would. I have to say that I am somewhat surprised—and perhaps slightly suspicious—that the Executive has not confirmed that. Clearly, it is very important because the protocol deals with two-tier workforces and with pensions issues. That is a subtle hint to the committee that it should ask a question of the minister.

The comparison with England is difficult. I have the same problems as previous witnesses; to be frank, there are no real LIFT schemes in England—there are only a lot of financial schemes that have been developed on paper.

There are also some differences in Scotland, which leads us to be concerned that more staff might be affected in Scotland. There are more health centres in Scotland, particularly in the major cities, whereas there are more private GP practices down south. Health centres are traditionally health board premises that have health board staff—both soft FM and hard FM, to use the PFI jargon. The other difference between

Scotland and England is that there is far more direct staff provision in Scotland in local authorities and in health boards, whereas in England there has been far more use of contractors. Those differences lead us to be concerned that there might be more staffing problems in Scotland.

Carolyn Leckie: I referred earlier to a comment in the E C Harris report. It states:

"It was believed that as a result LIFT in Scotland will be even more flexible with more exciting outputs."

That is in respect of the relationship with local authorities. I did not get an answer to my question about what "more exciting outputs" means, but it tends to suggest more extraction of profit. Does that relate to your concerns about terms and conditions?

Dave Watson: Many of the reports are littered with management speak. Phrases such as "flexible certainty", "purchase provider" and "how schemes might evolve" lead us to be concerned that there are risks. We would expect a rate of return of about 8 or 9 per cent on a normal premises contract that was developed by the NHS. That is typical if a contractor is brought in to build new GP premises. There are no clear figures yet for LIFT. It was previously indicated that the rate of return might be as high as 13 per cent, which is clearly much higher. Our understanding is that PFI schemes can have a rate of return of between 15 and 20 per cent. In other words, the rate of return on private finance deals is almost double that of conventional procurement, so it is clear that profit is an issue.

Unison has published documents—unlike commercial contracts, ours are all published on the website so that people can see them and read the analysis—that members can read and see that we have done a lot of work on refinancing and the costs that are involved in the secondary markets, where people effectively sell on their equity share in some schemes. There have been significant profits made. You do not have to take our word for that; the Public Accounts Committee at Westminster has produced many reports on the matter. There is scope to make additional profits and it is not difficult to do so. A typical PFI scheme might have a Standard & Poor's rating of BBB, whereas public authorities work on an AAA rating. It simply costs more to borrow money in the private sector than it does in the public sector. The profit is added, which leads to the additional cost of borrowing. That is not terribly clever economics but it is self evident. We will pay more through the LIFT arrangement.

Carolyn Leckie: What is Unison's position on Shona Robison's point that the matter is so important that it should be in stand-alone legislation? Are your concerns so fundamental, as mine are, that they undermine your support for the smoking ban?

Dave Watson: As you know, the provision was originally to be included in the forthcoming health service (miscellaneous provisions) bill. We were concerned that as soon as the smoking ban was included, other aspects would not get attention. In fairness to the committee, it is clear that you have identified and examined the various provisions.

To be honest, our position is to ask why have the lessons of PFI schemes to date not been learned. What more do we need to know? Do we need more Skye bridges, more Inverness airports, more Edinburgh royal infirmaries and more filthy sewage works? It is bizarre that the schools in East Lothian were cited earlier as an example; they were a shambles for at least nine months when Ballast Wiltshier Investments went bust. I point out that Ballast Wiltshier was consulted by the Scottish Executive on LIFT projects; I presume that the Executive thought that the company had something to offer the consultation. We have plenty of experience of PFI arrangements; we do not need much more. It seems to be pointless to go through what is a hugely expensive process, given all the people who are involved and the joint boards. Millions of pounds will undoubtedly be spent on consultants' fees simply to dress up the failures of PFI under the new name of LIFT.

Carolyn Leckie: Will the inclusion of the matter in the bill compromise your support for the smoking ban?

Dave Watson: Absolutely not. Our position on the smoking ban is clear; I will be back here next week to tell you that.

