HEALTH COMMITTEE

Tuesday 22 March 2005

Session 2

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HEALTH COMMITTEE
9th 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)
Mary Scanlon (Highlands and Islands) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Stewart Maxwell (West of Scotland) (SNP)

THE FOLLOWING GAVE EVIDENCE:

Mike Baxter (Scottish Executive Health Department)
Sarah Davidson (Scottish Executive Health Department)
Shaun Eales (Scottish Executive Health Department)
Linda Gregson (Scottish Executive Health Department)
Mr Andy Kerr (Minister for Health and Community Care)
Steve Lindsay (Scottish Executive Legal and Parliamentary Services)
Joe Logan (Scottish Executive Health Department)
Dr Hamish Wilson (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 22 March 2005

[THE CONVENER *opened the meeting at 14:02*]

Items in Private

The Convener (Roseanna Cunningham): I welcome everyone to the meeting. Item 1 on the agenda is to consider taking items 7 and 8 in private for reasons that are now well known to the committee. Item 7 is a discussion of evidence received today and will therefore be part of our drafting of the stage 1 report on the Smoking, Health and Social Care (Scotland) Bill. Item 8 is a preliminary discussion of options for the committee's work programme. Does the committee agree that those two items be taken in private?

Members *indicated agreement*.

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

14:03

The Convener: Item 2 is consideration of the Smoking, Health and Social Care (Scotland) Bill. I welcome to the committee the Minister for Health and Community Care. Members have received copies of the committee papers, which include submissions from the minister in letters dated 31 January, 16 March and 18 March, draft regulations that were circulated for last week's meeting and the Finance Committee's report. The Subordinate Legislation Committee's report will be available after the Easter recess. We will go through the various parts of the bill in turn. It is inescapable that this will be a long evidence session, although it will perhaps be more gruelling for the minister than for any member of the committee. I understand that the minister will be accompanied by different officials depending on which parts of the bill we are discussing. We will try to allow space for folk to move about when discussion on the part with which they are dealing is over.

Part 1 of the bill is on the prohibition of smoking in certain wholly enclosed spaces. For this part of the bill the minister is accompanied by Roderick Duncan, bill team leader, tobacco control division; Sarah Davidson, head of tobacco control division; and Joanna Keating, solicitor in the office of the solicitor to the Scottish Executive. I ask members of the committee to indicate questions that they want to ask about this part of the bill. Sorry, I am being hissed at that the minister will make a brief introductory statement. Sorry, minister.

The Minister for Health and Community Care (Mr Andy Kerr): Thank you. You can rest assured that my statement will be brief. It is good to be back before the committee and to have the opportunity to explain more of what the bill is about.

As you know, the bill is wide-ranging, so there will be occasional reshuffles at this end of the table of the officials who are here to support me. The bill is an important health measure and one that I think will deliver a significant change in the health of the Scottish people.

The bill has three main purposes. The first is the restriction of smoking by prohibiting smoking in certain enclosed places. The second relates to the provision of services by the national health service and, in particular, continuing the NHS modernisation programme. Within that broad area, the bill contains provisions for dental, ophthalmic and community pharmacy services as well as measures relating to discipline and measures that aim to impact on the operation of the NHS—for

example, to allow the NHS to participate in joint ventures to support the delivery of facilities and services. The third area comes under the theme of social care, and the bill incorporates a small number of provisions including amendments to the Regulation of Care (Scotland) Act 2001.

As we are all aware, the keynote provision of the bill is that which relates to smoke-free public places. I have said before that I consider the bill to be the most important piece of public health legislation in a generation. The decision to legislate on smoking was not taken lightly, but we believe that it is the right thing for Scotland.

First and foremost, as we are improving the health of the people of Scotland, we can no longer tolerate Scotland's reputation as the sick man—or, indeed, sick woman—of Europe. Action on tackling smoking will, undoubtedly, help us to improve our health record. The supporting papers that we have submitted highlight the health risks that are associated with passive smoking. Those risks are now clear and irrefutable, as is the potential health gain from reduced exposure to environmental tobacco smoke and smoking itself. I have monitored the work of the committee and I am pleased that the committee accepts that the health risks exist. I hope that you will be equally convinced of the potential health benefits that the bill will bring. As are other aspects of the bill, the smoking provisions are firmly embedded in health and, as such, lie clearly within the competence of the Scottish Parliament.

Although I am convinced of the benefits that will flow from a smoking ban, I am aware of the fears of business interests, particularly the licensed trade, of the possible adverse impact of the bill. I understand those fears but, as is clear in the regulatory impact assessment that accompanies the regulations, they are not borne out by international evidence and experience. Overall, as you are aware, we expect the bill to have a nil or a positive economic impact. I am also working with businesses, through the smoke-free areas implementation group, to involve them in the process of delivering the policy in terms of how we will make the bill work if it is passed by the Parliament in due course. We cannot allow one area of business to dictate the health of the nation; hence, we want to ensure that the bill is comprehensive in its scope and properly enforced.

We have driven for a bill that can be clearly understood and that will be simple to enforce. There are those who have questioned whether the comprehensive nature of the bill is compatible with individuals' rights and freedom to choose, and the issue of the European convention on human rights has been raised. However, as I have said in the past, just as smokers have rights, so non-smokers have a right to clean air.

Although, as the Minister for Health and Community Care, I would prefer people not to smoke for their own sake, nothing in the bill impinges on their right to do so. Nevertheless, it is clear that we want to provide the 70 per cent of Scots who do not smoke with a proper environment in which to partake of life, whether socially, through the workforce, through recreation or in any other way. We feel that the imposition of a comprehensive ban is the best way to protect the public's health; therefore, the draft regulations propose very few exemptions from the ban and for humanitarian reasons only.

The bill is an important step forward for the health of Scotland. I look forward to our discussion this afternoon and commend the bill to the committee.

The Convener: Thank you, minister. I welcome Stewart Maxwell MSP to the meeting.

Kate Maclean (Dundee West) (Lab): I have a question on the final point that you covered: exemptions. In a controversial bill, exemptions will probably be the most hotly disputed issue, once the principles have been agreed. What criteria were used when the list of premises that will be exempt from the smoking ban was compiled?

Mr Kerr: The approach was largely humanitarian and involved common sense, in my view. Residential homes are where people live and have their home. We felt that, as long as there was a smoking policy in such places, people would have the right to smoke where it was deemed to be their home, just as others in the community have that right. That applies to adult care homes, but not to children's homes.

Adult hospices are on the list of exempt premises for obvious humanitarian reasons. Psychiatric hospitals and units are included on the list because clinicians and others told us that that would be appropriate, if individuals' overall mental health and well-being were to be looked after. There were obvious humanitarian and other reasons for that exemption. An exemption was sought for police rooms because it has the potential to help the police with investigations and interrogations.

The ban is not so comprehensive when it comes to hotel bedrooms. Although all public areas within hotels will be smoke free, it is felt that if an hotelier opts to have smoking rooms within an hotel, an exemption would be appropriate in those circumstances, because those rooms would be clients' homes for the night or nights for which they stayed at the hotel.

I argue that there is clarity with the vast majority of public enclosed spaces. That will allow us to legislate effectively and to monitor and control smokers in those environments.

Kate Maclean: Hotel rooms will be treated flexibly on the ground that they are people's homes for the evening, but one could argue that if an adult cannot stay in their house on their own and must attend a day care centre, that centre is their daytime home for five days a week. Why have the same humanitarian criteria that have been applied to adult residential homes, or other places that could be deemed to be people's homes while they are staying there, not been applied to adult day care centres?

Mr Kerr: The reason for that is that adult day care centres are not the homes of the adults who attend them. I would argue that it is quite unusual for someone to attend such a centre five days a week, although that does happen, but regardless of how long they spend there, it is a place that they visit only temporarily; they still have their own home, in which they can smoke.

Kate Maclean: Does the same logic not apply to hotel rooms?

Mr Kerr: No, because guests hire hotel rooms for entire evenings; indeed, they could be in their room 24 hours a day for seven or 14 days. The situation is different for people who attend day care centres. They might spend just the morning or half a day there; how long someone spends in a day care centre is very much down to their individual circumstances.

Our approach has been to say that we want a ban that is as comprehensive as possible. To enhance public health, we want to provide as few opportunities as possible for people to smoke in public places. To all intents and purposes, a care home is the home of its residents; the same is not true of a day care centre. That has been the key determinant in our approach.

The Convener: I want to follow that up. Will you monitor that? If you found that, in a year's time, the number of people who were accessing day care centres was dropping because of the ban, would you revisit the issue? Would you keep an eye on that aspect of the ban if you found that people were missing out on day care as a result of it?

Mr Kerr: If any good evidence came to us during the parliamentary process, I would consider such matters immediately. As I have said, I think that day care centres are different because they are not home environments. If we created an exception for day care facilities, which are not people's homes, my worry would be that that would create an opportunity for people to come in behind that with other definitions that would weaken the comprehensive nature of the ban. We are determined that the ban's scope should be as broad as possible.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I would like clarification on the position of children's homes. Given that it is legal to buy and use tobacco products at the age of 16, how would the ban affect a child of that age who was in a home? Would they be allowed to smoke in that environment, which is their home?

Mr Kerr: No. We have taken the view that the majority of children in such homes are under the age of 16. If people can bring us other evidence on that, we will consider it. Although it is legal for a 16-year-old to purchase tobacco products, we would consider a children's home to be an inappropriate environment in which to allow smoking, so we will not do so under the bill.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I have known people decline to go to a day care centre because they knew that other people would be smoking. Likewise, the opposite might happen and people might not go because they could not smoke there. We know that it is better not to smoke, but some people can get distressed, after they get over the first stage of an illness when they cannot have a cigarette. Smoking is an addiction and it is difficult to deal with an addiction in someone who is in their 70s or 80s. Do you have a step-down process that will operate in relation to frail and elderly people and those who go into hospital with lung conditions?

14:15

Mr Kerr: Our intention is to ensure that environments that are used by non-smokers are smoke free. A day care centre fits that bill and, further, is also a place of employment for people who we would want to protect.

Having spoken to a number of people who work in cessation services, I would say no to your second point. When people are in hospital and have had a big scare, making it easy for them to smoke by providing a smoking facility undermines our cessation efforts. People who buddy such patients—either voluntarily or through the provision of health care services—would be aghast if we were to make that concession. When people experience a health scare, that is the time to harness their willpower and support them in their efforts to stop smoking. That is what the cessation services do. Having visited Wishaw hospital, where the smoking cessation team work in the critical care parts of the hospital that deal with coronary heart disease and respiratory illness, I know that that period of a patient's recovery period is key and I think that we would fail them if we made it easy for them to smoke at that time.

Further, we have to send a message to the public about public health. We should recognise

what Greater Glasgow NHS Board has done to make all of its health environments non-smoking. That sends the right message.

Kate Maclean: I support the legislation, but I think that I would find it difficult to justify allowing someone to smoke in a hotel bedroom—a room in which they might be spending only one night, mostly asleep—and not allowing someone to smoke who is being picked up at 8 o'clock in the morning to go to an adult day care centre and is dropped off at 6 o'clock at night. I am not saying that people should be allowed to smoke in adult day care centres; I am saying that, if they are not, it makes it hard to justify allowing someone to smoke in a hotel bedroom, even though they are capable of walking out to the street to have a cigarette.

