HEALTH COMMITTEE

Tuesday 17 May 2005

Session 2

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HEALTH COMMITTEE
14th 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:

Rhona Brankin (Deputy Minister for Health and Community Care)
Mr Brian Monteith (Mid Scotland and Fife) (Con)

THE FOLLOWING GAVE EVIDENCE:

Lesley Aitkenhead (Scottish Community Care Forum)
Bob Christie (Convention of Scottish Local Authorities)
Alan Dickson (Capability Scotland)
Annie Gunner (Community Care Providers Scotland)
Linda Gregson (Scottish Executive Health Department)
George Hunter (Association of Directors of Social Work)
Councillor Eric Jackson (Convention of Scottish Local Authorities)
Will Mallinson (EARS Independent Advocacy Service for Older People)
Susan Munroe (Scottish Partnership for Palliative Care)
Adam Rennie (Scottish Executive Health Department)
Jacquie Roberts (Scottish Commission for the Regulation of Care)
Helena Scott (Age Concern Scotland)
Andy Sim (Age Concern Scotland)
David Wiseman (Scottish Commission for the Regulation of Care)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 17 May 2005

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

Subordinate Legislation

Feed (Corn Gluten Feed and Brewers Grains) (Emergency Control) (Scotland) Regulations 2005 (SSI 2005/246)

The Convener (Roseanna Cunningham): I begin by reminding everybody to ensure that their mobile phones are turned off.

Item 1 on the agenda is a piece of subordinate legislation. It is a negative instrument. The committee is asked to consider Scottish statutory instrument 2005/246, which I note is about genetically modified maize lurking in animal feed from America. The Subordinate Legislation Committee has no comments on the regulations, and I have received no comments from any member of the committee. Are we agreed, therefore, that the committee does not wish to make any recommendation in relation to SSI 2005/246?

Members *indicated agreement*.

Smoking, Health and Social Care (Scotland) Bill

14:01

The Convener: Item 2 is oral evidence on the Smoking, Health and Social Care (Scotland) Bill. Ministers have lodged a stage 2 amendment to allow a variation of the frequency at which the Scottish Commission for the Regulation of Care is required to carry out inspections. A Scottish Parliament information centre briefing setting out the current inspection requirements has been circulated to members. The provision was not included in the bill when we considered it at stage 1, so the committee has decided to take some evidence today, given the nature of the amendment.

We are taking evidence in round-table format, which we have done successfully before, and we have representatives from a number of organisations with an interest in the proposal. All the witnesses are detailed on the agenda, and I welcome every single one of you to the meeting. You may not have participated in a round-table discussion before, but I assure you that it is relatively painless. Written submissions from the organisations that are giving evidence today, and a range of others, have been circulated, and I draw everyone's attention to the round-table introductory paper, which sets out the procedure for the session. There is also a seating plan, so that you can tell at a glance who the folk you are looking at are.

I thank all the witnesses for coming at such short notice, which was not something over which we had any control but was dictated by the arrival of the Executive amendment and the way in which the stage 2 process moves. We were unable to give longer notice, so thank you.

I shall ask the witnesses in turn to indicate whether they represent care providers or consumers—although I know that some represent both at the same time—and to give their view of the proposal. I specifically do not want speeches. However short you think your speech is, that is not what I am looking for. I am not looking for anything more than a couple of sentences—a paragraph at most—to say which side of the divide you are on and what your general view is of the amendment that has been lodged. I shall work through the witnesses on the basis of the order in which they appear on the agenda. A couple of organisations have two representatives at the table; I shall ask those organisations to nominate just one person to respond at this stage.

Once that is over, I shall invite questions from committee members and/or comments from other

witnesses. This is meant to be a slightly more free-flowing event than the straightforward question-answer format, so witnesses are invited to take up an issue with one of the other witnesses directly, rather than sitting back and waiting for committee members to ask questions.

We will invite the Scottish Executive and the Scottish Commission for the Regulation of Care to respond to the issues that participants identify, although that will happen more towards the end of the process.

I ask either Helena Scott or Andy Sim from Age Concern Scotland to start off by commenting very briefly on the organisation's reaction to the amendment.

Andy Sim (Age Concern Scotland): Age Concern Scotland, which represents consumers, is against the amendment, because it could erode some of the protection that is currently available to care home residents. Our response focuses particularly on care homes.

Alan Dickson (Capability Scotland): I represent a care provider. Although we appreciate the need to husband scarce resources, we are concerned that the proposal might represent a step backwards just when confidence is growing in the current system.

Annie Gunner (Community Care Providers Scotland): Community Care Providers Scotland represents almost 60 independent service providers in the voluntary sector. It is fair to say that the membership has mixed views on this matter. On the whole, the prevailing view is one of "Yes, but". We would like the measure to be implemented, but we also want a series of additional measures to be introduced to mitigate unanticipated consequences.

The Convener: I ask one of the two representatives from the Convention of Scottish Local Authorities to give us a brief comment.

Councillor Eric Jackson (Convention of Scottish Local Authorities): I am pleased to represent local government in this afternoon's discussion. Local government is both a provider and a procurer and, as our written evidence makes clear, we are broadly in favour of the minister's proposals because they will help to target resources at where they are needed. However, our submission contains a couple of caveats.

The Convener: We move next to Lesley Aitkenhead from the East Lothian community care forum.

Lesley Aitkenhead (Scottish Community Care Forum): Although I am from East Lothian, I am representing the Scottish Community Care Forum this afternoon. We are against the proposals. We feel that both visits should be retained, because they are essential and serve different purposes.

Susan Munroe (Scottish Partnership for Palliative Care): I represent Scottish hospices in the voluntary sector. We unanimously support the proposals, because the care commission's limited resources should be targeted at where they are really needed: improving the quality of care.

Will Mallinson (EARS Independent Advocacy Service for Older People): We have consulted advocacy services in Glasgow, greater Glasgow and Fife on this matter and feel that we are against anything that would reduce the meaningfulness of inspections. However, we would go with the proposals if there were caveats.

George Hunter (Association of Directors of Social Work): Like Annie Gunner, we broadly welcome the proposal, but take a "Yes, but" view of it. Although we accept the amendment, we seek certain conditions with regard to where and how risk assessment processes would be carried out.

The Convener: We are also joined by two representatives from the care commission.

Jacquie Roberts (Scottish Commission for the Regulation of Care): The care commission is in favour of the amendment, because it wishes to improve safeguards for people who use care services. We believe that having greater flexibility to target resources at services that are not providing a certain level of care will enhance the commission's ability to provide scrutiny.

The Convener: Now that everyone knows where everyone stands, we will move to the discussion of the amendment. It appears that the consumers are unhappy with the proposal; that the providers are happy with it; and that a few folk are ambivalent or take a "Yes, but" view.

Kate Maclean (Dundee West) (Lab): I will ask the Scottish Executive witnesses some general questions that refer to something that the convener said in her opening remarks. Why are the measures being introduced in an amendment at stage 2 instead of having been included in the bill as introduced? The amendment is substantial and would require more consultation and discussion than many measures that are in the bill already. Exactly what is being proposed? What will the new framework be? Because we have not had much time to consider the amendment, I am a bit confused about that. Does the Scottish Executive envisage that the new framework will be cost neutral, that it will cost more or that it will cost less? It is important that those issues be fleshed out, because we have not had the same opportunity to scrutinise the amendment that we had for other parts of the bill.

Adam Rennie (Scottish Executive Health Department): On the timing, the important point is that the regulatory system is relatively new, and the need for the proposed measure did not crystallise until it was too late to get it into the bill as introduced. However, ministers felt that it was sufficiently important to introduce it as an amendment at stage 2 rather than hang on until the next legislative opportunity, as we do not know when that might be. Ministers thought that the bill provided a good opportunity to make this important change at an early date.

It is essential to bear in mind the fact that the Parliament and the public will have ample opportunity to comment on any proposed changes when the power in question is exercised. If the committee agrees to the amendment, that will change nothing in itself, because any changes in inspection frequencies would be subject to consultation with the commission, then consultation with the general public and, finally, affirmative resolution in the Parliament. The amendment would introduce a new power, but it would not do anything specific until it was used.

I do not know whether that answers your question.

Kate Maclean: You did not answer the question about costs.

Adam Rennie: I am sorry; I answered your first question, and your second question was about the new framework.

At present, the Regulation of Care (Scotland) Act 2001 specifies the frequency with which the care commission must inspect care services. It distinguishes between services that provide 24-hour accommodation, such as care homes and hospitals, and other services, such as pre-school provision or housing support services, for which the inspection frequency is once a year. The amendment would enable ministers to make an order to reduce that frequency for specified care services or specified parts of care services. That order would then be subject to the consultation procedure that I described.

Kate Maclean: Why would ministers want to decrease but not increase the current statutory frequency of inspection? Would bodies that are opposed to the amendment not think that it could work either way? At the moment, the amendment seems to be about taking something away; it is not about varying the frequency in favour of those who receive care.

Adam Rennie: The point about the statutory minimum frequency is that it is a minimum that the commission is obliged to deliver regardless of the circumstances. It can always inspect more frequently at any time if it has concerns. Therefore, ministers did not think that it was necessary to introduce any provision to increase the minimum frequency but, unless there is a provision that enables ministers to reduce it, the care commission will always have to inspect every care service at the specified minimum frequency. There is no problem with the commission inspecting more often if that seems the appropriate thing to do.

Kate Maclean: However, ministers would not be able to increase the frequency by order, although they are giving themselves the power to decrease the current statutory minimum frequency.