The Convener: I will ask you a slightly different question. Is the issue of sufficient concern for you to argue that we should vote against the bill as a whole? The problem is that it contains provisions for free eye and dental checks, the smoking ban and other things. Do you consider the matter sufficiently important that your advice is that we should reject the bill? I would like to hear John Park's views on that as well.

Dave Watson: I am not in a position to say that at this stage. We hope that the joint ventures provisions will be amended out. If not, we will have to take a view of the longer term. It is clear that some parts of the bill are important—we have campaigned for a smoking ban in enclosed places for a long time and we supported the earlier member's bill on the subject. We would be reluctant to argue that the bill should be voted down, but we hope that MSPs will amend it so that the particularly pointless part on joint ventures is not included at the final stage.

John Park (Scottish Trades Union Congress): Our position on smoking is slightly broader

because we take into consideration the various positions of the affiliates of the STUC.

The Convener: I understand that.

John Park: We agree in principle with the proposed ban but, as the committee will hear next week, there are slight differences between the positions of our affiliates. We go through an internal consultation process to reach a final position. Sometimes we reach a position that is clear and sometimes we do not. There would have to be more internal discussions about where we stand and whether we feel strongly enough, given our slightly different position on smoking, to support the bill.

The Convener: We should watch this space.

John Park: Absolutely.

The Convener: Does Nanette Milne want to ask any questions about the position south of the border?

Mrs Milne: No, not at this stage.

Dr Turner: I have a question for John Park. You said that you are afraid of privatisation, but will you elaborate on that?

John Park: Do you want my personal opinion or the STUC's position on that?

Dr Turner: Both.

John Park: The STUC has a fundamental position, which will remain in place for ever and a day, I imagine. We believe in public services that are publicly funded and underpinned by fair employment practices, and all the good things that go along with that. The committee should understand that, where policy differences exist, we seek to work with the Executive and politicians. We have a PPP staffing protocol and we are prepared to work through matters. We are certainly not against partnership. We find attractive the idea in the E C Harris report that some partnerships might be public-public only. Private sector expertise is not necessarily required to make partnerships work—they can be driven not by profit, but by the desire to deliver excellent services.

17:45

The Convener: The STUC evidence expresses concern about accountability and about conflicts of interest, which might arise in relation to membership of boards and so on. I asked earlier witnesses about that. Are you aware of specific examples from south of the border in which accountability and conflicts of interest have been an issue, or do you just anticipate that the issue will arise?

John Park: Our concern is twofold. We anticipate that conflicts of interest might occur because people will be put into the lions' den—into situations that they have not been in before and with people who have been in the private sector for a number of years who have been involved in PFI and PPP schemes. There might also be a conflict of interests in working up of bids. If two or more private sector employers are involved, negotiation will take place between the private sector employers as well as with the public sector partners. We must bear it in mind that, if the scheme comes to fruition, issues might arise in the working up of proposals, not only when they are running.

Dave Watson: Members will be aware that, under the companies acts, directors have a fiduciary duty to all shareholders. It is conceivable that problems could occur. In our experience down south, the problems so far have been with letting retail units in some of the early schemes. With a 20-year project, an issue could arise in respect of what should be done if a conflict arises between providing a health-related lease for a new dentist or some other useful health function and a more commercially viable option. I am not saying that there might be tobacconists in health centres, but a clear conflict of interests might arise if somebody offers to pay a much higher rent than a doctor, dentist or some other health-related function. We should remember that the directors will have a fiduciary duty to all shareholders and that the schemes will be weighted 60:40 in favour of the private sector.

Janis Hughes: I declare an interest: I am a member of Unison.

I have concerns about how the LIFT model fits into community planning. Do you have any comments on the strategic planning aspect and about how cognisance can be taken of the NHS's strategic planning needs?

Dave Watson: Page 6 of the E C Harris report mentions tensions with community planning partnerships. In fairness to the people who attended the seminar—75 per cent of whom were from the private sector—I suspect that by "tensions" they meant lots of awkward local people asking awkward questions. To be frank, that is usually what big private companies say about the planning process, so I suspect that that is the difficulty.