I welcome the fact that private clubs will not be exempt from the legislation. Have any private clubs made a plea for support to be put in place? Does the Executive intend to make available to private clubs any support that would not be available to public houses or other licensed premises?

Mr Kerr: I am unaware of any special pleading on behalf of private clubs. My officials might be able to say whether there has been any. I understand the point that you made in the first part of your question but, again, I would point out that our policy is about the provision of smoke-free areas for members of the public who do not smoke. A hotel room is not a public area; an adult day care centre is. That is one of the key differences that we are talking about.

The Convener: The question about private clubs arises from evidence that we took last week from a representative of the Royal British Legion in Scotland who indicated that many of its clubs' finances are marginal and that they are liable to close as a result of the proposal. I do not know whether that representation has been made directly to you.

Sarah Davidson (Scottish Executive Health Department): The Royal British Legion might have made representations at the time of the initial consultation exercise, but I am not aware of that. No such representations have been made to us in recent weeks, but we are aware of the concerns that were expressed to this committee.

The Convener: Right, but your approach would be—

Mr Kerr: Our approach remains the same. This is not an economic issue; it is a health issue. While I am sympathetic to the concerns of private clubs and seek to work with them in relation to how we can best implement the measures, the issue relates to public health, the number of deaths that are caused by smoking, the number of non-smokers in Scotland and their right to fresh air. I appreciate the point that you make. We will do everything that we can to assist with implementation. We can try to support clubs—for example, we could change their very nature with cessation services and other work—but I stick to the principle that we want to create as many smoke-free places as possible in Scotland and the bill is the best way to achieve that.

The Convener: The British Legion made the point that its rules and regulations do not allow it to apply money that it raises to the work that it would need to do on its premises. I wonder whether that issue, which was raised last week, needs to be resolved.

Mr Kerr: I am more than happy to look at that. We will make arrangements to get in touch with them.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): I move on to enforcement. One of the things that struck the committee when it went to Ireland was how the Irish bill has been successfully implemented and enforced. There is a non-confrontational approach to enforcement and the system is very much self-policing. Often, if a public health inspector finds that smoking is taking place in an establishment he will visit it the next day and the matter will be sorted out without a public confrontation.

During our evidence-taking session last week, some of us were more than slightly alarmed by the approach of the City of Edinburgh Council, as opposed to the approach of the police. The council seemed to take the view that the law is the law and that section 1, which creates the

"Offence of permitting others to smoke in no-smoking premises",

is of equal measure with section 2, which creates the

"Offence of smoking in no-smoking premises"

on an individual basis. The council gave the impression that there could be a situation, say on a Friday or Saturday night in Edinburgh, of officials going out and slapping fixed-penalty notices on individuals who were breaking the law. We wonder whether that would be counterproductive to the enforcement of the law. Surely the best approach is the non-confrontational one that has been adopted in Ireland.

Mr Kerr: I certainly hear your view that the handling of the matter is critical, and I share your view of the need for a sensible, non-confrontational approach and I give due credit to professionals in the field. That is how they should be working and I am sure that that is what will happen. As I am sure you discovered in Ireland, people are generally law-abiding. That is an

important point; we should not forget that people want to obey the law and that they will invariably do so.

How environmental health officers apply the legislation is important. I have spoken to the Royal Environmental Health Institute of Scotland more than once and what struck me was that very point about the need for a sensible approach. Through the smoke-free areas implementation group's work with the licensed trade we want to ensure that everyone knows their role, understands how we will enforce the provisions and can handle any situations that arise. As long as the person who manages a bar has done what they need to do in relation to the legislation, we will understand the efforts that they have made. We expect certain things of bar owners in ensuring that they meet their end of the smoke-free bargain: to put up signage, to manage their clientele as best they can, and to ensure that ashtrays are not provided. We want to ensure that we work sensibly with bar owners and their staff as well as with the public.

I support the view that implementation and enforcement should be sensible. If observations are made in the evening, particularly on a Friday or Saturday night, it should perhaps be the next day when environmental health officers visit the bar owner and say, "You need to get a grip on this." Professionals have appropriate ways in which to approach members of the public whom they encounter and I am sure that they will continue to act in that way in the future. That also applies to provisions in other pieces of legislation, such as fixed-penalty fines for parking offences and—dare I say it—the provisions in the dog-fouling legislation. In handling such situations, professionals aim to reduce confrontation and tension, and I am sure that the enforcement of this bill's provisions will be no different.

Mike Rumbles: I am delighted to hear that the Executive's view is the same as the committee's view. However, when we put our questions to the people who will enforce the legislation, their view seemed to be that there is no hierarchy of offences in sections 1 and 2 and that the offences that are created in those sections will give them the authority to go out on a Friday or Saturday night and issue fixed-penalty notices. Can the sensible enforcement method that you have described be achieved by issuing guidance to local authorities, or should section 2 be amended? Should the bill be changed or should a direction or advice to local authorities be sufficient?

Mr Kerr: First, I will raise the subject at the next meeting of the smoke-free areas implementation group, so that we have an agreed commonsense approach on the right way to proceed. Guidance would be appropriate. I see no reason to change the bill. However, as I said in response to previous questions, if we find evidence that leads us to conclude that we need to amend the bill, we will do so, although I do not think that that is the case in this instance. We might come back to the issue at a later stage, following discussions with REHIS and others on implementation. However, I am sure that the approach that we have identified with REHIS is the best one, therefore I hope that we will simply produce guidance, rather than amend the bill.

The Convener: Our concerns arise out of last week's evidence, because what we heard from the City of Edinburgh Council was distinctly different.

Mr Kerr: I heard about that.

The Convener: There was general concern that if that one approach was pursued throughout Scotland, we would be in a different kettle of fish to that which we envisaged.

Mr McNeil: We saw at first hand in Ireland the positive implementation of the law and the high level of compliance with it. You mentioned that we have to send a clear message. Our observation as a committee was that a broad-brush approach was taken in Ireland. Will the integrity or enforcement of the bill be harmed by the contradictions that will arise, given the lax enforcement of the law against the underage purchasing of cigarettes, and the openly illegal sale of tobacco products that can be witnessed at any market week in, week out? People also smoke in and around schools and nurseries—as they drop kids off in the morning—and in and around NHS premises. At the same time, we are embarking on legislation that will take action against people for smoking in public places. I worry about that contradiction, and whether it will affect compliance and enforcement. What influence or powers can you bring to bear to address those issues with other ministers, directly or indirectly, even in the short term during the progress of the bill?

Mr Kerr: The package is bigger than the bill that we are discussing today. For example, our considerable additional investment in cessation services will go a long way towards supporting smokers. We are not out to get the smoker, we are out to help the smoker get off tobacco. That is why we have substantially increased those resources. In terms of the health service, we are getting cuter about smoking cessation teams and the work that they do, by intervening at the right point in people's lives, giving them long-term support, and providing the different tools to help them to quit cigarettes.

There is a balance to be struck. There is also a balance to be struck around the Executive's media work, in terms of health education. Our "smoke snakes" adverts, the message that we are trying to get across particularly to young girls, and the work

that we are doing to denormalise smoking, are all part of that package. Also raised was the enforcement of current legislation—which I am happy to consider with other ministers—and our powers on the age at which people can buy cigarettes. It is a balanced package, and I argue that we have it in hand at the moment.

The bill is not all about the ban; we are trying to achieve a balance of measures. We are trying to convince young people that to embark on smoking is not the right thing to do. We are also assisting smokers to give up smoking through cessation measures and denormalising cigarette smoking through the work that we are doing in the media. However, if other legislation is to be introduced—such as the Lord Advocate signing off the use of test-purchasing—it can all become part of the package. I accept that there are other things that we can do. We are taking a rounded approach to trying to denormalise and restrict smoking.

14:30

Mr McNeil: Do you accept the point that we must avoid giving smokers victim status? I am thinking of the people who would say, "I'm an adult and I am being prevented from smoking in a public place, when at the same time a 16-year-old can buy cigarettes or an under-age person can be provided with them. Why should I, as an adult, be fined for smoking in a public place—mainly down the pub—while other people are openly selling tobacco products illegally and not being prosecuted?" Surely that is what those people will say.

Mr Kerr: People who are selling products in that way are breaking the law and I hope that we would hammer them for their conduct, which is reprehensible. If people are doing that, we should use test purchasing to detect it and we should enforce consumer and trading standards. The police should enforce the law on illegal sales.

You raised the issue of 16-year-olds smoking, but that is the current age at which someone can buy cigarettes. I accept that one way in which we could try to change young people's attitudes to smoking is through increasing the age at which people can purchase tobacco. I suggest that the issue is more one of denormalising smoking. We need to make smoking untrendy; we need to make it clear that it affects young people's lifestyles and choices. An age barrier could make smoking sexier for young people—prohibition can do that—but I am happy to have a debate on the issue.

The Convener: We are in danger of going off-bill and I want to bring us back to its provisions. We have a lot of work to get through this afternoon. I call Helen Eadie.

Helen Eadie (Dunfermline East) (Lab): I want to address the issue of penalties. As you said, minister, we need to begin to hammer people for not obeying the law. What provisions are there for ensuring that the penalties address the issue?

Mr Kerr: I am sorry, but did you say, "What measures"?

Helen Eadie: I asked about the provisions. What provisions are being made for penalties to increase over time? Let us return to the example of parking fines. If someone does not pay the fine, they are given the option of paying £30; if they do not pay that fine, they have to pay £60; and if they continue not to pay, the fine rises to £90. The issue of penalties came up last week in our evidence taking. The committee took the view that some landlords could arrive at a considered view each year on fines. They could add a sum of, say, £10,000 into their balance sheet for the year as the amount that they are prepared to write off for fines.

Mr Kerr: As you know, fine levels are set out in regulations; they will be £200 for an owner and £50 for the individual. The fines that we are putting in place are set at what we think is an appropriate level. Again, our proposals will be consulted on and views will be gathered.

Speaking bluntly, I believe that it is easy to spot cases in which someone is taking an economic gamble by saying that they can afford to get caught X number of times. In cases in which a landlord is deliberately buying their way out of their obligations under the legislation by simply paying fines, the ultimate sanction of licence removal should prevail.

The levels of fines, which are the subject of consultation at the moment, must be appropriate. We are clever enough, as are our enforcement officers, to detect such practice. As I said, if we detect it, we will impose the most drastic of sanctions, which is the removal of the licence.

Helen Eadie: The Finance Committee report says:

"the costs of enforcement are largely unknown."

How will the Executive ensure that the funding to meet the costs is made available? Is the Executive committed to funding additional enforcement costs?

Mr Kerr: I appreciate the point that the Finance Committee made. I am also aware of what the Convention of Scottish Local Authorities has said about its expectations of the bill. The financial memorandum to the bill shows a figure of £6 million, which we think is the upper level of the costs.

Given that Ireland has about 50-odd enforcement officers, we thought that we should have 70-odd officers. We think that that is the appropriate number, based on the fact that, if enforcement has worked in Ireland with 50-odd officers, we should add an appropriate number of officers to the Irish total. We tried to work through the methodologies that the Irish had employed. The numbers have not been plucked out of the air, but they are up for discussion with the people on the front line—COSLA and REHIS people, and others. However, we think that we have made a fair assessment of the costs of enforcement and the number of people whom we would require for that job.