14:15

Adam Rennie: That is right, but ministers have powers of direction and, in principle, they could direct the care commission to inspect care services more frequently. At present, we cannot direct the care commission to inspect less often than the statutory minimum frequency, because ministers cannot tell the commission to break the law.

The amendment does not necessarily have any impact on costs. When the power is exercised, it will enable the commission to target its available resources more effectively at care services. In principle, it would be possible for the commission to reduce the resources available in response to a reduced frequency of inspections, but that would defeat the object of the exercise, which is to enable the commission to increase its input into the services that need more resources. In principle, the measure is cost neutral. It could lead to changes, but it need not do so.

The Convener: A significant cost issue has been raised in evidence from a number of organisations. It has been said that the good providers, which are inspected less regularly, will have to pay for the not-quite-so-good providers that you will want the commission to inspect more often. Consequently, there will be detriment to good providers.

Adam Rennie: What you describe already happens under the present regime. The commission inspects various service providers at more than the minimum frequency, but all providers pay it the same registration fees, annual continuation fees and so on. If the amendment were agreed to and the power were exercised, it is likely that cross-subsidising would increase in affected care services, because there would be more headroom for the commission to inspect some providers more frequently, while keeping the others at the new, lower minimum frequency. There is nothing intrinsically new in that—the principle is already established. It is important to make the point that the annual continuation fee covers a great deal more than inspection. It also

covers complaints, which are a major part of the commission's work.

Susan Munroe: The cost to some of the smaller organisations of preparing for and undergoing an inspection is not insignificant. The savings from not having to do that twice a year will balance out the feeling that good providers are subsidising poor services.

Annie Gunner: This is a significant issue for members of Community Care Providers Scotland. Although I agree with Adam Rennie that cross-subsidising already happens, we believe that the amendment stretches it to breaking point. Fees are paid annually, so if there are to be inspections at a less than annual frequency, we may end up paying a fee for no activity. That undermines the Executive's policy on fees. All the regulatory impact assessments that were produced said that fees are based on the level of activity that a provider receives, on a value-for-money basis. I agree that cross-subsidising is nothing new, but our opposition to it is not new either. When the committee discussed the original provision, many of the same issues were raised. I do not want to hijack the entire discussion, because there are other matters that we need to consider, but this is a significant issue.

David Wiseman (Scottish Commission for the Regulation of Care): We want to make it clear that, if a provider does not have an inspection because a risk assessment determines that it does not need so many inspections, that does not mean that there will be no activity or contact. We will require all care services, regardless of the frequency with which they are inspected, to be subject to an annual assessment. When carrying out risk assessments, we will need to consider providers' performance and the improvement that they have made. We will also need to take account of the views of service users. That will not be done through inspection visits. In the case of some services, such visits are not required, because the services are provided in people's homes. Visiting the office of an agency that provides a service does not tell us what the service user is engaged in. We will also consider issues such as how many complaints there were. There will be complaints investigations even against services that are assessed as performing well in inspections.

Jacquie Roberts: I want to summarise. Inspection is only one part of the activities that we undertake, and it is dangerous to assume that we scrutinise services only through inspection. It is important to take a broader view of our activities. We would not support the proposal if we did not think that increased flexibility in the inspection regime will enable us to spend more time investigating complaints and more time with the people who use care services. To use the words that Mr Mallinson used, what we are after is more meaningful scrutiny. The proposal is not about reducing any form of scrutiny; it is about targeting more wisely and meaningfully and spending more time with the people who use care services.

It is also important to register that we cover many different types of services and not simply care homes. We might not recommend at this stage that we go any less frequently into care homes, particularly care homes for older people, because there is a higher rate of breaches of regulations in such homes. We seek flexibility across services, which will mean that, instead of undertaking routine activity, we can spend our time carrying out scrutiny that really matters and getting in touch with the people who really matter—the people who use the services.

The Convener: Under the new regime, might there be services that will go for a whole year with no inspection?

Jacquie Roberts: That could be the case, but we would recommend that only on the basis of a risk assessment, one element of which would be consideration of whether another scrutiny body was going in. For example, Her Majesty's Inspectorate of Education inspects day care services for children. Under the proposals, we will be able to create a much more intelligent regime and, as David Wiseman pointed out, we will still receive information from those services.

Alan Dickson: What Jacquie Roberts says makes remarkable sense, but we would have preferred a fuller evaluation of all the powers and responsibilities of the care commission rather than just one element—the frequency of inspections—being drawn out. We do not wish to see the creation of multiple tiers of and timescales for inspection. In particular, we do not want a system in which a less frequent inspection regime applies to a whole organisation. The regime must be based on individual services. As a large voluntary care provider, we provide a huge number of services and the system needs to be associated with each of those services individually rather than with the organisation as a whole.

Janis Hughes (Glasgow Rutherglen) (Lab): As we heard from the Health Department, the amendment does not seek to change the frequency of inspections but it will give ministers the power to do so, if they wish, after consultation with the care commission and any other relevant persons. Will that be done on the basis of one organisation, one home or one facility? An important point has been raised about who will make the decision and how wide it will be.

Adam Rennie: The consultation duty will fall on ministers and the first consultation will be with the

care commission—that is clear. The next consultation is the one that you are asking about. The Executive has a standard procedure for consulting a wide range of organisations and individuals and we use that procedure for all sorts of purposes. It is standard procedure for legislation to provide that ministers must consult such persons as they consider appropriate.

Our intention would be to consult all the representative organisations that we know about in relation to the service concerned. Obviously, that will vary from service to service. In some cases large numbers of users will be involved but, in others, the service might be specific to a small group of users. It is not possible to say categorically exactly how we will consult, but our intention will be to ensure that when ministers come to the Parliament with an order there has been enough time for everyone who has input to make to have done so. If we fail to do that, the Parliament, if it thought that the consultation had been inadequate, could use the affirmative resolution procedure to say to ministers, "No, that won't do. You will have to go and think again."

George Hunter: I have a question for Jacquie Roberts. Would the care commission take into account the other performance monitoring arrangements that are already taking place? I am picking up a point that was made by Community Care Providers Scotland about local authorities stepping up inspections if the commission was stepping down. Inevitably, local authorities have some responsibilities in relation to the protection of vulnerable people and the proper scrutiny of how the public pound is spent, and there is scope for the care commission to take more account of other performance monitoring processes that might already be in the system. Rather than simply duplicate those processes, the commission could be more co-operative in its approach.

Jacquie Roberts: That is precisely what we wish to do. We would base our risk assessments on existing knowledge of the types of service—that would be one level of risk assessment—and on individual services. We have a number of questions—which David Wiseman could read out to you—about the sort of risk assessments that we would be considering. We would take information from the local authorities, from the care managers and from other scrutiny bodies. The new Social Work Inspection Agency would have information about services delivered in a given area. That is the whole point. Any consultation would have to include not only the providers but other stakeholders in the commission of services, particularly the people who use the care services to ensure that they feel that they can still make complaints to the care commission if they have concerns about the service.

One of the big issues about having to devote so much time to inspection activity is that that can distract from pursuing and investigating complaints in depth, and from following up what needs to be followed up from those complaints. We are stuck to a level of activity and inspections that may not be targeting our time where it should be targeted.

Will Mallinson: I want to ask the care commission what is happening to the recruitment and role of lay inspectors.

David Wiseman: We are in the middle of a pilot of the lay inspection process, and we have piloted the use of lay inspectors in a number of areas in the care commission and in a number of different types of care services. When the care commission came into being, we inherited a position in which the use of lay inspectors had not been consistent throughout the country. We are trying to find the best model for involving lay people in the inspection process. The early indications from the pilot are that lay inspectors bring a perspective to the inspection that adds to the process. As well as bringing an extra dimension to inspection, lay inspectors have been very much accepted by care providers. However, we cannot yet fully evaluate the pilot.

The Convener: From the inspections that you have done so far, what percentage flag up issues that you think need to be pursued? What percentage would you designate non-problematic? We will not hold you to the figures; we are just looking for a broad-brush, across-the-board idea.

Jacquie Roberts: I can give you three broad-brush figures from samples. From the sample of care homes for older people, we would be looking at following up 45 per cent of homes because they are not meeting all the regulations. We make requirements in the report and ask care homes to submit an action plan. For childminders, the figure is about 44 per cent, whereas for day care for children it is only 18 per cent. That shows already that we could reduce the frequency of inspections for some of the services that we regulate. As I said, at the moment we are not recommending any change in the frequency of inspections in care homes for older people or for childminders—we would also be considering the vulnerability of the age groups and the vulnerability of the people concerned. We are looking for greater flexibility to work more intelligently where it really matters.

14:30

The Convener: The submission from Community Care Providers Scotland says:

> "the Care Commission does not inspect against all the national care standards at each visit: it takes several years of inspections to cover all the standards for a service."

Will you confirm whether that is true?

Jacquie Roberts: It is true that the care commission board decided that we should focus our inspections for all services of a certain type on a specific number of the standards. If we have concerns about a service, we look at all the standards and regulations. That is the routine. If we inspected against all the standards all the time, that would probably take us 10 times longer. We are trying to target our attention. For example, one year we might be particularly concerned about health and safety, especially fire safety, in care homes, in which case we would devote more time in that year to looking at those issues.

The Convener: A number of people have their hands up. We will hear from Councillor Jackson, then Helen Eadie.