Community planning partnerships are important, particularly in Scotland. The partnerships in Scotland are not replicated in England; England works with more market-oriented public service provision. In Scotland, we have tried to build co-operation throughout the public sector, which is the strength of our community planning process. It is still early days, but our process does not fit the

commercial relationships that have been developed in England as part of the LIFT process. Fundamental questions need to be asked about how commercial designs can be matched with the broader planning arrangements that we are trying to develop in public authorities in Scotland.

The Convener: I ask Carolyn Leckie whether she has any other questions.

Carolyn Leckie: I do not, because the elaborate evidence that has just been presented makes an overwhelming case that contrasts sharply with the evidence that we heard earlier. I ask the witnesses to round up their comments.

The Convener: Carolyn, will you concede that I am the convener of the committee? Before I ask anybody to round up their comments, do other committee members have any further points that they wish to make or questions that they wish to ask?

Members: No.

The Convener: Is there anything that we should have cognisance of that we have not asked you or previous witnesses about?

Dave Watson: There are a few matters that you might wish to consider asking witnesses about at some later stage. One of those is land development, which has been hinted at in some of the documents. In our experience of the work in England, the attractiveness of some schemes has been very much dependent on the ability to develop land for housing, for example, as an earlier witness said. You might examine closely how the schemes sell off health board property to create attractive development opportunities for the private sector.

Another matter that you might want to consider is how LIFT schemes are unlike PFI schemes in Scotland, although they are not always unlike PFI schemes in England. With PFI schemes in Scotland, we have learned the lessons; the property is often handed back to the health board at the end of the scheme. It is perhaps not quite such good value as you might think, but that is what often happens. With LIFT schemes, the property stays with the private company so that, at the end of 20 years, the local partners are not left in a very strong bargaining position. A health centre might have GP surgeries and other facilities in it—social work, for example, could be in there, and we are very keen on having one-stop shops with police and other facilities—but will be in the hands of a private company. That company will have everyone over a barrel unless there is another health centre, police station and everything else just down the road that is ready for them to move into. As a trade union official, I am well versed in bargaining positions; I would not want to be in such a bargaining position at the end of the 20 years.

There are other matters that you might want to ask questions on. I might have missed it, but I cannot see a definition of the word "services" anywhere in the bill. The word "facilities" is defined, but not "services". At one seminar that my colleagues attended, a Department of Health official was quoted as saying that they saw no reason, in principle, why clinical services should not be included in the schemes. I noticed that that possibility was also floated in the Harris report or one of the other reports. In England, a number of big American corporations have been keen to get into primary care by employing large numbers of GPs, for example. If the scope of a scheme is wide enough, there is the possibility that companies will move beyond facilities and into clinical services on that basis. That would be of concern to us.

The other issue that is not mentioned anywhere in the bill is whether the Executive proposes to offer subsidies in the form of either direct subsidies for schemes or subsidies relating to development money or pump-priming cash. There is no mention of that in the documents that I have seen. Our experience elsewhere is that, suddenly, large sums of money—in effect, subsidies—are made available to the various PFI units in the Scottish Executive to promote development of schemes. That money has to come from somewhere. If it goes to management consultants, lawyers and so on to pay for developing a new type of scheme, it does not go to the NHS capital budget to develop schemes in the normal way. In essence, we are saying that conventional borrowing is cheaper and therefore worth considering.

The simple quick way to develop schemes is obviously to allow local authorities to use their prudential borrowing powers to develop the facilities using conventional borrowing. Health boards do not have that power. It is a complex area of health service finance, but it may be worth considering whether health boards could be given similar prudential borrowing powers. The problem with the local authority powers is that the Executive provides subsidy only if they go down the PFI route, which is where the schools problem has arisen. In our view, if prudential borrowing is to work, it has to work on the basis of there being a level playing field for both types of financing.

Those are the main points that have not been covered. As always, we will not be slow in writing to you if anything has been missed out or if anything develops.

The Convener: Okay. As with previous witnesses, if there are things that you wish to draw to our attention before the end of the process, feel

free to do so. Thank you very much—you are now free to go.

That ends today's business in public, so I ask members of the public to leave the committee room.

17:54

Meeting continued in private until 18:09.

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