As committee members will be aware—from your visits and other work—we think that the costs will tail off fairly sharply. That has been the experience elsewhere, once legislation has been put in place and has become normal. In a few years' time, I genuinely think that people will look back and say, "What was all that about? You mean that people used to smoke in pubs here?" I think that we will get to that position fairly quickly and that the costs of enforcement will drop dramatically.

Mr McNeil: You said that an important objective of the bill was to reduce smoking overall. I agree with that objective; it is the big challenge to us all. You recently announced £12 million or so for cessation policies. How did you arrive at that figure? How will that £12 million be used? Is it sufficient? Will it target communities such as Shona Robison's, with 18,000 smokers? Will such communities gain more benefit than, for example, Mike Rumbles's communities, with fewer smokers? Will there be effective targeting?

Mr Kerr: Money will be distributed to the health boards in the normal way. Going into the details of that would probably be unhelpful, but we can consider different routes to cessation. Some are more expensive than others. If I remember correctly, £350 buys nicotine-reduction therapy plus some counselling. Other cessation tools can cost less.

We have a set of possible interventions. We are dealing with individuals, so we will allow the smoking cessation teams in the health service to tailor the package for each individual. Some innovative work is going on. We will consider the available tools, such as chewing gum, patches and therapy; we will consider the individuals, who are all different; and we will then decide what will work best for each individual. It is therefore difficult to say that 30,000 or 25,000 people will receive treatment. It is horses for courses.

Mr McNeil: Surely the £12 million will not be distributed equally to each health board.

Mr Kerr: At the moment, distribution is determined by the Arbuthnott formula. However, we acknowledge the existence of huge inequalities and are considering how best to target other resources to deal with them effectively. We are doing that in health, as in many other areas.

Mr McNeil: You are going a step beyond Arbuthnott. Will you be sharing that work with the committee?

Mr Kerr: Once we have worked things out.

The Convener: When committee members were in Ireland, it was clear to us that the Irish Government had not done many follow-up studies on the impact of the ban. Do you plan to monitor smoking rates? Bearing in mind the displacement arguments, do you plan to consider the impact on the domestic environment? Will you consider how jobs and revenue are affected? In Ireland, it was remarkable that very little of that kind of monitoring had been done. Will the Executive be more proactive?

Mr Kerr: We want to have smoking cessation targets in each health board area, to ensure that we reduce the absolute number of smokers. That will be important. We will also track the economic impact. We in Scotland will become part of the worldwide effort to convince people of the benefit of the approach that we are taking. We have learned a lot from places such as New York and Ireland. For example, we will be able to track the improvement in the health of bar workers. The bill is a high-profile piece of legislation and I want to ensure that we can provide the Scottish public with evidence of its effects. I also think that we will be able to add our weight to the international crusade—if I can call it that—against smoking in public places.

Mrs Nanette Milne (North East Scotland) (Con): There was a long lead-in time in Ireland before legislation was introduced. As a result, the public were ready for it when it arrived. However, the lead-in time in Scotland will be much shorter, with the ban essentially being implemented within a year. A number of witnesses have suggested that that timescale is too short. Was any consideration given to a phased introduction?

Mr Kerr: Because we are learning from the experiences of everyone else who has been in this situation, we can implement the ban more quickly and effectively. Moreover, we have taken a very inclusive approach. For example, the smoke-free areas implementation group includes everyone that you would expect to be sitting around the table for any discussion about how to prepare publicans, their staff, their customers and the Scottish public for the legislation. I see no reason not to set the target that we have set. After all, the matter has been discussed frequently and

reported in local and national newspapers. As people know all about it, I see no reason to stall or phase implementation. We need to get this done and start improving health; indeed, we must remember that, as soon as people stop smoking, their lungs begin to recover.

Mrs Milne: It was made plain to us that there had to be awareness-raising campaigns to let the public know what was happening. What smoking cessation campaigns are proposed in the run-up to and beyond the ban?

Mr Kerr: That is precisely what is being discussed by the smoke-free areas implementation group, which includes representatives of the Scottish licensed trade and club owners, for example. As a result, we are working with the people on the front line.

We are also recruiting advertising agencies to help us in the substantial task of putting together a comprehensive set of public awareness and information campaigns that, in the build-up to implementation, will inform people about our smoke-free Scotland policy and, after that, will inform them about their rights and responsibilities. Again, convener, in the interests of time, I am happy to forward an outline of those measures to you.

The Convener: That would be very useful.

We have pretty much reached the end of our questions about smoking. However, before we move off the subject, I wonder whether, given his background, Stewart Maxwell wants to raise any questions.

Mr Stewart Maxwell (West of Scotland) (SNP): I have one small question for clarification.

The Convener: Could you ask it very quickly?

Mr Maxwell: Yes. Has the minister thought about approaching the issue of adult care homes from the other angle by including in the smoking ban public areas in adult care homes but, because people live there, providing for smoking rooms, which might be bedrooms or some other arrangement in the home?

Mr Kerr: I am happy to bring Sarah Davidson in on this question, because she was closer to some of the discussions on that matter. We found that, because of health and safety issues, people could not smoke in their rooms, which meant that we had to delineate what could or could not be done. As a result, we have said that each care home must have a very clear smoking policy.

Sarah Davidson: I do not have anything much to add to that comment, other than to say that we will discuss with the Scottish Commission for the Regulation of Care the effective implementation of extensive smoke-free areas in those premises to ensure that staff, patients and visitors who do not want to be exposed to smoke can avoid it completely.

The Convener: Thank you very much. If officials want to swap places, we will move on to part 2 of the bill, which covers general dental services, general ophthalmic services and personal dental services.

Shona Robison (Dundee East) (SNP): The Finance Committee has expressed concerns about the financial implications of free dental checks. It stated in its report:

> "the Committee is deeply concerned that it is being asked to scrutinise the financial implications of a Bill where the staffing and service implications which crucially determine the cost do not appear to have costed in a manner that gives the Committee confidence in the figures … The Committee is extremely concerned that Parliament is being asked to authorise the release of funds when it is not certain of what the cost of legislation is likely to be."

Given that we have now heard a ministerial statement, do we have more information for the financial memorandum and its contents?

14:45

Mr Kerr: Last week's announcement on dentistry went a long way towards addressing some of the issues about which the committee is concerned. Although, in our own minds, we have the budget that we require to implement what we want to implement with respect to eye and dental checks, a negotiation is involved. We want that negotiation to be carried out properly, so we do not want to declare our hand at this point with regard to what we expect the enhanced examinations to be.

What we are seeking is health improvement. The issue is different from that of sight tests, to refer to the ophthalmic side; it is about an engagement with the professions on how best to deliver the service and then a negotiation over the price. I am not sure if that is the clarity—or the lack of clarity—that you would expect, but to start allocating costs to the particular tests concerned would be inappropriate.

Shona Robison: I am not clear about where that leaves the financial memorandum. As you have said, the figure of £9 million to £12 million for dental checks will change as negotiations continue on the extent and cost of oral health assessments. With respect to the parliamentary process, when will we get a true figure in relation to the financial memorandum? We surely cannot be expected to sign blank cheques. The Parliament must know what the costs will be before it can approve the financial resolution.

Mr Kerr: To be fair, the existing financial memorandum is based on the cost of the existing

check. My understanding is that the memorandum is accurate with respect to the proposed legislation. What is now required, as a result of Rhona Brankin's statement last week, is a discussion with the profession around the enhanced check. I am confident about the financial memorandum with regard to the current check and the £7.05 figure.

That does not reflect what we now envisage in the action plan on modernising dentistry, in which we have said that we are taking a—I was going to say "holistic" approach, but I hate that word—health improvement approach to dental examination. In our minds, we have costed some of the impacts of that, but we need to have a negotiation with the profession around what the examination is and what it will cost the taxpayer.

Shona Robison: I am not clear about what you are saying. I understood that the free dental check, which is referred to in the financial memorandum, would effectively cease to exist, as it would be replaced by the new oral health assessment. I thought that that was what the bill was introducing. Are you now saying that the free dental check will be a basic check and that the oral health assessment will be something different?

Mr Kerr: The financial memorandum reflects the old form of the dental check. Hamish Wilson can add further light to that.

Dr Hamish Wilson (Scottish Executive Health Department): I can confirm that that was the basis on which the financial memorandum was drawn up. We intend to discuss with the dental profession the nature and frequency of the oral health assessment and the effect that that might have on the existing dental check. An oral health assessment might be carried out as an initial assessment; a dental check will be an updating of that assessment on an on-going basis. It might be that both will exist in the future. The financial memorandum was based on the existing set of arrangements.

Shona Robison: I am not entirely clear about the distinction. I take it that you will be keeping the committee abreast of any further financial implications as the negotiations proceed. That would certainly be helpful.

I turn to the 25 per cent increase in the cost of checks as a result of people being more likely to take up the free dental checks and/or oral health assessment, depending on what we are talking about. What was the basis of that figure of 25 per cent? How was it calculated?

Mr Kerr: I will deal first with the point about the check. It is an enhanced check and it will cost more because it does a different job. You would be right to criticise us if we did not engage with the profession on what that check should be and how much it should cost the taxpayer. It is correct that we should come back to the committee when we can to talk about those issues.

The 25 per cent increase is based on our experience of the change in the public's behaviour when we introduced the free sight check for the over-60s. That was the only sound piece of evidence that showed how people behaved once a check became free.

Dr Wilson: That is absolutely right. We were trying to make the memorandum as helpful as possible by explaining that the best evidence for what might happen came from our experience of extending free sight checks to the over-60s. In that case, uptake increased by about 25 per cent. We thought that it would be helpful to put that into the financial memorandum to show the scale of the possible increase.

Shona Robison: I take it that you will have room for manoeuvre if the uptake is significantly more than that.

Let us move on to consider the workforce that will be needed to deliver the checks and oral health assessment. How likely is it that there will be a sufficient number of dentists to deliver the proposals? How have you calculated what you require?

Mr Kerr: This is almost "Groundhog Day", as a lot of these issues were discussed last week in the statement on the modernising dentistry action plan. We have already increased the number of students who are in training; we are increasing the number of allied professionals; and we are seeking to support the education of our dentists via the Aberdeen facility. A range of measures has been put in place that will allow us to be confident that we can fill the gap in dental services. The increased use of allied dental professionals will ensure that dentists can focus on the work that they are required to do. I have every confidence that the substantial investment that we announced last week will deliver that. Training and qualification take time, but we are sure that we can meet the target number of dentists who have to be in training to make the system work.

Mr McNeil: You have referred to the importance of professionals who are allied to dentistry. I am sure that you are aware of the recent study that highlighted the importance of those professionals and of an increase in dentists' productivity. It also highlighted the shortage of dental nurses. What incentives have you put in place to recruit and retain those professionals?

The Convener: Can you be brief please, minister?

Mr Kerr: The incentives largely relate to the announcements made last week for support for training, particularly for people in rural areas, through training grants, facilities, information technology equipment and premises. We will also give support for the provision of places in our education system to attract people into the field. We have a basket of supporting measures.

In addition, we are trying to ensure that dentists who are tempted by the private sector will stay with us by reducing from 450 to 50 the number of item-of-service payments. That will reduce the red tape around dentistry and incentivise the process much more effectively. We hope to work with dentists to help young people to see dentistry as a career opportunity as well as using additional incentives to persuade dentists to stay with us.

Mr McNeil: How do we ensure that the dental nurses and hygienists also benefit from that process?

Mr Kerr: It is all part of our workforce planning measures.