Councillor Jackson: My question is for Jacquie Roberts. Jacquie, you have mentioned care homes for older people on a number of occasions and you said that you would not reduce the frequency of visits, on the basis that a large percentage of complaints concerned such homes. We have a particular issue with residential child care units and would like to see the number of visits maintained on the ground that they provide an opportunity to young people to speak to someone independently. What is your view on that?

Jacquie Roberts: We agree. The figures that I was talking about were about 36 per cent or 38 per cent of care homes not meeting the regulations. We agree—again on the basis of a risk assessment—that, in those cases, service users are more vulnerable and need to have as much external scrutiny as possible.

The Convener: I have a related question. If one aggregates services to older people with services for those young people, what percentage does not meet the regulations?

Jacquie Roberts: There are 1,740 care homes, which account for 11.7 per cent of our registered services.

The Convener: Are those homes for older people?

Jacquie Roberts: That is all care homes—for older people, children and some adults with learning disabilities or sensory impairment.

Helen Eadie (Dunfermline East) (Lab): I note that some of the messages in the correspondence that we have received in our in-boxes about this subject are suspicious that the proposal is driven by concerns about resources rather than quality. In my local authority area, people are most concerned about the protection of vulnerable adults and children; they remember when residential homes were regulated by local authority staff and feel that we should maintain that baseline provision. I am reassured to hear that you are directing some thought towards that.

In its submission, the Scottish Association for Mental Health said that it favoured inspections based on a rewards system—for example, care homes that received an excellent inspection result for three consecutive years could receive a gold star rating and, on condition that they retained that star rating, would be inspected only once a year, for example. Such a system would motivate providers to improve standards in order to receive a gold star rating; it could be a useful tool to drive up standards. We might smile at that, but it happens in VisitScotland and across a whole range of service provision. What are your comments on that?

Jacquie Roberts: I would like David Wiseman to respond to that, because we are doing some detailed work on how we will make information about the quality of services available to providers and service users.

David Wiseman: We are in the middle of developing a framework that will allow us to look in much more detail at quality against the national care standards. It is important to measure the outcome for people who use care services. Saying that a particular care service is a one, two or three-star service might not be as useful as saying how well the service performs against quality standards. To someone wanting to use the service, some aspects of the national care standards might be more important than others. We want to know the strengths of the service and the areas in which it might have to improve, but the approach has to be a bit more sophisticated than offering one, two or three stars.

Another issue is how inspections might relate to incentives. A factor to be considered is how well an organisation is performing. The risk assessment process, about which I may be able to say more later, will consist of two tasks: one will inform our recommendations to ministers on the frequency of inspections; the other will consider individual services within that service type.

Our approach will have to recognise that, for some providers and for some service types, the frequency of inspection could be reduced. However, we have to have a way of knowing about any trigger points or changes, because a good care service or a good care sector can suddenly change. We might suddenly see a high staff turnover or a huge increase in the number of complaints about a service type. In such cases, we might—despite there being a reduction in the minimum frequency of inspections—decide to increase the frequency of inspections ourselves.

The care commission would be able to carry out random surprise inspections. It might have been

determined that the service type should have a minimum frequency of inspections of one a year or one every two years, but there would be nothing to prevent us from doing random inspections. We need to keep people on their toes so that they do not become complacent and think that inspectors will not be coming around. Unannounced random inspections often help to bring about improvements.

The Convener: How do you monitor staff turnover?

David Wiseman: We request information on staff turnover from providers. We do a pre-inspection return every year, during which we ask for details on qualifications and staff turnover. Organisations have to tell us if there is a change in manager—

The Convener: May I cut you off there? A pre-inspection return presupposes an inspection. Under the new regime, that may not happen.

David Wiseman: No. Under the new regime, we would want such information as part of the assessment process every year. As I said, we would need to have an annual assessment.

The Convener: So, you are saying that although some organisations may not get an inspection, they would still have to go through the pre-inspection.

David Wiseman: Yes.

The Convener: So a certain amount of the bureaucracy associated with inspections will continue.

David Wiseman: Some of it will continue, but bureaucracy can lead to information that is crucial to making decisions on priorities.

Annie Gunner: Self-assessments are going ahead for pre-inspection returns. Providers do that, but there is an issue over whether we should pay a significant fee for work that we do ourselves.

I wanted to pick up on a point that George Hunter made, but it is not on the topic that we are discussing now. We should let this one run.

The Convener: All right. I will bring in Shona Robison, who was, I think, involved in the original legislation that led to the status quo.

Shona Robison (Dundee East) (SNP): Yes. I wanted to make a comment before asking a couple of questions. During the passage of the Regulation of Care (Scotland) Bill, the level of inspections was a contentious issue. A number of us wondered whether the existing inspection regime would be adequate and we argued for two unannounced visits rather than one pre-arranged visit. It concerns me slightly that, within a relatively short period, we are back round the table discussing the matter.

Another issue that was raised at the time were the possible repercussions of the care commission being self-financing. Is the fact that we are now sitting round the table again one of the repercussions? Jacquie Roberts said that the care commission would like to be able to spend more time dealing with complaints but that, because of the inspection activity, it is not able to do that to the extent that it would like. That says to me that the commission is having to make a choice, when surely both roles are important. We want to ensure that the care commission is resourced to carry out both roles adequately. Is the fact that a choice is having to be made a result of the self-financing regime? Obviously, that is a ministerial policy decision and I would not expect you to comment on it specifically. However, would you not prefer it if you were able to do both things to the extent that you would wish?

Jacquie Roberts: I chose the example of the complaints and inspection activities competing because the inspection activity is a statutory requirement each year. By January, February and March, we have certain things to complete in order to meet the statutory requirement. If the number of complaints suddenly went up or if we received a serious complaint that we needed to investigate, that would inhibit our inspection activity. That is the sort of competition that I am talking about. It does not help us to look at where the risks in services really are. We have to carry out certain routine inspections, but we should not only be about routine inspections.

The issue is not about full cost recovery; it is about the intelligent use of resources, no matter how we are funded. I assume that members of the Scottish Parliament would not want to spend more and more money on scrutiny at the expense of investing in the delivery of services. We are trying to have a more targeted and intelligent scrutiny regime that helps services to improve and gets information flowing better between the providers, the regulatory body and the service users. The issue is not that we think that we should do more inspection; it is about how we do our work.

I say in response to people who are wondering about the timing that, from quite early on, the care commission and its staff have not been certain that we are doing the best, most meaningful form of scrutiny simply by carrying out inspection activity. We think that we need to look at a more rounded process that includes all the work that we do with the providers in getting the information. We also need to work with other scrutiny bodies, such as HMIE and the people in local authorities who find out information about services.

Shona Robison: One of the difficulties that you will face will be in convincing the public that the agenda is not resource driven—given some of the high-profile cases that have been in the public domain, that is a real concern. The fact that the issue has suddenly arisen without much notice may not help to reassure the public. The proposal is almost like an add-on to which not an awful lot of thought has been given.

During this discussion, we have heard that the policy intention would not be to reduce the inspection level of care homes for the elderly—that is what the care commission has said. However, in reality, would not that be a possibility, if you decided that it was to happen in the future? Although you are saying that, for the time being, the policy intention is not to reduce the level of inspection, the fact that the legislation is being changed makes such a reduction a distinct possibility.

That would be the big concern for many members of the public, as care homes for the elderly are the sector in which the most high-profile cases have been raised. How can you enshrine what you say about the commission's policy intentions a bit more solidly than just in a round-table discussion that is recorded in the *Official Report*? You say that that is your thinking at the moment, but there is nothing to make it so for ever and a day. The situation is a bit fluid.

14:45

The Convener: Could you come to a question, please?

Shona Robison: What we are dealing with is a fluid situation; we are learning stuff as we are going around the table.

The Convener: You are taking a very long time to ask your question.

Shona Robison: I am suggesting that what we are doing is not the best way—

The Convener: It is the situation that we are in at the moment and you are going on a wee bit, Shona. Focus a bit.

Shona Robison: Can you say whether your intention would be enshrined in some kind of long-term policy?

Adam Rennie: Your question was addressed to Jacquie Roberts, but it is mainly a matter for the Executive, as it would be ministers who would need to consult the commission and the public and bring forward the orders. The decision on whether any particular care service category would be the subject of an order would be for ministers. However, as Jacquie Roberts has made clear, the amendment obliges ministers to consult the commission closely beforehand.

The issue of care homes came up just last week in the media. I am sure that you all saw the Deputy Minister for Health and Community Care's letter in the press the next day, which said that the Executive has no plans to make an order in respect of care homes for older people. The powers will be used only when it can be demonstrated that the quality of a particular care service will not be affected. Indeed, the purpose of using the power is to enable the overall quality of the particular care service category to be driven up by making more effective use of the regulatory resources that are available for that category.

If the question is whether the change in the legislation opens up the possibility of the power being used in respect of care homes for older people, the answer must be yes. However, to put what Jacquie Roberts said the other way around, nearly 90 per cent of the care commission's registrations are not overnight-type services and are subject to the once-a-year minimum inspection requirement, not the twice-a-year requirement. The purpose of the amendment is to enable sensible changes to be made to the system over the years, as experience of the use of the system grows, with the safeguard that the Parliament will always be able to say no to any particular proposal.

The committee might or might not find it reassuring to know more about the situation in England. There, nothing is set down in primary legislation about inspection frequencies and ministers have a power to make orders, but those orders are subject to a negative, not an affirmative, procedure. Ministers have never made orders, however, and the inspection arrangements in England are made as a matter of policy. The situation in Wales is similar.

In Scotland, we have a tightly defined situation with regard to inspection frequency. The amendment seeks to introduce the possibility of varying that situation when it seems sensible to do so and subject to the final control of the Parliament.

The Convener: Do you have a follow-up question on that point, Shona?

Shona Robison: No, that is fine.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): The submission from the Scottish Pre-School Play Association highlighted a point that has been touched on. It says:

"Many day care services in the voluntary sector are vulnerable to frequent changes in management and/or staff. Lengthening the time between inspections may contribute to a diminution in the quality of service."

Do you have enough staff to scrutinise the information that you collect and to double-check the forms that are submitted? An establishment that might be okay at one point might have a frequent turnover of staff. Many of those workers are not well paid and are in and out of their jobs. In a lot of establishments, I have seen for myself the situation that the Scottish Pre-School Play Association talks about. I have seen qualified staff have a half hour deducted from the morning nurse's shift and the afternoon nurse's shift to the point that they did not have a changeover period during which they could pass over information. The workforce is what makes such institutions work.

Jacquie Roberts: Under our current system, the individual care commission officer who is responsible for the regulation of the service receives that information and makes a risk assessment in consultation with their team manager about the relative risks of that service. The commission has the capacity to consider the information that is available and has three years of experience and inspection reports to look back on.

Dr Turner: An establishment that seems to be perfectly good could turn into one that is not so good immediately after a form has come in and staff have visited it. How can it be checked up on? If the period between inspections is lengthened, the fact that the establishment is not so good might not be picked up on as quickly as it was. I am trying to examine that issue.

David Wiseman: The proposal requires us to be provided with information when there have been significant changes, for example. Therefore, we will be required to be informed of a change of manager, which is a potential trigger point for us, as a manager can be crucial to the provision of quality in a service. Obviously, a change of manager means that we must look back and ask whether we should go in and dig deeper.

Of course, concerns can also be raised with us through the complaints process. There have, on occasion, been high numbers of complaints about staffing issues. Changes or reductions in staff levels will start to raise concerns about the quality of care that is provided. The service may have been seen as having performed extremely well over the past couple of years, but we would want a number of trigger points to be in place to ensure that any changes lead us to a position in which we can decide whether to alter our assessment of the need for a more in-depth inspection or more frequent inspections. It is important that we try to focus our time on areas of service that require more scrutiny in order to drive the improvement agenda. Rather than visiting everything every year, we must take into account the fact that some people need more support, encouragement and scrutiny to develop their services.

Alan Dickson: Everyone around the table recognises that any number of inspections will not guarantee that there will never be a problem in any service at any time. Staffing is a particularly important issue. A national workforce group, which is chaired by Euan Robson, is currently considering the whole social care sector and its recruitment and retention difficulties. There may be one, two or 30 unannounced inspections, but that will not guarantee that there will be no problems.

Unlike in England, a system has been put in place here that has gained public confidence—the public and service providers have had confidence in the care commission's work. In some instances, there is contract monitoring by local authorities and there are all the other inspection processes and monitoring programmes that are in place. It seems to me that we are in danger of considering only one element—the number of inspections that the care commission has carried out—without looking at things in the round and seeing all the various aspects.

We must ensure that we do not look at things in isolation and that the substance of any change—that is, how such a variable system might work—is developed in conjunction with the industry. We must ask how a change will work, what it will look like and what it will mean, but we will not put such matters to bed today. There must be wide consultation with the public, because there is a danger that the confidence that has been generated can be ruined, regardless of who is right or wrong, by the perception that the need for inspections is somehow being reduced.

Lesley Aitkenhead: I speak on behalf of service users and their carers and want to say something about what Alan Dickson has said. There is confidence in the care commission at the moment, but that can be lost. I return to what Shona Robison said: keeping public confidence is important. Service users and carers have made complaints to the care commission and have done so uncomfortably, as they have reported on facilities that they are using, but it is important to understand that many people do not complain.

I am interested to know whether the one visit would be unannounced or scheduled. People want an unannounced visit, because they want to be able to see that the provider is providing. Unannounced visits should not be ad hoc. They should take place once every three years, for example. The issue is how that is built in to the system.

The Convener: I will bring in Andy Sim, because he might pick up on some of the same issues.

Andy Sim: Alan Dickson makes a good point, as does Lesley Aitkenhead on trust and confidence. Without regular contact with inspectors, care home residents' perception of their ability to complain will be eroded. We know that there is a problem around complaints. Care home residents are still afraid to make complaints, because they do not have security of tenure. They can make a complaint and it can be upheld, but the next week they can be evicted from their care home. That is the worry that people have.

Allied to that is the shortage of other protective elements, such as access to advocacy for care home residents. Currently, only around 12 per cent of the advocacy pot for Scotland goes to older people. They are by far the largest group of care service recipients, but they receive a tiny amount of the money.

We talked earlier about agreeing to the amendment. Our caveat is that, if minimum inspections are taken away, we would like further regulation in other areas, such as the right to advocacy and security of tenure.

The Convener: Your written evidence states that you

"would wish the inspection process to be more wide reaching and integral through the inclusion and involvement of residents"

and others. That is partly what you have been saying, but in a sense it runs counter to the proposals. The care commission wants to reduce inspections, whereas you want to strengthen them.

Andy Sim: Will Mallinson asked the care commission about lay assessors and received a good response. He might like to pick up on that.

The Convener: Would the care commission like to pick up on that?

Jacquie Roberts: David Wiseman also wants to come in on this point. We are not talking about reducing the attention that is paid to people who use care services. We are talking about greater flexibility. One of the proposals is to spend more time with service users. If we do not have to go through a lot of routine processes, we will have more time to build even greater confidence.

It is good to know that we are gaining the confidence of people who use care services and that they have confidence in our response to complaints. Having more flexibility will give us even more time to spend with people who are making complaints and to help people who receive care services to feel confident about making complaints, not only to the care commission as an independent scrutineer, but to the people who provide the services, so that they can learn about what they need to do to improve their services.

David Wiseman: We use announced and unannounced inspections in the process—both have a part to play. It is important to recognise that we are not talking about reducing contact. We are talking about reducing the number of inspections in certain cases where there is risk assessment. That will mean that we can develop a lot more contact in some areas, particularly with carers and people who use care services.

Our main contact with people who use care services is during an inspection, so our role is limited in that respect. We want there to be more opportunities during the year to hear from carers and people who use care services about the level of service that is provided. That is not just done by putting in place an inspection process. Other techniques can be used to have contact with people and to meet them outwith the inspection process. We are talking about engaging much more with people who use care services.

The Convener: Andy, do you want to come back on that?

15:00

Andy Sim: I do not think that that is what I was saying. I was saying that tightening other areas of regulation might reinforce the rights of care home residents. I was not making a criticism of where the care commission is going, but the concern is that the proposed reduction of the number of inspections could undermine trust.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I would like to hear more from the people round the table about what we do in the round. As has been said, we should not believe that one inspection—or even 30 inspections—would be a cure-all. The process is hit and miss and pretty negative. My observation is that it allows some care home operators to transfer their responsibility for standards on to somebody else and to say, "Well, it's not really my responsibility, so we'll wait and see what the report says before we institute any action." There seems to be a defence of something that is four years old and which is a moveable feast. The purpose of the process is to examine how the legislation is working, because it was made four years ago, so I would like some feedback on what could be done to improve the situation and to support flexibility.

Public confidence is important, although surely it should not override the need for inspections. We should not do anything differently just to appease public opinion. However, I need an assurance, on the record, about what Andy Sim said. Does the care commission, or anyone round this table, have any evidence whatever that an elderly person in a residential home who has made a complaint has been evicted from that home as a consequence? If

that claim cannot be substantiated, we are perpetuating the fear and the myth that people should not and cannot complain and that, if they do complain, there will be dire consequences. We need to clear up that point.

The Convener: Perhaps somebody from Age Concern Scotland can answer that.

Andy Sim: There was a report in the *Daily Record* about 15 months ago about a lady whose relatives made 10 complaints, of which nine were upheld. She was evicted, or put out—often the situation is not described as an eviction, but will be referred to as a case of the home not being able to meet the resident's needs, the resident exhibiting challenging behaviour or a number of other euphemisms that mean that the care home does not want the resident there. Another advocacy organisation in Edinburgh brought me the case of a chap who was threatened with eviction after making a complaint. That threat was made in front of somebody else. The case was resolved, but partly because there was an advocate there, so there was a safeguard.

Will Mallinson: I can back that up. Eviction is a real threat for many people and we have seen an increase in the number of residents who have been threatened with eviction.

The Convener: Do you have evidence of that?

Mr McNeil: Could you supply that evidence to the committee?

Will Mallinson: Yes.

The Convener: If that is the case, it is quite important for you to provide us with the evidence. Duncan McNeil is right to say that the issue is serious.

Andy Sim: I was given permission to present evidence about somebody's case, so I can give that to the committee.

The Convener: I invite the witnesses from the care commission to comment.

Jacquie Roberts: We have quite a lot of evidence of cases of a breakdown in the relationship between relatives and care home providers and of the resident being moved to another care home. I do not have any direct evidence of people being evicted because of the level of complaints, but I know that there are examples of relationship breakdowns.

Alan Dickson: I want to pick up on that point. I speak for Capability Scotland, and I am sure that I also speak for many of the organisations represented by CCPS. It is not a question of waiting for the care commission or a local authority to judge whether or not our services are appropriate for our service users. We are determined to do that work ourselves and to have our own audit procedures and quality assurance. Indeed, that is a requirement on us and in any case we would be constrained by the care commission's request for information. One of the key roles for the majority of providers, particularly for large organisations and local authorities that require a large number of services, is monitoring their own service provision.