Mr McNeil: Are you talking about pay and conditions?

Mr Kerr: Yes. Those are the additional incentives that we put in place to encourage people to enter dentistry. The package applies to them as well.

Shona Robison: I come back to "Groundhog Day". I do not know whether you are aware that Stewart Stevenson has just received an answer to a question that he asked about the percentage of dentists in Scotland who accept NHS patients. The reply was that that information is not held centrally. It seems strange that you would not have that information if you were trying to gauge what is required to meet the commitments in the bill. You do not know your starting point, which is how many dentists carry out the work.

Mr Kerr: Those matters are dealt with through the health boards, which is where the information lies.

Shona Robison: Yes, but you need to know the numbers, because you are sitting here telling us what you think is required in terms of the workforce to meet your legislative commitments. Surely you need to have the information to make an assessment.

Mr Kerr: We do not carry out workforce planning in isolation; we work with employee representatives, the boards and personnel people from the health service to determine the future shape of the workforce and to identify the pressures that exist locally. We discuss with health boards workforce planning measures and what they need to deliver the service. The workforce planning processes that Executive officials carry out include getting information that the health boards hold. That has informed the conclusions that we have reached about what we need to do to ensure that everybody has access to dentistry in Scotland.

Shona Robison: I turn finally to vulnerable groups' take-up of free dental checks. What plans do you have to address the physical access problems that exist in so many dental surgeries? Have you considered screening programmes to target the most vulnerable groups?

Mr Kerr: Sadly, there are huge inequalities in health, which relate to poverty and rurality. Some of the pilots on which we want to embark will ensure that we focus on the people affected by those factors. The statistics for dental decay in Glasgow show those inequalities. We are working on the grants that we apply to the dental service relating to premises. We will discuss later joint ventures, which apply to dentistry as much as to other community health settings and for which we will try to increase resources. My colleague Rhona Brankin recently attended the opening of a new centre. The issue is investment. There have been pretty substantial increases in investment; there have been increases of more than 70 per cent since 1999 in some of our capital investments. That comes back to the idea of having a package of measures.

We are focused on addressing issues of physical accessibility of dental services. We acknowledge that specialist dental services might be needed for those with special education needs or physical disabilities. We are focused on that part of our community to ensure that inequalities are ironed out and that a proper service is provided. The issue is about our having a spectrum of measures.

Mike Rumbles: For the benefit of the committee, I want to be absolutely clear about oral health assessments and comprehensive eye examinations. Are you saying that the Executive's intention is to provide a comprehensive oral health assessment and follow-up dental checks and a comprehensive eye examination and sight tests? The bill is not about one test replacing another, but about a comprehensive package. Is that correct?

Mr Kerr: Our proposals are about preventive health in action; they are about preventive measures. You have postulated a position in which the oral health examination might be followed up by checks. Let us talk to the professionals about that and come back to the committee. I do not want to be prescriptive about the best way of proceeding. I am happy to listen to professionals about what is the most effective way of delivering what we want, which is all about preventive health. In the action plan that we

published last week, we set targets on dental decay for different age groups.

Dr Turner: I know that you cannot say exactly what the oral health assessment will add up to. However, it might lead to more orthodontic crowns and bridge treatments. Worries have been expressed about that. Will there be a restrictive approach to treatments that result from enhanced oral checks? The NHS does not carry out all bridge treatments; some are private.

Mr Kerr: I will defer to Hamish Wilson on that point. As I understand it, what is provided currently will not be affected detrimentally as a result of the process. Anything that we do in health that takes the preventive route creates a bounce effect elsewhere in the service, for which we plan.

Dr Wilson: That is correct. An oral health assessment can perhaps more accurately determine the needs of the patient and, therefore, the treatment plan that will be required for that patient. There is no intention to reduce what is available under general dental services.

Dr Turner: So you are prepared for an expansion in treatment. Thank you.

15:00

Helen Eadie: One of the challenges that still besets you and your colleagues, minister, is the fact that, historically, much of the statistical information just has not been gathered. It seems to the committee that there is a lack of information at health board level about oral health. In that context, we wonder what plans you have to gather information to inform your decisions about implementing the proposals that will deliver general dental services.

Mr Kerr: I am not short of stats; I am just short of stats that make a difference. That is what I want to sort out. We are working with the information and statistics division and other professionals around the service to address the point about measurement that you make. We have set out in the dentistry paper targets for how many adults we expect to have some of their own teeth and how many fillings we expect our young people to have. Those imply that measures will be taken to ensure that, overall, we improve the oral health of the people of Scotland. We are not devoid of stats, but I share your view that we need stats that are more effective in proving delivery. If delivery is not made, how do the stats help us to ensure that delivery occurs?

The Convener: Before we move on to general ophthalmic services, will you clarify for the *Official Report* that both the basic dental check and the more comprehensive oral health assessment will be free?

Mr Kerr *indicated agreement*.

The Convener: Thank you.

Mr Kerr: Sorry, I should have said yes. For the *Official Report*, the minister nodded and then said yes.

The Convener: Let us move on to general ophthalmic services.

Kate Maclean: As the minister is probably aware, I chair the cross-party group on visual impairment, which is an area in which I have a particular interest. I have a couple of questions on the eye examination. There could be an eye test to determine whether someone needs spectacles and what prescription for spectacles they need. There could also be an eye examination to diagnose other health problems or eye problems, which, if carried out early enough, could prevent or reduce sight loss later in life. What type of eye examination is proposed under the scheme for free eye tests? Will any specific measures be introduced to help groups that are difficult to test, for example people who have learning disabilities or Alzheimer's? Also, what measures can be introduced to ensure that people take up the tests? At the moment, 20 per cent of schoolchildren have some degree of undiagnosed sight loss, despite the fact that they are entitled to free eye tests and checks. What measures will you introduce to ensure that the groups that are least likely to take up the free tests to which they are entitled take them up in future?

Mr Kerr: Your latter point about active management of individuals' health and not waiting for customers to come through the door is a broader point for the whole health service. We are doing much more on that through the pilot schemes that we are organising. The general medical services contract for GPs is much more assertive about looking for problems that can be resolved earlier in people's lives and that should apply equally to the use of eye examinations.

The free examination is an eye examination. A sight test will be carried out if one is required, but the examination is about detecting the sort of problems that you identified. It is also about preventing problems that could arise, and I am sure that it will cover all such problems. The examinations are not free for the general population at the moment, but the fact that they will be free will be an incentive for people to take them up. It is part of the education process in which we are all involved.

I also believe that the community health partnerships, which were designed for the purpose of health improvement in a local setting, will help to deliver some of the change in uptake that you mentioned. Again, I think that a range of measures can be deployed through our schools, the CHPs

and so on that will ensure that problems do not go undetected in the way that you describe.

I am hopeful that the fact that the service is free will mean that uptake will increase.

Kate Maclean: I do not think that that will necessarily follow. Although I regard myself as being a good mother, I never took either of my two children for a sight test because they never had any symptoms that would have led me to do that. That is probably the case with many people. Going to the dentist every six months is one thing, but I think that it is less common for people to take their kids to have their eyes tested regularly, even though it is free. I am not sure how the fact that the service is free will encourage a group of people who do not tend to get screened for lots of conditions to get their eyes tested.

Mr Kerr: As I said in relation to a previous question, our experience is that uptake increases by 25 per cent, which means that a larger pool of people will be coming forward to take the tests. The argument that you make applies equally to tooth brushing and to all the other preventive health measures that we are involved in. It relates to the campaign of educating people about their rights and responsibilities and to the role of parents and our schools.

In relation to the review of eye care that is being undertaken, we will consider issues such as access and uptake to ensure that we increase the number of people who get their eyes tested. As the Minister for Health and Community Care, I can say that it makes sense to identify conditions at an early stage not only in the interests of people's quality of life and so on but financially as well. The professions will assist us in that process and I am happy to come back to the committee to talk about any innovations that we think are appropriate.

Kate Maclean: Would the Executive consider setting up a sight-screening programme that would test children in primary 1 and again when they go into secondary school? Around 20 per cent of that vulnerable group have undiagnosed sight problems and such a programme would ensure that those were picked up at an early stage.

Mr Kerr: I would take advice from those in the professional field on whether a national screening programme would be worthwhile. Not all national screening programmes provide value for the individual patient. I do not approach the issue from a financial perspective, but the question clearly relates to whether we want to devote our resources to that task. I would not rule out having such a programme, but I would have to consider its effect on the prevention that we want our measures to achieve.

Kate Maclean: I know that the Executive is conducting an eye care review. What impact will it have on this provision or vice versa? Are the two linked at all?

Following on from Shona Robison's question about dental checks, do you have a firmer idea yet of the cost of the free eye checks?

Mr Kerr: We are conducting two pieces of work in relation to the points that you ask about. The eye care review will examine children's services and the issues that you have raised before coming up with proposals, and a report is being prepared on screening. I am happy to share the proposals and the report with the committee.

I cannot say, off the top of my head, how much the free eye checks will cost. We have not yet talked to the profession.

Kate Maclean: I just wondered whether you had a firmer idea of how much the policy would cost. I guess that you would give the same answer as you gave to the question about dental checks.

Mr Kerr: We have an estimate, within a banding, of the costs that we expect to incur and, later, we will enter into negotiations with the profession about the scope and cost of the examination.

Mrs Milne: Most of the witnesses were happy with the new listing arrangements for ophthalmic practitioners and dentists. However, I gather that it is proposed that the disclosure provisions will apply only to new entrants to the lists. Why will they not apply to existing listed practitioners?

Mr Kerr: I can reassure you that they will also apply to existing practitioners.

Dr Wilson: That is, they can apply if we so wish.

Mr Kerr: Oh, that is a different answer. I ask Hamish Wilson to continue.

Dr Wilson: The bill allows us to apply the disclosure requirements both to existing and to new practitioners.

Mrs Milne: So the bill allows the Executive to do that, but it will not necessarily ensure that that happens. It seems appropriate and sensible to require existing practitioners on the list who have not already done so to go through the disclosure procedure as well.

Dr Wilson: That is what the legislation allows.

Mrs Milne: We have all heard about the length of time that can be involved in the disclosure procedure. What steps will be taken to ensure that extending the list of those who are required to go through the disclosure procedure will not exacerbate an already difficult situation?

Mr Kerr: Given our work on the subject, we hope that the new measures that will be put in place will make the process quicker rather than

slower. There is no reason to suggest that that will not be the case. The provisions will allow quicker reactions from health boards and quicker determination of individual cases. Again, I ask Hamish Wilson to confirm that.

Dr Wilson: We need to discuss the details with Disclosure Scotland to ensure that there are no delays in the system. Therefore, the potential volume of checks if we were suddenly to include all existing practitioners as well as all new practitioners is relevant. We need a sensible and practical approach to allow us to do the most effective thing quickly.

The Convener: We will now move on to consider part 3 of the bill, which deals with pharmaceutical care services. Nanette Milne and Jean Turner want to raise an issue about part 3.

Mrs Milne: A number of us have received representations from people who deal with those who need stoma appliances. In my reading of the bill, I found it hard to see where this slots in, but people are clearly concerned that the service that is currently available to patients who require such appliances might be impaired if the appliances need to come directly from community pharmacists. I think that the stoma appliances that are currently provided by ileostomists and so on are almost bespoke devices.

Mr Kerr: I do not think that the bill particularly affects that situation. We considered the procurement route for stoma appliances, which is captured by the section that deals with appliance suppliers. The policy intention with regard to the fitting of stoma appliances and other such products remains the same. Although the provision of such appliances will become a service in its own right, that should not change the patient's understanding of the treatment that they receive. However, unless Hamish Wilson can help me out, I will need to re-examine the evidence that the committee has received about the impact that the bill will have on such patients.

Dr Wilson: Given the correspondence that we have seen—I think, literally for the first time today—I think that there might have been a misunderstanding on the part of some patient groups. As the minister said, the intention is that the supply of such appliances will become a specific service in its own right that health boards will secure either from existing appliance suppliers or from a small number of community pharmacies that currently provide the service. Such appliances are not part of pharmaceutical care services but are a separate service that requires its own standards and quality assurance, which it has not had in the past. The intention is not only to protect the existing service but to improve it in future.

Mrs Milne: There was concern that if health boards were given the responsibility for such things, they might not have the funding to cope.

Dr Wilson: That is not the intention.

Mr Kerr: The arrangements that are available for patients to engage with people in securing the appliances and having them fitted will remain the same. As Hamish Wilson indicated, we think that patient groups might have misunderstood our intention, given the correspondence that has been received. I will deal with that later, but I can reassure patients that the net effect of the provisions will be to ensure service improvement rather than diminution. The appliances will remain the same and the fitting procedures will remain the same, but the service will become a specialist service within the NHS.

Mrs Milne: That is helpful.

The Convener: Is Jean Turner's question on a separate issue?

Dr Turner: No, it is connected with that issue. Some patients deal directly with manufacturers and have made-to-measure appliances. For them, the issue is very personal. Confidence comes into it, and there is a worry that they might not be able to continue to deal directly with the manufacturer, which some people definitely feel is the only way in which they can get the service that they want; they feel that they would not be able to get it through a pharmacy. If they were hindered by having to use another company, that would not suit them.

15:15

Mr Kerr: There are set quality criteria for health care services. As long as the existing supplier matches those quality criteria, whether that supplier operates directly or through another provider, there will be no change. The bill deals with the organisation of the service in its own right; we want to increase quality and provide a better service.

Dr Turner: So no one need worry.

Mr Kerr: Absolutely. If we have received correspondence from groups that are worried about a diminution in the number of suppliers or about not being able to use their regular supplier—I have not seen any such correspondence—we will be able to reassure them about that.

The Convener: Thank you. We need to move on to part 4 of the bill, which deals with discipline. The minister is still accompanied by the same officials. Janis Hughes will lead off.

Janis Hughes (Glasgow Rutherglen) (Lab): Although it is fair to say that there was broad agreement on part 4 among the people from

whom we took evidence, a few issues were raised that we would like the minister to clarify. One witness suggested that the bill should include a definition of professional and personal misconduct. What do you think about that suggestion?

Mr Kerr: It would be quite restrictive to include such a definition in the bill; I would prefer the definitions to be dealt with through guidance.

Janis Hughes: Concerns were raised about the regulatory bodies having disciplinary procedures that are different from those of the NHS tribunal and about duplication of work by those bodies. What efforts have been made to harmonise disciplinary procedures and to save time and effort by joint working?

Mr Kerr: That is a valid point. I am assured that consultations on that are on-going. In an effort to ensure that there is no duplication, we are discussing the matter with the relevant bodies.

Janis Hughes: When will we know the outcome of that consultation?

Dr Wilson: As a result of the Shipman inquiry, all the national regulatory bodies are under review. Although we can continue our discussions, it could be difficult to conclude them until we are sure about the precise future role of the regulatory bodies. I am sorry, but I cannot give you a timescale for that.

Janis Hughes: Are you likely to be able to conclude your discussions prior to the conclusion of our consideration of the bill?

Dr Wilson: I am afraid that that is not within our direct control, as matters to do with the regulatory bodies are reserved.

Janis Hughes: The bill proposes that if a family health service professional is suspended for investigation, they will still be paid. In other words, they will continue to receive full pay pending the result of the investigation. In sectors such as optometry and dentistry, practitioners would find suspension very difficult, as they are self-employed and do not get paid unless they work, although they would continue to have staff and premises costs. What are your views on that?

Mr Kerr: We are discussing that with the professional bodies involved and we have not come to a conclusion. I imagine that we will be able to come back to the committee on that more quickly than we indicated before, because those matters are within our control. That issue has not yet been resolved.

Janis Hughes: That would be helpful, because there is a concern about the apparent disparity, which would affect staff.

Mr Kerr: Suspension should have a neutral effect. The fact that someone has been suspended suggests that the matter has not been investigated and that they have not been found guilty of malpractice or anything else. We are discussing the matter with the relevant bodies.

Janis Hughes: So you will come back to us on that.

Has the Executive considered including trainee professionals and students under the discipline umbrella, given their close contact with patients?

Dr Wilson: Students are in a different position from trainees because students are not registered and are not on a list. The discipline procedures relate to the listing. Whoever is listed to perform services becomes subject to the disciplinary process. Students are not listed but some trainees will be. There is a distinction to be made.

Janis Hughes: Another omission that has been highlighted is to do with NHS 24. The minister has told us that employees of NHS 24 will not be covered by an NHS tribunal. Are parallel procedures being worked on?

Mr Kerr: There are existing procedures. As we develop one side of the business, we will have to ensure that there is a matching effect in NHS 24.

Dr Wilson: In this context, NHS 24 is a health board like any other, and the employees of a health board are subject to their own internal disciplinary procedures.

The Convener: We now move to part 5 of the bill, which is on hepatitis C. I will allow a moment for new officials to come to the table.

Shona Robison: The Executive's justification for the exclusion from the compensation scheme of those who died before 29 August 2003 is that that was the date on which health ministers across the UK announced the UK scheme. Do you believe that that is a good enough reason for determining eligibility?

Mr Kerr: Yes, I do. In such difficult circumstances, one has to draw a line somewhere. We are compensating people for changes to their lifestyle because of what happened to them. We are thinking about supporting people who are still with us. We drew the line at that date so that the announcements of the four relevant UK ministers coincided.

I fully understand some of the views on this issue—they have been expressed to me forcefully. However, we must bear in mind the effects of different methodologies on the NHS. We must also bear in mind what all this is about—trying to assist those who are suffering as a result of contracting hep C through past engagement with the NHS. Sadly, it is not about those who, unfortunately, have passed away; it is about supporting those who are still with us.

Shona Robison: I am sure that you would accept that many relatives will also be suffering financially, especially if they have lost the main breadwinner of the family. Are you prepared to keep the issue under review? Evidence from Skipton Fund Ltd seems to indicate an underspend. At the moment, it has spent £9.81 million out of the £15 million that was allocated. Skipton Fund has indicated that it has not received as many applications as were expected, so it expects an underspend. If that turns out to be the case, will you reconsider extending the eligibility to allow relatives whose loved ones died before 29 August 2003 to come within the scheme?

Mr Kerr: I am always happy to discuss these matters, especially with the Haemophilia Society, which has been in to see me and with which I have corresponded. However, I say again that I have to consider the protection of the health service as a whole. The costs of taking the radical step that you propose would affect the health service, so I am not inclined to take it.

I do not think that it is a question of how much money is left over from the amount we set aside and whether we should change the principle as a result. The principle remains sound in relation to what we want to achieve. The situation is unfortunate and distressing for those involved, but I believe that the principles of the decision made by the four UK health ministers stand. Whether or not there is money left in the budget is a different matter. The money might be used later, because there are a number of outstanding claims that we expect to come in. I am always willing to listen to those who are directly involved and to discuss the issues with them, but at the moment I do not see a change of view on the issue.

Shona Robison: Will you commit to keeping that £15 million set aside for people with hepatitis C one way or another, or, if there is an underspend, do you envisage the money going elsewhere?

Mr Kerr: We will have a long tail on the fund—much beyond my tenure as Minister for Health and Community Care, I am sure—to ensure that, when people come forward, their cases can be dealt with. A diagnosis might be made many years in the future, and the rights of those individuals must be protected. I am not saying that the fund will go on for ever, but I do not envisage any change to the approach for now.

Shona Robison: The appeals process is not yet in place. In your correspondence, you say that you hope to get it in place soon. Will you be more specific?

Mr Kerr: Sadly not, because others from the rest of the UK are involved. I raised the issue with John Reid, the UK Secretary of State for Health, just yesterday. It is a pressing matter and I fully understand why the Haemophilia Society in Scotland is concerned about it, but I continue to try to push as hard as I can to get a result. We have a four-nation agreement and we need to stick to it when considering arrangements for the appeals process, so I will alert the committee as soon as I am aware of significant moves in that direction.

Shona Robison: The Haemophilia Society in Scotland has raised the point that those who can claim should be defined according to whether they were infected by NHS Scotland rather than according to their place of residence at the time of making their claim, as the bill currently proposes. Your letter seems to imply that, as long as the person is resident at the time of the claim, it does not matter if they move after that. Is that the case?

Mr Kerr: Yes.

Shona Robison: If they happened to have moved two weeks before the scheme was announced, say to America, so that their family could look after them, would they be ineligible? Would they be debarred from making a claim? That does not really seem fair.

Mr Kerr: I would need to seek legal advice on that point, because the fund is based on residence in the UK. I am not sure whether anybody else could claim. I apologise for not having that information, but I can provide the committee with information on overseas residents claiming two weeks after contracting hepatitis C. Is that your point?

Shona Robison: No. The point is that someone could have been eligible for money from the scheme, but they might happen to have moved out of the country shortly before the scheme was announced. Under your residency rules, that would debar them. It does not seem fair that, because they happen to have left the country—perhaps because they were not well and their family had offered to look after them—they will be debarred. We cannot be talking about a large number of people who are in that situation.

Mr Kerr: I do not make legal decisions in committees, because that would be a dangerous thing to do, but that is a valuable and fair point and I am happy to consider it and come back to you.

The Convener: Perhaps we could get that information from you in writing.

Dr Turner: What justification is there for the Skipton Fund rule that states that, if eligible persons die after 5 July 2004, payments will be made to their estate only if the eligible person claimed while they were alive? Thompsons the lawyers have indicated that at a stressful time in someone's illness, things can fall apart in many ways, and that might well be the case. People

might have been busy dealing with their illness and their relatives might have been coping with such matters, so that people who perhaps should have claimed did not do so before they died, although they would have been eligible. That is what I took from the information that we got.

Mr Kerr: Recently, I met the Haemophilia Society in Scotland and its legal advisers, and they never raised that issue with me, but I am happy to consider your point. We are involved in a UK deal, so I have to think about the implications of what I say for the rest of the UK. The point is valid, and I am happy to get back to the committee with clarification.

15:30

Dr Turner: If people are paid from the Skipton Fund, will they be able to take up other procedures? Is it a separate issue?

Mr Kerr: What do you mean by "take up other procedures"?

Dr Turner: Will they be able to go down a legal route that is separate from their claim?

The Convener: You said recently that you would consider an amendment to rectify an anomaly in respect of Skipton Fund payments being taken into account in other proceedings.

Mr Kerr: Yes.

The Convener: Is that still likely to form an Executive amendment?

Mr Kerr: Yes. We have had questions about the Skipton Fund that are not directly relevant to the bill, but the issue is relevant. We wish to ensure that people who benefit from Skipton are not affected elsewhere in the system. We will do that.