The question is not simply whether the public has confidence in the system. The care providers and the clients of those services must also have confidence. Moreover, I am talking not just about the public perception of confidence. If confidence breaks down in any system, we will not be able to deliver quality services. I realise that our debate should not be constrained simply because some people might not fancy it—that is certainly not my point—but I am concerned that we should move away from the issue of the number of inspections. I take from Jacquie Roberts's comments that that is not the intention behind the amendment. However, the danger is that the proposal will be seen solely in those terms and that we will not be able to have enough of a debate about what it will mean. That is why we must interact with everyone before any decision is taken. In other words, any decision to reduce the number of inspections must not be taken before a full consultation has been carried out and people have determined how effective the measure will be.

Annie Gunner: On Duncan McNeil's comment that some care providers might want to hand over responsibility for quality assurance to the care commission, local authorities or anyone else, our submission makes it clear that we want much more harmonisation between the regulatory process and providers' own quality assurance systems, many of which are quite sophisticated, to ensure that the question is not simply whether someone turns up on the doorstep once every six, 12 or 18 months. We want a system that is validated by the care commission, which means that there will be constant monitoring.

For us, the proposal is less about the reduction in the number of inspections than about the reduction in the minimum frequency of inspections, which means that although some people will get less attention, others will get more. The question then is how we determine who gets more and who gets less. If we can tie that in with the quality assurance systems in provider organisations, we will be halfway there.

George Hunter referred to the relevance of local authorities' own performance monitoring of the services that they purchase. We should remind ourselves that the Regulation of Care (Scotland) Act 2001 removed responsibility for registration and inspection from local authorities and gave it to the care commission. We supported that measure

at the time and still do. We believe that the care commission should carry out that work.

Although I realise that local authorities have a duty of care to the people on whose behalf they purchase care services, the implication that regulation should somehow become a joint venture between local authorities and the care commission concerns me. I have no problem with local authorities agreeing the risk assessment tools that should be used; however, once that is done, they should let the care commission get on with its job. Local authorities in some areas are already beginning to duplicate some of the care commission's processes, and the committee ought to be concerned about that real problem. There are several factors to take into account, and providers' own quality assurance systems represent one of the most important that we can come up with.

The Convener: Does Duncan McNeil want to come back on any of that?

Mr McNeil: No.

George Hunter: In response to Annie Gunner's comments, I fully accept that the care commission is responsible for regulation. However, as Alan Dickson pointed out, we can make sense of this matter only by examining all the broad areas of performance monitoring, including providers' own quality assurance mechanisms. Local authorities are required to review the situation of individuals who are in the care of or are receiving services from particular providers. We cannot duck that obligation. When we commission a service to a service specification, we have an obligation to ensure that the service is being provided to that specification.

I have some sympathy with the fact that that can appear to duplicate what the care commission does. I am making a plea not to share the regulatory responsibility—we do not do that—but to examine the variety of quality assurance processes that exist in the service and to take them all into consideration. To me, it is the care commission's responsibility to do that. If there are regulations, requirements and conditions to be imposed, that is the care commission's responsibility. I am not looking to share that responsibility; I am simply asking that we consider the performance monitoring framework that exists for all services in its entirety.

The Convener: Does Annie Gunner want to add anything to that?

Annie Gunner: No, thank you. I just welcome that statement.

The Convener: Is anybody waiting to jump in on any specific topic?

Bob Christie (Convention of Scottish Local Authorities): I would like to follow up Duncan McNeil's useful question on the capacity and flexibility of providers to improve services on their own behalf. We have identified a number of the elements that make that possible. Clearly, the providers' own service improvement framework is important. There is an onus on them; they should not place the onus on the regulatory bodies. There is the care commission's inspection regime, with its recommendations and requirements and, where appropriate, the local authorities' quality assurance frameworks. However, the real capacity and flexibility to make improvements comes from the resources that are available to the provider. Unsurprisingly, that leads us into the cost implications of a full cost recovery policy for registration and inspection. I know that it is not quite the subject of this debate, but it is difficult to see how we can achieve the quality improvement that we are all aiming for when full cost recovery limits providers' ability to achieve it.

The Convener: It is clear from the evidence that significant contention surrounds that issue, which is not central to the amendment although we are not ignoring it. The Health Committee is about to embark on an inquiry into care in Scotland, and I invite witnesses to consider whether it might be appropriate to raise some of those issues in that context.

I have a couple of mopping-up questions, and I will come back to the care commission and the Scottish Executive for a final round of questions if that is desired. I have noted a couple of minor issues as the debate has progressed.

First, a little way back, Jacquie Roberts commented that the care commission was not about carrying out routine inspections. I would like to take you up on that. Lots of things in society are subject to routine inspection, including schools and prisons. What do you mean when you say that the care commission should not be about routine inspections? Routine inspections are part and parcel of many of the services that are delivered in Scotland.

Jacquie Roberts: I meant that the care commission is not only about routine inspections. I was talking about inspections being part of a much bigger range of regulatory activity. We have been asking how scrutiny can contribute to improved services. We believe that that can be achieved through greater flexibility and by considering scrutiny to be much wider than inspections. That is how we will improve.

The Convener: You were not suggesting that the care commission should opt out of conducting routine inspections altogether.

Jacquie Roberts: No.

The Convener: My second question is for COSLA. Your written submission indicates that you are, quite rightly, representing the majority view, although a minority of the councils that you managed to get responses from did not want a reduction in inspections. I am not asking you to name those councils; that would not be fair. How many councils did you manage to get comment from and how many comprise the minority?

Bob Christie: We got comments from 19 or 20 councils. You will appreciate that it was quite a rushed consultation.

The Convener: Yes, I appreciate that.

Bob Christie: Looking closely at what we received from councils, we feel that the minority view is a view mainly on care homes for the elderly and, to a lesser extent, residential care for children, whereas the majority view relates largely, but not exclusively, to care services such as nursery classes. In the time available, we could consult only officers—directors of education and social work. There was not a coherent, politically approved response.

15:15

The Convener: How many of those consulted took the minority view?

Bob Christie: Six or seven.

Councillor Jackson: The good thing about today's meeting is that it has given people a chance to express their views. I have certainly understood where people are coming from. Had some of those who took the minority view been here today, they might have changed their response to us, given the evidence that has been presented, in particular by the care commission.

The Convener: I hope that copies of the *Official Report* of today's meeting will be sent to all the councils that responded.

My final question concerns a conflict that I perceive between the evidence from Capability Scotland and that from the Scottish Partnership for Palliative Care. Susan Munroe spoke about the issue of care at home, as opposed to care in the hospice. Her view was that the Scottish Parliament should

"reconsider the requirement to register this service separately"

and that hospice services should be treated as a singleton. That is in direct conflict with comments by Alan Dickson and the written evidence from Capability Scotland, which states:

"If there are to be different status for different services, it has to be applied to all the services within an organisation and not just the organisation itself. To allow a whole organisation providing several services to be inspected less frequently would create potential loopholes".

Would Susan Munroe and Alan Dickson like to discuss the apparent contradiction that I have identified? It is interesting that there are two opposing views of the situation. Will the witnesses explore what they mean?

Susan Munroe: I suspect that the issue is the definition of key services. On the whole, our care at home services involve one or two clinical nurse specialists working from a hospice as part of the multidisciplinary team that is based in the hospice. The care that is delivered in a patient's home is advisory, supervisory, supportive care, not physical, hands-on care.

Alan Dickson: The issue is probably as Susan Munroe has described—at least, that is my excuse, and I am sticking to it. Earlier I made the point that a number of different organisations will provide different forms of services of a different size and on a different scale in different parts of the country. I speak on behalf of an organisation that is quite widespread. As we said earlier, organisations need to be able to show that their systems, processes and quality procedures are embedded in and cascaded throughout the organisation. However, I am concerned that, if an organisation is seen simply as a quality provider, there is a danger that a specific service could go off the rails, given the points that were made earlier about high turnover of staff and so on. I am concerned that we could find ourselves in a difficult position as a result.

Susan Munroe: There is also an issue about levels of service provision. I work for Marie Curie Cancer Care, which has two hospices in Scotland. There is one service provider, but I do not believe that the hospices should be regarded as one service and have one inspection. They should be registered and inspected separately. However, all the services that are delivered by each hospice should be regarded as one service.

The Convener: Your comments have resolved an apparent conflict, which is useful.

In a moment, I will seek final comments from the care commission and the Scottish Executive—if the Executive has anything to add. Before that, we have 10 minutes in which to take mopping-up questions from members.

Shona Robison: I have a question about the process. I am still not clear why this issue was not flagged up earlier. Were discussions happening behind the scenes? Did someone suddenly realise that there was an opportunity to change the regime?

Adam Rennie: The Smoking, Health and Social Care (Scotland) Bill was proceeding in accordance

with its timetable. As I said earlier in response to a question from Kate Maclean, the idea of amending section 25 of the 2001 act emerged during the passage of the bill. Ministers had to decide whether to include the provision in the bill or to leave it until a later legislative opportunity.

We were keenly aware that the Health Committee was to review the Regulation of Care (Scotland) Act 2001; various colleagues mentioned that. We have various ideas for other things that could be done to improve the act. The care commission has a shopping list and there have been various other ideas; Susan Munroe made a point about the registration of services. We thought that this idea was sufficiently important to introduce now instead of waiting until the wider review is completed, because at the time it was unclear what the timetable for the review might be and it was certainly unclear what the timetable would be for any legislation that would follow the review.

Shona Robison: I wondered why the issue was not sufficiently important to be raised at stage 1.

Adam Rennie: Do you mean in the course of the stage 1 debate?

The Convener: No, in the course of the evidence gathering sessions that took place in the run-up to the stage 1 debate. Why was the issue not in the draft bill?

Adam Rennie: It was not in the draft bill because the decision had not been taken at that point to go ahead with the legislation. I think that I am right about that, although I would have to check the timing. It happened quite late in the day. We were certainly not sitting on a complete amendment and letting the bill proceed without it, with the intention of producing the amendment at a later stage.

The Convener: Perhaps Linda Gregson has a comment.

Linda Gregson (Scottish Executive Health Department): Adam Rennie is right. Other areas of the country were producing reports on better regulation. The care commission had been in place for a relatively short time but we were not sitting on the idea. We needed time to crystallise our thinking about what we needed to do.

The Convener: Had the representatives of the consumers who are here picked up any rumours that something was in the offing? If so, can they remember when they picked them up? Perhaps they did not pick up anything.

Helena Scott (Age Concern Scotland): We echo what Shona Robison said. We only knew about the amendment about a week and a half ago.

The Convener: So you have not been involved in any conversations about the amendment.

Helena Scott: No.

The Convener: Were any of the other consumer representatives involved? I appreciate that some people are consumers and providers. No one seems to have been involved until now.

Will Mallinson: I wanted to mention something that has been raised a couple of times today: the national care standards. If inspections and assessments are to be measured against those, they need to have some teeth, because providers know that they are for guidance only. That might require to be considered with the legislation.

Mrs Nanette Milne (North East Scotland) (Con): Have any of the consumer representatives who voiced concerns at the beginning of the session gained reassurance or otherwise from what we have heard this afternoon?

Alan Dickson: Yes. I have been reassured by what Jacquie Roberts and David Wiseman said, but I still come back to the fundamental point that more work needs to be done before the decision is taken.

Lesley Aitkenhead: I agree. For example, I do not understand how a mental health service user can inform the care commission, or how the care commission will pick up on stuff if it is making just one inspection per year. I have not got to grips with the process. The care commission seems to be relying on people making complaints and I am not sure about that. The inspections will need to be more thorough.

Councillor Jackson: We were broadly supportive in the beginning and I will talk to those colleagues who expressed concerns and give them chapter and verse on what has happened here to see if that will change their minds at all.

Andy Sim: It is reassuring that there are no proposals to hit older people in care homes with fewer inspections. However, there is still a worry that that could happen in future.

The other point is about unannounced inspections; we really hope that they will continue, otherwise—like the Queen—the inspectors will think that the world smells of fresh paint.

The Convener: I invite the witnesses from the care commission to make a final, brief comment. As you have responded throughout the discussion, I do not think that you need to give a long response, but perhaps you could pick up on some of the concerns that have been expressed.

Jacquie Roberts: It is important to emphasise again the different types of services that we inspect. We have had a lot of pressure from people in the housing sector—we regulate housing

support services, in particular sheltered accommodation for people with lower levels of vulnerability—and the child care sector, who say that it is not right to have a one-size-fits-all approach. It is important to note that the legislation will enable us to consult on what we might do for different types of services. We absolutely do not want to lose the concept of unannounced inspections and we are about to go into a big public consultation about how we do registration and inspection. The amendment will allow us to consult on the minimum frequency of inspection, which is a small part of the work that we do.

The Convener: Thank you. I do not want everybody from the care commission to say something if that is not necessary. Does Adam Rennie wish to make a final comment?

Adam Rennie: Yes. The strong message that I have heard is that consultation is desirable even if, as in this case, we think that we have good reasons for our proposals. That was a learning point for me. Our thinking was that the proposal will acquire meaning only when it is applied in relation to particular care services. Many of the comments that have been made were about care home services for older people and there will be consultation on that. As Jacquie Roberts said, the proposed power is an enabling power. I can see that we will have to go back to the drawing board next time we have a bright idea. Nevertheless, I think that it is important that we do this.

I give an unequivocal assurance that unannounced visits will continue. It is a requirement of the 2001 act that where services get two inspections per year, one of them must be unannounced. The only difference in our proposal is that instead of there being two inspections per year, there will be two inspections every 18 months or whatever, but one of them will still be unannounced. The commission has the power to do unannounced visits anywhere at any time.

As I have mentioned, we acknowledge that it is desirable to consider issues in the round and the Health Committee's inquiry will afford a tremendous opportunity to do that. I stress that the amendment will not change anything. The care commission will still be under a duty to do exactly what it does now. It is only when the Executive has consulted the care commission and the public, when it has come to the Parliament with proposals and when the Parliament has approved them that anything will change. That will obviously take some time, and assumes that the amendment is agreed to.

Finally, I stress that the purpose of the amendment is to improve the effectiveness of our regulatory system to drive up service quality for users. That is why it has been lodged.

The Convener: It is always salutary to be reminded that what is self-evident to us is not necessarily self-evident to everybody else. Even things that we think are self-evident need to be tested. I remind members that they will have the opportunity to debate the matter with the minister on 31 May. I expect that some of the issues that have arisen in today's session will be raised at that meeting.

I thank all the witnesses for their contributions. I hope that you found the exercise useful and that you got more out of it than if you had been sitting as panels of witnesses with the normal question-and-answer format. In a sense, you have heard from the horse's mouth some reassurances that it might otherwise have been difficult to get.

15:29

Meeting suspended.

15:36

On resuming—

Smoking, Health and Social Care (Scotland) Bill: Stage 2

Section 9—Free oral health assessments and dental examinations

The Convener: I welcome the minister and her officials to this afternoon's session. We expect to reach amendment 11 today. We hope to deal with this item in about an hour—that is the plan.

Amendment 23, in the name of Nanette Milne, is grouped with amendment 24.

Mrs Milne: Convener, you will have to guide me as this is my first experience of stage 2. Do I move both my amendments together?

The Convener: Speak to both amendments, and move amendment 23.

Mrs Milne: Amendments 23 and 24 would remove free dental and eye checks from the provisions of the bill. My colleagues and I consider that to provide free eye and dental checks for everyone by 2007 would not be the best use of public resources—free checks are already available for people who need them. The difficulty lies in persuading those who are eligible for free checks to come forward for them and, in the case of dentistry, in finding sufficient national health service dentists to carry them out. Moreover, once the checks are done, there are in many parts of the country not enough dentists working in the NHS to carry out treatment that may be required. It is neither sensible nor ethical to make a diagnosis and then not to carry out the treatment.

The Executive's recently announced dental health action plan is intended to correct the lack of NHS dentists, but despite the plan, dentists are still leaving the service. Only yesterday in Aberdeenshire, yet another Grampian dental practice left the NHS. As was predicted, dentists are not impressed by what is on offer. It seems pointless to legislate for free dental checks that are unlikely to be carried out. It would make more sense to try to ensure that people who are currently eligible for free services actually make use of them.

On eye tests, many optometrists already offer free eye checks, together with good financial deals for purchasing spectacles. I can see little point in subsidising the system with taxpayers' money that could be put to better use, for instance in improving retinal screening for diabetes or in expanding the use of photodynamic therapy for treatable macular degeneration. The Conservatives do not feel that the proposal for free dental and eye checks for all will be a sensible use of scarce public resources.

I move amendment 23.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): It comes as no surprise to find that the Conservatives are moving to amend completely the bill that will give free eye and dental checks to all. The Scottish Parliament's approach to legislation is evidence-based. Every witness who gave evidence to the committee—evidence to which Nanette Milne listened—accepted that free eye and dental checks would improve the state of the nation's health; some argued that it would improve it dramatically. Every single piece of evidence suggested that that will be the case. I do not like the ideological approach to the bill that the Conservative party, which Nanette Milne represents, is taking. Her group does not approve of the measures, but it could not find anybody who could give the committee evidence to back up its claims.

I am gobsmacked by the suggestion that it would be unethical to approve the measures. If it were the case that we could not provide but were offering free eye and dental checks, the suggestion might have some veracity, but that is not the case. Nanette Milne knows as well as everybody else does that there are already enough optometrists to give free eye checks to all and that the minister recently announced a dental plan, which from my perspective is an excellent plan. Every initiative for which the British Dental Association asked has been provided for in that plan and there is to be a massive funding increase of 75 per cent, which is dramatic by anyone's standards. The measures are designed to ensure that the service exists when the free checks are introduced.

Apart from the Conservatives, all members accept that the provisions are a major part of the bill. Amendments 23 and 24 would ruin the bill—there is certainly no evidence to suggest that we should support them. I urge members to reject completely the Conservative amendments, which are wrecking amendments.

Shona Robison: I hope that that automated blind's movement is not a sign of the curtain coming down, Mike.

I echo Mike Rumbles's remarks—amendments 23 and 24 are ill-advised. Although Nanette Milne raises some important concerns—which many members share—about the challenges of delivery, particularly in relation to the capacity of NHS dentistry, that should not detract from the principle that the measures are the right thing to do. In fact, the pressure on the Executive will be increased,

because it will have to ensure that it delivers the oral health assessments.

One important point is that the bill will introduce oral health assessments, not dental checks in the traditional sense that we understand. The assessments will be far more in-depth than were previous dental checks—they were a cursory look in the mouth—and will be a far better preventive health measure. The amendments are ill-advised and I will certainly not support them.