The Convener: We move on to authorisation of medical treatment in cases of incapacity. Jean Turner has a question.

Dr Turner: I am anxious about the increase in the duration of a certificate of incapacity to three years. I know how busy general practitioners are. It could be that everyone who is involved in a case is busy and that the annual, or more frequent, checks could be ignored; three years can go in quickly. Everybody might think that the checks have been done but—golly—the three years might pass with nobody having examined the patient.

Mr Kerr: I share that concern, but I do not think that that will happen. As we expand the range of people who are able to authorise medical treatment, we will provide superior treatment for patients and we will reduce and change the workload of people who are under pressure. We are responding to feedback on that point.

Three years of cover can be given as long as it is the absolute exception, for example in cases in which there is—to put it bluntly—little prospect of improvement because, for example, of degenerative illness or because the diagnosis is that a condition will not improve. That will not change the clinical engagement with the individual concerned, or the treatment and support that they will get from the health service. The bill will increase the term of certificates under current legislation, but I will seek to ensure that that does not affect the care that is given to patients.

Dr Turner: So there will be some way of monitoring patients in between assessments.

Mr Kerr: That would go on anyway—it is in the nature of the service. Of course, the people who will be able to fill out the forms will be given training to enhance their skills and understanding, therefore I hope that we will improve the condition of patients, not just for one year, but for the three years.

Helen Eadie: You have a list of professionals to whom you propose to extend powers of assessment. How did you compile that list?

Mr Kerr: It was arrived at by considering who has an impact on the well-being of particular people and the services that are provided to them. That was the key driving force in producing the list of professions.

Helen Eadie: Why are some professions, such as clinical psychologists, not included?

Mr Kerr: First, the list is not exhaustive. If good arguments are made by professional bodies, the committee or others for the inclusion of particular people, we can make the change. Secondly, it is about interventions and the effect that the clinician can have on the patient. A judgment was made about who would be on or off the list. As far as the treatment of individuals is concerned, we felt that dentistry, ophthalmology and—crikey, I have just forgotten the last one. [*Interruption.*] Nurse specialists, dentists and ophthalmologists have the biggest direct impact on patients. We are more than happy to consider any valid arguments for other inclusions; however, we focused on the interventions that professionals apply to patients.

Helen Eadie: Has there been progress in ensuring that GPs and medical practitioners receive proper training under the Adults with Incapacity (Scotland) Act 2000?

Mr Kerr: The medical profession has received training from, I think, NHS Education for Scotland. Joe Logan will come in on this question, but I believe that NES is extending the scope of its modular support and training.

Joe Logan (Scottish Executive Health Department): At the moment, we are consulting

NES on a specific proposal, on which we intend thereafter to consult various professional groups. We think that, under that proposal, GPs will be supplied with further training.

The Convener: Evidence that we received last week suggests that there are still issues to address about application of existing procedures and that, so far, training has not been particularly effective in quite a few areas. Do you accept that?

Mr Kerr: We want to revisit some of those issues.

Joe Logan: Take-up of the initial training has been patchy. Having said that, I point out that training has been offered on the code of practice, and that a video and leaflets about the Adults with Incapacity (Scotland) Act 2000 were produced. Furthermore, one of our professional advisers in the Executive held a series of roadshows across Scotland in an attempt to reach as many people who would be affected by the act as possible. However, we accept that take-up has been a bit patchier than we hoped. We hope to do something about that with the proposed follow-up training, which, with NES's involvement, will be more detailed.

Janis Hughes: You said that the medical profession will receive the training, but will every other profession that is involved in treating patients with incapacity also receive it?

Joe Logan: Yes.

Janis Hughes: It will go across all the professions.

Joe Logan: It will be available to professionals who seek to issue certificates of incapacity.

Mr Kerr: It is all to do with professionals' ability to sign off such certificates.

Janis Hughes: Okay.

Mr Kerr: You cannot sign off the certificates unless you have been through the training.

Janis Hughes: Does the current consultation include organisations that support patients with incapacity?

Joe Logan: The consultation on NHS Education for Scotland's specific proposal has still to take place, but it will include representatives from the patient bodies.

Janis Hughes: The minister indicated that draft regulations will be available in June. Will you confirm that those are still on schedule? Obviously, the committee will want to see those regulations before stage 3, if the bill should reach that stage.

Mr Kerr: That is our target—we will deliver on it.

The Convener: We move on to questions on joint ventures.

Helen Eadie: Are the powers in the bill intended to cover only the introduction of projects under the English local improvement finance trust—LIFT—model? If so, why are they so broad?

Mr Kerr: With the joint ventures proposals, we want to enhance local authorities' ability to work with health boards, and to allow the private sector to put additional investment into our health service. Their purpose is no broader than that.

We are dramatically increasing the amount of capital that is available to our health boards in Scotland, but we want to ensure that the additional resource is available to them not only to attract new investment, in addition to the substantial increases that they have already had, but to ensure that there is joint-venture planning with local authorities. There are some good examples of such work; the bill's provisions on joint ventures are designed to allow such work to take place. It is about the LIFT model being used in Scotland to deliver joint ventures, be they public-public or public-private projects.

Helen Eadie: In your letter to the committee, you refer to the way in which risk will be shared between parties to a joint venture, but there is no comment on how services will be provided if a project collapses. Will you comment on that?

Mr Kerr: Are you talking about property joint ventures?

Helen Eadie: Yes.

Mr Kerr: As with any public-private partnership, the legal provisions around the project will ensure that the risk is transferred, if that is the design, to the private-sector provider in the partnership, who will ensure delivery. In that sense, such a scheme will work like any large PPP scheme; it will provide surety to the taxpayer and patients in respect of delivery. Such projects will be simply PPP schemes at local level that will work as amalgamations of smaller community-based projects, so the risk will remain with the provider.

Helen Eadie: What is the Executive's position on the future of co-operative development agencies? I know that it was positive towards and supportive of them. Have you and your officials examined the projects in Plymouth that have gone down the mutual route? Do you see scope for that route in Scotland?

Mr Kerr: I am not sure about the projects in Plymouth; I will defer to my colleagues if they know more. On mutuals, the Executive has never taken a position against them; that is another model that people work up and which becomes available. We provide traditional capital substantially to renew and modernise our NHS

estate. It is the best-value approach that matters, whether in respect of the large increases that are available through traditional capital routes, the LIFT schemes that will exist if the legislation progresses, or mutuals. The delivery vehicle for investment is the choice of the boards. As long as they get the delivery vehicle to stack up and it goes through the public sector comparator, that will continue to be the case.

Helen Eadie: I ought to declare an interest as a sponsored member of the Scottish Co-operative Party.

Mr Kerr: Mike Baxter has more detail on the matter.

Mike Baxter (Scottish Executive Health Department): We have a governance arrangement that was established through the joint premises project board, which will consider the various models. The powers that we seek are generic. To be fair, the LIFT model is established; it is working and appears to be delivering. We can learn many lessons from that. The National Audit Office has also examined the LIFT model and is due to issue a report on it in April or May; we will also consider the lessons from that. We would be interested to hear details of the projects in Plymouth, although we have had contact with schemes in England on the planning and delivery processes that have been used there.

The Convener: The evidence that we took was that none of the schemes south of the border is far enough down the line for us to be able to use it as a clear model. However, you said that those schemes can be used as models. How can you be sure?

Mike Baxter: There are several aspects. First, the joint-venture concept, as it has been developed in the LIFT model, is about providing a vehicle to bring various parties round the table. It is based on a strategic planning framework. We can look at the experience to date and consider how that framework has developed by examining the broader service strategy and how it relates to premises development.

The second aspect is the commercial model itself and how its finances work. Deals have been signed and premises are being built; there is acceptance of the market and the commercial model has been tested.

The Convener: Is not it the case that there has not been much service delivery yet?

Mike Baxter: In terms of the operational phase of the schemes, I accept that that is the case.

Dr Turner: Evidence that we heard at a previous meeting suggests that LIFT schemes are usually smaller projects, such as small health centres or practices, rather than the bigger PPP-type hospitals. Concerns were expressed that some of them were getting involved with strictly commercial ventures, which were not necessarily related to the NHS; for example, shops that were not opticians.

15:45

The Convener: There is evidence that in some ventures south of the border, parts of premises have been used for ordinary commercial ventures such as newsagents, which surprised us.

Mr Kerr: I am impressed by such projects, which allow investment in areas where community regeneration has otherwise been at a standstill. If we aggregate public sector expenditure, bringing in health services—say, a dentist, a doctor and a physiotherapist—a post office, a police station, a newsagent's and a hairdresser's, that is good news for the community.

The Convener: Is that what is envisaged?

Mr Kerr: Yes—that is what joint ventures can and should deliver.

Dr Turner: That sounds good but, as time goes by, medical premises have sometimes to expand, so it might be difficult for practices, once they are tied into such commercial joint-venture arrangements, to have enough flexibility to pluck out what the NHS requires. We have some doubt about that.

Mr Kerr: The skill lies in contract negotiations and specification procedures, which allow scalability in projects. Mike Baxter has worked on that.

Mike Baxter: We do not envisage a one-size-fits-all approach. The needs of communities vary throughout the country, as will the opportunities for joint working between health and local government and the commercial opportunities at particular sites. We are keen that there be diversification in premises development. The commercial spin-offs of third-party revenues of joint-venture companies can bring financial benefits to the public sector. The public sector will be a stakeholder in any such companies; therefore, any profits will be shared proportionally between the public and private sectors. The ability to generate third-party revenue will have an impact on the level of rent that can be charged to the public sector tenant. There will not be commercial opportunities in every case, but the model is flexible enough to allow that.

The Convener: Last week's evidence from the Convention of Scottish Local Authorities and the NHS Confederation in Scotland suggests that they do not feel that they have been properly consulted, as they wished. Are there plans for further discussions with those bodies about the proposals and their implementation? They clearly indicated

to us that they do not feel that they have been consulted much so far.

Mr Kerr: We have been long and weary in discussions since July 2002, I think. Far more structures have been set up, and there is co-chairing of those structures. Many papers have been produced and much official time has been put in. I was surprised by that evidence, but I seek to resolve any concerns that exist.

The net gain could be substantial. The Dalmellington centre might represent a different model of delivery, but the change that such a facility can make to a community, with the service delivery that it can offer, is simply fantastic. Lothian community treatment centre is another example of the sort of development that I want more of. If there is not enough faith or confidence among partners, however, that is a problem for me, which I will seek to remedy.

The Convener: It would be useful if you could do that, and if you could keep us informed in that regard.

Company law dictates that directors' first responsibility is to shareholders; your letter addresses the issue of guarantees being offered so that joint ventures prioritise health services and facilities over commercial development. Those two things seem to present a bit of a contradiction. Commercial development might be more profitable. Are you confident that you can bring those two apparently contradictory positions together?

Mr Kerr: I am confident that we can do that as long as we correctly carry out the planning process for delivery of individual projects. We are all aware of what the balance of the package is with respect to commercial development opportunities—pure commerce—the provision of the NHS facility and the position of the local authority. As long as they are all aligned in the project, the partners will know what each will gain from it. That will be determined by the overall bundling of the project.