The Deputy Minister for Health and Community Care (Rhona Brankin): The Executive and, I hope, the committee cannot support amendments 23 and 24. The introduction of universal free eye and oral health examinations is, as has been said, an important part of the Executive's commitment to improving public health through comprehensive and preventive care. At stage 1, the Health Committee and Parliament accepted the principle of free eye and dental checks for all. The free checks are preventive health-improvement measures—our purpose in introducing them is to assist in early detection of oral cancers, diabetes and conditions such as age-related macular degeneration, detaching retinas and certain cancers and tumours.

Amendments 23 and 24 would prevent members of the public from receiving oral health assessments and eye examinations free of charge. Instead, we would be left with the current situation, whereby only patients who are eligible for free NHS dental treatment or for full help with charges under the NHS low income scheme would benefit. Nanette Milne will recall that the evidence that the committee took on the provisions was wholly supportive of them and that the committee's stage 1 report recognised the universal support for the measures.

Delivery of dental services is a challenge that the Executive intends to meet. We will do so through the modernising dentistry agenda that we announced on 17 March, under which new funding of £150 million has been made available over three years to support oral health and dentistry. The challenge is one that the Executive intends to meet. For that reason, I cannot support amendments that fly in the face of professional opinion. I invite Nanette Milne to withdraw amendment 23 and not to move amendment 24.

15:45

The Convener: I ask Nanette Milne to wind up and to say whether she will press, or seek leave to withdraw, amendment 23.

Mrs Milne: I have little to add to what I said earlier. My concern is that, despite their eligibility for free eye and dental checks, many of the most vulnerable people do not come forward for them. I would prefer to see the Executive target what is a scarce resource on those people; they need to be brought into the system so that their oral and eye health is checked. It is not good to pass a law when it is pretty well known that the provisions that it contains cannot be carried out. I will press amendment 23.

The Convener: The question is, that amendment 23 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Milne, Mrs Nanette (North East Scotland) (Con)

AGAINST

Cunningham, Roseanna (Perth) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 23 disagreed to.

Section 9 agreed to.

Section 10—Free eye examinations and sight tests

Amendment 24 moved—[Mrs Nanette Milne].

The Convener: The question is, that amendment 24 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Milne, Mrs Nanette (North East Scotland) (Con)

AGAINST

Cunningham, Roseanna (Perth) (SNP)
Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

The Convener: The result of the division is: For 1, Against 8, Abstentions 0.

Amendment 24 disagreed to.

Section 10 agreed to.

After section 10

The Convener: Amendment 25, in the name of Nanette Milne, is in a group of its own.

Mrs Milne: The argument for amendment 25 follows logically from what I said about amendment 23. Given that the aim of amendment 25 is straightforward, it can be dealt with quickly. It would provide that the Executive place a duty on health boards to ensure that people who are eligible at the present time for free eye and dental checks are targeted more effectively. The people to whom I refer are the most vulnerable people in our society, yet their health is most at risk because they escape the net and therefore fail to have the checks carried out. Even if free checks become available to everyone, those people will still need to be targeted.

I move amendment 25.

Mike Rumbles: Again, the Conservatives have missed the point of the bill and of the debate on targeting and universal benefits, which is that we have to ensure that the very people to whom Nanette Milne referred obtain the health benefits that are available to them. Obviously, all experience shows that some people do not take up benefits even though they are eligible for them; those people are either not sure whether they are eligible or find the process too complicated. The point is that, if benefits are provided universally, everyone will be clear that the benefits are freely available to them.

Rhona Brankin: Unlike the previous two amendments that Nanette Milne lodged, I have some sympathy for the principles of amendment 25. That said, I am unable to support it. Its prescriptive nature would mean that an unreasonable duty would be placed on health boards. For example, in terms of the categories of people who would be entitled to receive free sight tests and dental examinations, health boards would in future always be required to refer back to 1 April 2006. The requirement to do so could become excessively burdensome 10 or 20 years down the line.

The Executive has made it clear that it supports measures to increase uptake of free checks. We have made a commitment to work with health boards to target the vulnerable groups who are eligible for those checks. Although I support the principle of encouraging uptake of free eye and dental checks, I believe that amendment 25 is unduly restrictive.

Improving uptake of free checks should be done flexibly and responsively in partnership with health boards. The Executive believes that this is not a matter for primary legislation. I invite Nanette Milne to seek leave to withdraw amendment 25.

Mrs Milne: Given the minister's reassurance that the people to whom I refer will be covered, I am prepared to seek to withdraw the amendment.

Amendment 25, by agreement, withdrawn.

The Convener: Amendment 26, in the name of Kate Maclean, is in a group on its own.

Kate Maclean: I have some sympathy with the principle behind what Nanette Milne outlined in amendment 25, in as much as the existence of free provision will not necessarily mean that people will take up the opportunities for sight tests or dental checks. I have lodged amendment 26 because I consider the bill to be a good legislative vehicle for measures on eye examinations and dental inspections for school pupils because it already contains provisions on sight tests and dental checks. Provisions on dental care exist in the National Health Service (Scotland) Act 1978, and proposed new subsection (2A) that amendment 26 would insert into section 39 of the 1978 act would introduce ophthalmic care as well.

As I said when we discussed the matter at stage 1, one school pupil in five has undetected sight problems. We have already debated the fact that children who have access to dentists and already have free dental checks have the worst oral health records in Scotland. The rest of amendment 26 would provide for sight tests and dental checks at primary 1 and secondary 1. The minister might refer to the fourth edition of "Health for all Children"—Hall 4—which mentions provision for sight tests between the ages of four and five, but there are conditions that might show up after that age and, although sight tests can be far more meaningful after children become literate, Hall 4 does not recommend testing vision after entry to primary school. I have had some discussions with the minister about that and I hope that she has a response for the committee on the matter, because most members of the committee felt strongly about it.

I move amendment 26.

Dr Turner: I am anxious that children should have more frequent eye checks, so I agree with Kate Maclean. It is sad that, although we used to have school eye and hearing examinations, as well as a general health check, those do not now seem to be standard throughout Scotland. Nothing would hinder a child more than inability to see or hear properly, so there should be even more frequent checks throughout primary school because many children get missed. I am not sure whether we can change that through the bill, as I am not sure whether that was the intention, but I agree with Kate Maclean that there should be more frequent tests throughout primary school.

Mr Brian Monteith (Mid Scotland and Fife) (Con): I support amendment 26. It is a practical measure that makes a great deal of sense. Had such tests not been available to me routinely, the fact that I required spectacles might not have become obvious to me until later in my life. It is important to set out such a routine to ensure that

such checks are carried out on people who might not be aware that their sight is failing, or of other problems associated with their physical well-being. I welcome the amendment as a chance to include that in the bill.

Helen Eadie: In our e-mail today, we received a briefing from the Royal National Institute for the Blind Scotland supporting Kate Maclean's amendment 26. I urge the minister to consider the issue, because the RNIB Scotland supports the amendment strongly. My experience of the need for glasses being picked up at an early age was similar to Brian Monteith's. It is important.

Rhona Brankin: I thank Kate Maclean for raising an issue that is clearly important to the Health Committee and which is important to me, as somebody who worked in education for many years. I, too, came across youngsters in secondary schools whose problems had not been picked up. There is concern.

We need to ensure that suitable provision is made for screening children and we need to ensure that vision disorders in children are picked up early. The Scottish Executive is taking action to ensure that more consistent and effective arrangements are in place throughout Scotland. Kate Maclean referred to the fourth edition of "Health for All Children"—or Hall 4—which was published last month and which recommends vision screening by an orthoptist for all children between the ages of four and five in their pre-school year. That reflects the recommendations of the Royal College of Paediatrics and Child Health's expert working group, which recently reviewed the evidence for all childhood screening and surveillance activity. That working group found insufficient evidence to support more frequent vision screening in schools. It also found that vision screening is significantly less effective when it is carried out by doctors, health visitors and school nurses rather than orthoptists.

The recommendations of Hall 4 have been endorsed by the UK national screening committee, which was established in 1996 to advise the UK Administration on screening policy. In forming its advice, the committee draws on the latest research evidence and the skills of specially convened multidisciplinary expert groups, which always include patient and service-user representatives. The committee assesses all proposed new screening programmes against a set of internationally recognised criteria, which cover the condition, the test, the treatment options, and the effectiveness and acceptability of the screening programme.

I have had some discussions with Kate Maclean and I am aware of the position of RNIB Scotland. I am happy to consider the range of evidence that is available, and RNIB Scotland has agreed to take forward some work in the area. Following that, it would be open to us to submit any new evidence to the national screening committee. I am happy to discuss the matter further with Kate Maclean, and on that basis I ask her to consider seeking to withdraw amendment 26.

Kate Maclean: RNIB Scotland has campaigned on the issue for some time, and I have been involved in meetings on the matter with previous health ministers. Nothing has happened, and this is the first—and probably only—legislative vehicle through which we will be able to deal with the matter for some time. Amendment 26 is based on a strong recommendation of the committee. Also, evidence from the College of Optometrists suggests that the Hall 4 guidance would lead to a decreased service.

If the issue is not resolved before stage 3, I will be strongly minded to lodge an amendment then. Given the minister's assurance that she will discuss the matter with me and consider the evidence, I am prepared to seek to withdraw amendment 26, although I reserve the right to lodge an amendment on the issue at stage 3.

The Convener: In view of what is stated in the committee's stage 1 report, I ask whether other members of the committee are content for amendment 26 to be withdrawn.

Dr Turner: I agree that something should be done before stage 3, so that the matter is finally decided upon.

Amendment 26, by agreement, withdrawn.