The risk will be transferred to the private sector partners and their funders, who must ensure that a project continues to be delivered if it goes wrong. Such situations have happened in the past with, for instance, East Lothian schools. Although an uncomfortable delay occurred when the company from Holland that was involved—its name escapes me—went bust, another provider was found and the project's financial stability was underpinned by the bank that was involved in it. All the players round the table will agree on the commercial involvement in the project, and the public sector will sign off the project. If it goes wrong, protection exists in contractual arrangements to ensure that the public's needs are met. I am therefore relatively comfortable with the arrangements.

The Convener: My question was more about whether the proposals are robust enough to overcome the issue of directors' first responsibility being to shareholders.

Mr Kerr: I am happy to pass that to Mike Baxter—I am not sure that I understand the question.

Mike Baxter: There are a number of ways in which that issue is dealt with. As we said in the letter, the situation is not unique to joint ventures. Any corporate body needs to be able to deal with conflicts of interest. In the articles of association and shareholder agreements for the companies that have been established under the LIFT model in England, the objects of the company are closely aligned to public sector bodies, which provides a mechanism for minimising such conflicts of interest.

The Convener: So you are confident that the proposals are robust enough to overcome any difficulty in that respect.

Mike Baxter: Yes.

The Convener: As far as I understand the matter, under the joint-venture set-up about which we are talking, the assets would not revert to the health service at the end of the joint-venture period. However, in PFI projects, the assets revert to the health service at the end of the contract. As we have a choice between a situation in which, in the final analysis, the assets come to the health service and one in which they do not, why are we opting for a situation in which they will not?

Mr Kerr: The contract value and the price that the public sector pays reflect the fact that we do not get the asset at the end of contract.

The Convener: So it is cheaper.

Mr Kerr: Yes.

The Convener: Right. So it comes down to the calculation that it is cheaper to concede the asset. You have calculated that, in the long run, that will be better.

Mike Baxter: Under the joint-venture model, the property will not transfer back to the health service at the end of the period, so the residual value of the property and the risk will stay with the private sector firm. That is the prime risk transfer, which is a fundamental difference from traditional PFI models in which, as you rightly say, the asset transfers back. From a public sector point of view, joint ventures will also provide more flexibility in the way we manage our estate, because tenants or shareholders can disinvest from the premises.

The Convener: Does that relate to the issue that Jean Turner raised about the possibility that requirements will change over the years, which might mean that premises are no longer particularly appropriate for what they were originally built for?

Mr Kerr: Yes, but under the traditional PFI/PPP model, it is for the procurer—that is, the public sector—to decide whether it wants to take the asset back; it can decide not take the asset back. It is not a must-do under PFI/PPP, but it is under LIFT. That reflects the smaller size of the properties that are involved in LIFT.

Shona Robison: On disinvestment, can both parties—the private sector and the public sector—disinvest? If so, and the public sector wanted to disinvest early, would there be a financial penalty for doing so and how would it be worked out?

Mike Baxter: Options for exit strategies from the firm will be contained in the shareholders agreement, which sets out the rights and obligations of shareholders, including lock-in periods; that is, how long they must stay involved with the firm. The condition for disinvestment is that the other shareholders agree to the selling on of the disinvesting shareholder's shares. There are provisions in the contract arrangements and the shareholders agreement on the shareholders' obligations to maintain or exit from the joint-venture company.

Mr Kerr: It is a standard form of contract.

The Convener: Do the details of the contracts, such as the shareholders agreements, have the capacity to vary from project to project? Will each one be a stand-alone contract?

Mr Kerr: Each contract will suit local circumstances. What the private sector and other public sector players bring to contracts will vary, as will the scope and length of contracts and the provision of facilities. However, underlying values will require us to assess each contract against the public sector comparator to ensure that the risk that is transferred is appropriate and the cost represents best value. At the moment, PPP contracts, whether in education or health, are various in their approach, but the underpinning values are still there in the relationship between the public procurer and the private supplier.

The Convener: We have almost exhausted our questions, but I want to sweep up one thing. We had a letter from the minister dated 18 March, which signified the Executive's intentions for stage 2. Although it is only a short time since you wrote the letter, I wonder whether there is anything you want to add to it. Are there more issues about, or do you want to comment on, stage 2?

Mr Kerr: I am desperately trying to ensure that there are no significant amendments at stage 2.

The Convener: That would be useful.

Mr Kerr: We still have only three amendments. I hope that they are pretty straightforward. That is the way I want to keep it.

The Convener: I thank you for coming along. I also thank all your officials for attending.

I suspend the meeting until 4.05 pm.

15:56

Meeting suspended.

16:05

On resuming—

Subordinate Legislation

The Convener: We have 10 Scottish statutory instruments to consider under the negative procedure. The Subordinate Legislation Committee raised a number of issues on the instruments, several of which are of current interest to the committee, including those that relate to dentistry and the Regulation of Care (Scotland) Act 2001.

I have asked officials from the Scottish Executive and the Food Standards Agency Scotland to come before the committee to explain the purpose of the instruments and to answer questions from members. Although all the officials are sitting round the table, not every one is relevant to each instrument. They are all at the table together because that will save time; we will not have to swap folk to and from the table for each group of instruments.

Regulation of Care (Excepted Services) (Scotland) Regulations 2002 Partial Revocation Regulations 2005 (SSI 2005/96)

Regulation of Care (Fees) (Scotland) Order 2005 (SSI 2005/97)

Regulation of Care (Scotland) Act 2001 (Transitional Provisions) Order 2005 (SSI 2005/98)

The Convener: The first group of instruments—SSI 2005/96, SSI 2005/97 and SSI 2005/98—relate to the Regulation of Care (Scotland) Act 2001. I welcome our first two witnesses, who are from the Scottish Executive Health Department; Shaun Eales is from the delivery of care services branch, and Linda Gregson is from the care standards and sponsorship branch.

The purpose of SSI 2005/96 and 2005/98 is to extend the responsibility of the Scottish Commission for the Regulation of Care to include the regulation of independent schools with boarding provision, education authority residential special schools and school hostels. SSI 2005/97 introduces new fees for those schools, including fees for registration with the care commission and cancellation of registration. The instrument also increases existing fees for services that are regulated by the care commission.

Last year, the committee wrote to the Executive to express its concern at the level of increase in fees for registration with the care commission. The Executive's response says that ministers

"will continue to keep a close eye on the impact of fees".

What action has the Executive taken to monitor the impact on schools and hostels of their having to pay fees on services that are regulated by the care commission?

Linda Gregson (Scottish Executive Health Department): Last year, when the timetable for moving to full cost recovery funding of the care commission was extended to 2006, I think we said that we would work with the care commission over this year and next year to consider what the full cost recovery fees might be for the range of care services that the care commission regulates.

There are two aspects to the setting of fees, the first of which is the overall cost to the care commission. The care commission cannot just do what it likes; it has to work within the requirements of the Regulation of Care (Scotland) Act 2001. Its ability to deliver proportionate risk-assessed regulation is constrained by the requirements of the act. That said, the care commission is doing a number of things to keep its costs down. For example, it has introduced an integrated fee regime for providers who deliver more than one type of care service. That regime applies where services are considered alongside each other at the time that consideration is given to what the level of fee might be. For example, if the fees are determined by the number of staff, the care commission will take the number of staff across the two services and apply a single fee.

The care commission takes a limited risk assessment approach to regulation. It carries out either a concise or a standard inspection. That depends—

The Convener: Yes, but that is not about the impact of having to pay the fees. You are giving the committee an explanation of how the care commission arrives at the setting of fees, whereas we are concerned about who will monitor the impact on the providers of various services of having to pay the fees. The payment of money in fees will impact on services. Who is monitoring that?

Linda Gregson: Sorry?

The Convener: Who monitors the impact that the fees will have?

Linda Gregson: The fees are subject to a wide-ranging consultation exercise. I think that we issued 14,000 consultation documents on fee levels, and we have had no hard evidence to suggest that a significant number of providers are closing because of the cost of regulation.

The Convener: That is still not very clear on the issue of monitoring.

Mike Rumbles: When you say that there is no sign of a significant number of providers closing, how many are you talking about?

Linda Gregson: It is difficult to know how many. I do not have the figures to hand.

The Convener: Can you get them for us?

Linda Gregson: We can get the number of cancelled registrations from the care commission. If a care home closes, it has to apply to the care commission for cancellation of registration. The care commission will have information on the number of services that have cancelled their registration, but that may not always be because—

The Convener: Do you ask why there has been a cancellation of registration?

Linda Gregson: The care commission needs to know the reasons for a cancellation. So, yes, we can get that information for the committee.

Shona Robison: A lot of concern was raised during the initial stages of the Regulation of Care (Scotland) Bill about the impact of fees, especially when they go to full cost. You said that the consultation produced little hard evidence; that suggests that there is quite a lot of soft evidence. What sort of evidence have you received? Have a large number of respondents to the consultation raised concerns about the impact of going to full coverage of costs?

Linda Gregson: In the recent consultation round, we got 137 responses from 14,000 consultation papers—sorry, it was about 12,000 this year and 14,000 last year. It is fair to say that concerns were raised about the proposed increases in fees, but there was no suggestion that services would close because of the increases—certainly, not in response to the consultation.

The Convener: The situation is still unclear, though. Your answers do not suggest that you are doing any hard post-increase monitoring. The committee has raised that as a concern in the past, and your answers suggest that the concerns that we have raised are not being addressed.

Linda Gregson: We do not have any research in place at the moment to monitor that.

Dr Turner: I understand that, in some cases, you are reducing the number of mandatory visits from two. Is there a connection between that and the fee? It has been stated that perhaps it is not necessary to visit some establishments twice. Does that have something to do with the number of places that you have to visit, or is it connected with the fee?

16:15

Linda Gregson: That is the point that I was going to make earlier. The care commission is required by the 2001 act to inspect all care services at least once a year, with residential services being inspected at least twice a year. That limits the care commission's scope for manoeuvre in targeting its resources on poor performance and driving up quality. We propose to lodge an amendment—it is one of the three amendments to the Smoking, Health and Social Care (Scotland) Bill to which the minister referred—to give ministers the power to vary the number of inspections that must be done in a year. That could have an impact on the cost to the care commission, which will possibly drive down fees in the long run. That saving will feed through into the fees.

There are two aspects to fees, the first of which is the amount of time that is required to regulate services. The care commission is gathering evidence for us on that aspect across the range of services and regulatory activities that it undertakes, which will feed into the consultation before fees are set at full cost recovery level. Secondly, fees are affected by the cost of running the care commission, which must be efficient and effective. Ministers agree the care commission's budget on an annual basis and we expect them to make efficiencies in 2005-06, in relation to early-years services, by modifying the joint inspection arrangements with Her Majesty's Inspectorate of Education—that approach might feed into other services. Currently, the care commission is part funded through fees and we are still moving towards full cost recovery, so in 2005-06 we do not know what the impact of full cost recovery is likely to be. However, we will receive information that will feed into our understanding later in the year.

The Convener: I understand that the Deputy Minister for Health and Community Care signed the declaration on the regulatory impact assessment for the Regulation of Care (Fees) (Scotland) Order 2005 (SSI 2005/97), which states:

"I am satisfied that the balance between cost and benefit is the right one".

What work was done in the regulatory impact assessment to enable the minister to reach that conclusion?

Linda Gregson: The work that was done relates to the original regulatory impact assessment, which was done during the passage of the Regulation of Care (Scotland) Bill. The principles that were set out in that RIA still apply.

The Convener: Has no new assessment been done in the light of the new situation?