Section 11 agreed to.

Section 12—Arrangements for provision of general dental services

The Convener: Amendment 2, in the name of the deputy minister, is grouped on its own.

16:00

Rhona Brankin: Amendment 2 is a technical amendment. Section 12 is concerned with the expansion of the categories of persons with whom health boards can enter into arrangements to provide general dental services. The amendment will extend the list to include bodies corporate, which are generally referred to in practice as dental corporations.

Amendment 2 is consistent with the policy intention to allow health boards to take a more active role in securing and providing general dental services. The particular intention is to enable health boards to make arrangements with individual dentists or dental corporations to undertake to provide general dental services. Health boards could also themselves provide

general dental services, through salaried NHS staff.

Dental corporations are not new; 26 currently operate in the UK. Amendment 2 will complete amendment of section 25 of the National Health Service (Scotland) Act 1978, and will clarify that a body corporate may provide dental services, in addition to dental practitioners' being able to do so.

I move amendment 2.

Amendment 2 agreed to.

The Convener: Amendment 3, in the name of the deputy minister, is grouped with amendments 12 to 14.

Rhona Brankin: Amendments 3 and 12 to 14 are technical amendments. Taken together, they will create a single definition of

"carrying on the business of dentistry"

under the terms of the National Health Service (Scotland) Act 1978. Such a definition is necessary because the bill now contains a number of references to

"carrying on the business of dentistry",

so it makes sense to consolidate them.

Amendments 3 and 12 will remove existing definitions from sections 12(b) and 22(3)(e) of the bill respectively. Those definitions will be replaced by amendment 13, which will insert a single definition of

"carrying on the business of dentistry"

in section 108 of the 1978 act, which is that act's interpretation section.

Amendment 14 is consequential on amendment 3, which will delete section 12(b) from the bill. Section 12(b) would have the effect of repealing section 25(3) of the 1978 act, which places restrictions on remuneration that is paid to dental practitioners. The deletion of section 12(b) will make it necessary to repeal section 25(3) of the 1978 act through schedule 3 of the bill, which will be achieved by amendment 14.

I move amendment 3.

Amendment 3 agreed to.

Section 12, as amended, agreed to.

Section 13 agreed to.

Section 14—Provision of certain dental services under NHS contracts

The Convener: Amendment 4, in the name of the deputy minister, is grouped with amendment 5.

Rhona Brankin: Amendments 4 and 5 amend section 17AA of the 1978 act, and are consequential on part 3 of the bill, which, through new section 17V of the 1978 act, makes provision as to how contractual arrangements between pharmaceutical care services, contractors and health boards or other health service bodies are to be treated. Existing section 17AA makes provision for certain services to be treated as NHS contracts for certain purposes.

An NHS contract is an arrangement whereby one health service body provides goods or services to another health service body. Although the contract might contain all the usual range of contract terms, it does not give rise to contractual rights and liabilities. Any disputes are settled using internal NHS procedures, rather than the courts. The services may be provided by community pharmacy contractors, among others.

New section 17V makes provision for the future providers of pharmaceutical care services to be regarded, if they wish, as health service bodies. The contracts between such providers and health boards would be classed as NHS contracts. In effect, the new provision makes the existing section 17AA provision redundant, and amendment 4 removes it.

Amendment 5 is consequential on amendment 4 and removes the definition of a pharmaceutical list from section 17AA.

I move amendment 4.

Amendment 4 agreed to.

Amendment 5 moved—[Rhona Brankin]—and agreed to.

Section 14, as amended, agreed to.

Section 15—Lists of persons undertaking to provide or approved to assist in the provision of general dental services

The Convener: Amendment 6, in the name of the deputy minister, is grouped with amendments 7, 9 and 10.

Rhona Brankin: These are minor amendments that amend sections 25(2A)(a) and 26(2A)(a) as they are inserted into the 1978 act by sections 15 and 17 of the bill respectively. The amendments will allow for regulations to provide for subdivisions in either part of the lists of persons who provide or are approved to assist in the provision of general dental and general ophthalmic services. The Executive's policy is that all principal and non-principal dentists and optometrists who provide or assist in the provision of general dental services or general ophthalmic services should be listed in each health board area. The reason for providing for further subdivisions of each part of the list is to provide for practitioners who may provide a more limited or specialist type of dental service.

I move amendment 6.

Amendment 6 agreed to.

Amendment 7 moved—[Rhona Brankin]—and agreed to.

The Convener: Amendment 27, in the name of Nanette Milne, is grouped with amendment 28.

Mrs Milne: The amendments are intended to ensure that those who are already providing dental or ophthalmic services are subject to the same disclosure checks, in the same timeframe, as those who are being added to the registered list. In my view, if disclosure checks are necessary for new practitioners before they can be listed, they are necessary for all registered practitioners. That should be made clear on the face of the bill.

I move amendment 27.

The Convener: As I recall, the issue with which the amendment deals was raised at stage 1.

Rhona Brankin: I appreciate what Nanette Milne is trying to achieve with amendment 27. I support in principle the suggestion that both those applying to join a list and those who are already on one should be subject to the same requirements for disclosure of appropriate information. New subsections (2A)(e) and (c) of section 25 of the 1978 act allow for regulations that will apply equally to those who are currently on a list and those who are applying to join one.

In its consultation paper on improving primary care services, which was published in February 2004, the Executive proposed that all list applicants and those who are already on family health service lists should be subject to disclosure requirements. I make clear that it has always been the Executive's policy intention that a requirement for disclosure of information should apply equally to people applying to join a list and those who are already on it. Nanette Milne's amendments 27 and 28 as drafted will not achieve that end and are not required.

The scope of the amendments is very wide. They refer to

"any previous list of persons".

That could be taken to mean any current or historical list and could be construed to include non-practising, retired and deceased individuals. That would be illogical. As amendments 27 and 28 are not required, I invite Nanette Milne to withdraw amendment 27 and not to move amendment 28.

Mrs Milne: With the reassurance that the bill addresses the principles behind my concerns, I will ask to withdraw amendment 27.

The Convener: The point arose from the committee's stage 1 report. Are members content for the amendment to be withdrawn?

Amendment 27, by agreement, withdrawn.

The Convener: Amendment 8, in the name of the deputy minister, is grouped with amendment 11.

Rhona Brankin: Amendments 8 and 11 make it clear that regulations may require providers of general dental or ophthalmic services to be included in a health board's list. The bill will insert new sections 25(2B) and 26(2B) in the 1978 act, which will make explicit provision that regulations may provide that people may not assist in the provision of general dental or ophthalmic services unless they are on the second part of the list. No similar explicit provision is made that regulations may provide that people may not provide services unless they are on the first part of the list.

The policy intention is to take a belt-and-braces approach to make it clear and explicit that only those who appear on the first part of a board's list may provide general dental or ophthalmic services. Amendment 8 concerns the providers of general dental services and amendment 11 concerns the providers of general ophthalmic services. The amendments will improve patient protection for health service users by ensuring that all practitioners—whether they provide or assist in providing general dental and ophthalmic services—are included on a board's list.

I move amendment 8.

Amendment 8 agreed to.

Section 15, as amended, agreed to.

Section 16 agreed to.

Section 17—Lists of persons undertaking to provide or approved to assist in the provision of general ophthalmic services

Amendments 9 and 10 moved—[Rhona Brankin]—and agreed to.

The Convener: Will Nanette Milne move amendment 28, which was debated with amendment 27?

Mrs Milne: As amendment 27 was withdrawn, I will not move amendment 28.

Amendment 28 not moved.

Amendment 11 moved—[Rhona Brankin]—and agreed to.

Section 17, as amended, agreed to.

The Convener: That ends today's consideration of the bill at stage 2. Before everyone rushes off, I inform members that the target for next week's meeting is to complete consideration of part 3, which is on pharmaceutical care services, and of part 4, which is on discipline. The deadline for lodging amendments is noon on Thursday 19 May.

I suggest that for subsequent stage 2 meetings, I lodge committee amendments—those that derive directly from recommendations in our stage 1 report—in my name, with a supporting member's name. The supporting member will deal with the amendment at the meeting, but as it will be in my name, it will be clear that the amendment derives directly from our stage 1 report. Other members would be required to support amendments, as otherwise I would have to vacate the chair every time that a committee amendment arose. Potential committee amendments would be circulated in advance, to ensure that members were content with their drafting. Are members happy to adopt that procedure? This afternoon, Nanette Milne moved not only an amendment that arose from our stage 1 report, but amendments of her own.

Kate Maclean: I was not aware that provision existed for committee amendments. I thought that amendments were the responsibility of individual members.

The Convener: That is the case, but our stage 1 report contained several recommendations and we need to find a way to show that an amendment derives directly from those recommendations and is not an individual member's proposal.

I have made the suggestion because, this afternoon, one member moved amendments on her party's behalf and an amendment that derived directly from our stage 1 report. It was difficult to distinguish between the two types of amendment, so an attempt is being made to clarify the situation for future meetings.

Helen Eadie: I am not entirely happy with the proposal. If you are saying that you and other members wish to lodge amendments that derive from our report, that is fair enough. However, you should not tie other members into supporting amendments without their agreement.

The Convener: We would do nothing without members' agreement. That is par for the course. If committee members are content to continue in the present way, we will do that. However, I ask members who lodge amendments that derive directly from the stage 1 report to say that they are doing that. That information is needed because—with the best will in the world—committee members might have forgotten that they unanimously agreed a position previously. We want to make clear where amendments derive from.

Meeting closed at 16:16.

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