Linda Gregson: No. We have plans to carry out such an assessment before we set fees at full cost recovery in 2006-07.

The Convener: Do you know how the minister reached her conclusion about the balance between cost and benefit?

Linda Gregson: No, sorry.

The Convener: Was it in response to advice that you gave?

Linda Gregson: No.

The Convener: Was it in response to advice that Mr Eales gave?

Shaun Eales (Scottish Executive Health Department): No.

The Convener: That is clear, but it is not satisfactory. Do members have further questions in the light of what we have heard? I have concerns about the matter.

Mike Rumbles: According to the schedule to SSI 2005/97, the fee for the "small school care accommodation service", which applies to schools that take fewer than 40 kids, is £4,340. However, for a school that takes 40 kids, the fee jumps to nearly £6,000. What criteria did you use to justify such large jumps in fees? It seems odd that the fee for a school that takes 40 kids is 50 per cent higher than the fee for a school that takes 39 kids.

Linda Gregson: I do not have the detailed figures in front of me. However, the fees are based on the estimated time that it takes the care commission to regulate services and they were agreed in consultation with the sector. We had a number of meetings with the Scottish Council of Independent Schools, at which we discussed fee levels and the split between small, medium and large schools.

Mike Rumbles: I am glad that there was detailed discussion, but would it have been fairer to have devised a system whereby the more kids who boarded, the more fees the school would pay? Could not the fees have been set out on a per-head basis? The approach that has been taken strikes me as arbitrary.

Linda Gregson: The fees for school care accommodation services have been changed. The commencement date for the regulation of such services applies to schools that were not already regulated. Fees that were based on a cost per place were already in place for school care accommodation services, but the sector was unhappy with that arrangement. We considered alternatives with the sector.

Mike Rumbles: The sector made the suggestion?

Linda Gregson: Yes, in consultation with the Scottish Council of Independent Schools. Representatives from the sector were at the meetings that we had.

Mike Rumbles: I am surprised, but thank you.

Mrs Milne: People who run care homes for older people are seeing the increases come alongside local authorities not paying them the rates that the Convention of Scottish Local Authorities says should be paid. They are concerned about the combination of those two factors. Do you have any comments on that?

Shaun Eales: Since 2001 and up to 31 March this year, a national agreement has been in place with the voluntary and private sectors. In that time, the Executive and local authorities have put an additional £140 million into care home fees. In May last year, local authorities and Scottish Care commissioned the Scottish local authorities management centre to produce another model for paying care home fees; that model will kick in from 1 April 2005. The Executive has accepted that. In years 2 and 3 of the current spending review, the Executive will provide an additional £94 million specifically for care home fees.

Mrs Milne: Is that to the satisfaction of the people who run the care homes?

Shaun Eales: Scottish Care made known its concerns about matters such as the regulation of care, water rates and training costs. However, it is difficult to catch the anticipated fee levels over a period of three years. We can project some costs, and the SLAMC report tried to identify projected costs for training and water rates; it also built in an inflationary increase. Scottish Care and the voluntary sector were happy with that.

The Convener: I advise the committee that the Subordinate Legislation Committee had no comment to make on the instruments. However, what the committee has heard this afternoon might mean that we should write to the Deputy Minister for Health and Community Care about the concerns that are being expressed. Is the committee agreed on that course of action?

Members *indicated agreement*.

The Convener: Otherwise, are we agreed that the committee does not wish to make any recommendation in relation to SSI 2005/96, SSI 2005/97 and SSI 2005/98?

Members *indicated agreement*.

National Health Service (General Dental Services) (Scotland) Amendment Regulations 2005 (SSI 2005/95)

The Convener: The next instrument is on general dental services. Dr Hamish Wilson, the head of primary care in the Scottish Executive Health Department is still with us. The instrument, which provides for the introduction of reimbursement of dental practice expenses, including rent and staff costs, has been introduced as a result of the consultation on modernising dental services in Scotland.

The Executive note on the instrument states that provision has been made in the general dental services budget to meet the cost of reimbursement of practice expenses. The instrument has been introduced to amend the National Health Service (Scotland) Act 1978 as a result of the consultation on modernising dental services. Provisions in part 2 of the Smoking, Health and Social Care (Scotland) Bill will also amend the 1978 act. The committee is keen to scrutinise subordinate legislation that results from the consultation, because members have received evidence that the devil is in the detail. We must, therefore, keep our eye on the detail.

Why was an amendment not included under the provisions in part 2 or schedule 3 of the Smoking, Health and Social Care (Scotland) Bill?

Dr Wilson: To clarify, the amendment will be to the GDS regulations. It is not an amendment to the 1978 act.

The Convener: Okay, but it relates to what we are doing. Why was it not included in the current bill?

Dr Wilson: The issue did not need primary legislation through the bill; it simply required an amendment to secondary legislation.

I will explain briefly how the remuneration system operates. We have what is called the statement of dental remuneration, which is a set of directions on how dentists who provide general dental services are paid their fees and allowances. The statement, which has been referred to during our various discussions, contains a number of determinations in relation to fees and allowances but, at present, there is no heading for the reimbursement of practice expenses, which is a new item. Therefore, the regulations need to be amended so that the statement of dental remuneration can go into the details of how practice expenses will be reimbursed under the national contract under which dentists provide general dental services. That is why we are amending secondary, not primary legislation.

The Convener: Right, but the measure is tied up with the issues of provision.

Dr Wilson: That is correct—it flows from the modernisation.

The Convener: Yes, but the amendment is being made by means of an instrument that is dealt with under the negative procedure, which is a different process. Will there be more such instruments, in addition to the regulations that will be introduced under the Smoking, Health and Social Care (Scotland) Bill?

Dr Wilson: The bill that is before the committee contains the power to make regulations, for example in relation to listing, which was referred to earlier. Therefore, regulations will flow from the bill, which was the subject of earlier discussion. There is no other current matter in relation to modernisation on which we require amendments to existing regulations, although amendments will be required to the regulations that arise from the bill.

The Convener: So nothing similar to the regulations that we are considering is coming along.

Dr Wilson: The regulations are a specific item—they are the result of a requirement for an addition to the existing secondary legislation.

The Convener: There are no further questions. I advise the committee that the Subordinate Legislation Committee had no comment to make on the regulations. Do members agree to make no recommendation in relation to SSI 2005/95?

Members *indicated agreement*.

Plastic Materials and Articles in Contact with Food Amendment (Scotland) Regulations 2005 (SSI 2005/92)

Colours in Food Amendment (Scotland) Regulations 2005 (SSI 2005/94)

The Convener: The regulations relate to food safety issues. We have with us Sandy McDougall, from the Food Standards Agency, and Steve Lindsay and Isla McLeod, from the office of the solicitor to the Scottish Executive. The witnesses are not those whose names were on the original agenda.

SSI 2005/92 lays down specific rules to ensure that consumers are protected from chemicals that might migrate into food from plastic food-contact materials and articles. SSI 2005/94 sets out the purity criteria for mixed carotenes and beta-carotene, including a limit on the permitted levels of heavy metals in mixed carotenes. The Subordinate Legislation Committee raised two issues in relation to the regulations, which are

intended to transpose into domestic law an amendment to European Community law; the committee's comments are contained in a paper. The Subordinate Legislation Committee does not accept the Executive's argument that existing Scottish regulations remove the requirement under European Community law to consult on the amending regulations. That is a clear conflict of understanding between the Executive and the Subordinate Legislation Committee. I ask the witnesses to explain the logic behind the decision not to consult on the regulations.

Steve Lindsay (Scottish Executive Legal and Parliamentary Services): I was the lawyer who was engaged with both sets of regulations, particularly and generally. Neither the Food Standards Agency nor the Executive takes the view that there should be no consultation; in fact, we accept unreservedly that consultation is required on both sets of regulations. We had a written exchange with the Subordinate Legislation Committee on what I assume to be a technical drafting matter that is associated with how one refers in the regulations to the fact that consultation has taken place.

The Subordinate Legislation Committee is concerned that, in the part of the regulations that we call the preamble, which contains all our powers—the primary legislation that allows us to make the regulations—we should also refer to the fact that a consultation requirement exists. We have taken the view that, because of the guidance that we follow within the Executive in preparing the instruments, that reference should go in a footnote. I hope that I do not diminish the point by suggesting that that is the difference, but that, in effect, is the substance of it.

16:30

The Convener: But you are confirming to us that there will be consultation.

Steve Lindsay: There will be consultation. I am clear that colleagues from the Food Standards Agency are in no doubt about, and have no difficulty with, the fact that they must consult in advance of making such regulations. They consulted on making both these sets of regulations. Only when there is an acute emergency might they be relieved of the obligation to consult. Of course, that is sometimes the case in relation to what we call FEPA orders—orders that are made under the Food and Environment Protection Act 1985—which are emergency orders to prevent food coming on to the market because of the toxins that are contained in it.

The Convener: The Subordinate Legislation Committee suggested that an accompanying transposition note should have been prepared to explain how the instruments will implement the European Commission directive. Can you explain why there is no such note?

Steve Lindsay: I am afraid that, in this case, resources did not allow us the time to prepare one.

The background is that my office—the office of the solicitor to the Scottish Executive—has agreed to take a lead in providing guidance to all Scottish Executive departments, and to the Food Standards Agency and other clients that are not part of the Executive but which bring forward legislation, to get them geared up to be able to produce the right sort of information in the transposition notes. Such notes would usually be drafted not by lawyers but by our clients, in the same way that Executive notes are prepared by our clients. I am afraid that progress on that has not been quite as quick as we would have wished, but good progress is being made and we hope to finalise the guidance shortly.

My section of the Executive has been developing pilot programmes on how we would set out the information, with a view to coming forward very shortly to test the committees' reactions and establish whether the notes contain the information that the committees would want. Committees could seek a range of information about what a directive does and how we go about transposing it. We are trying to focus the information so that it is as clear as possible—perhaps it will be in tabular format—and so that we cover as many as possible of the items that the committees want to be covered by such notes.

My expectation is that we will begin to produce specimens of those notes, which will probably arise from the work of the Food Standards Agency and the Scottish Executive Environment and Rural Affairs Department, after the Easter recess.

The Convener: In this case, however, it was a time issue.

Steve Lindsay: I am afraid that it was. It is as simple as that.

The Convener: Are we agreed that the committee does not wish to make any recommendation in relation to SSI 2005/92 and SSI 2005/94?

Members *indicated agreement*.

National Health Service (Optical Charges and Payments) (Scotland) Amendment Regulations 2005 (SSI 2005/119)

National Health Service (Dental Charges) (Scotland) Amendment Regulations 2005 (SSI 2005/121)

Road Traffic (NHS Charges) Amendment (Scotland) Regulations 2005 (SSI 2005/123)

National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2005 (SSI 2005/124)

The Convener: We will now consider four SSIs under the negative procedure: SSI 2005/119, SSI 2005/121, SSI 2005/123 and SSI 2005/124. The Subordinate Legislation Committee commented on SSI 2005/119, in relation to the need to consolidate the regulations that the instrument amends. The committee's comments are reproduced in the paper that has been circulated.

The Subordinate Legislation Committee did not comment on the other three instruments and no comments have been received from members. Are we agreed that the committee does not wish to make any recommendation on the instruments?

Members *indicated agreement*.

The Convener: Thank you very much. I thank the officials for attending.

16:33

Meeting continued in private until 17:12.

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