SUBORDINATE LEGISLATION COMMITTEE

Tuesday 23 September 2003
(*Morning*)

Session 2

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SUBORDINATE LEGISLATION COMMITTEE
7th Meeting 2003, Session 2

CONVENER

*Dr Sylvia Jackson (Stirling) (Lab)

DEPUTY CONVENER

Gordon Jackson (Glasgow Govan) (Lab)

COMMITTEE MEMBERS

*Mr Stewart Maxwell (West of Scotland) (SNP)
*Christine May (Central Fife) (Lab)
*Mike Pringle (Edinburgh South) (LD)
*Murray Tosh (West of Scotland) (Con)

COMMITTEE SUBSTITUTES

Bruce Crawford (Mid Scotland and Fife) (SNP)
Alex Johnstone (North East Scotland) (Con)
Maureen Macmillan (Highlands and Islands) (Lab)

*attended

THE FOLLOWING GAVE EVIDENCE:

Lorna Clark (Scottish Executive Health Department)
Jane Martin (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Alasdair Rankin

ASSISTANT CLERKS

Joanne Clinton
Alistair Fleming

LOCATION

Committee Room 3

Scottish Parliament

Subordinate Legislation Committee

Tuesday 23 September 2003

(*Morning*)

[THE CONVENER *opened the meeting at 10:32*]

Delegated Powers Scrutiny

Primary Medical Services (Scotland) Bill: Stage 1

The Convener (Dr Sylvia Jackson): I welcome everyone to the seventh meeting of the Subordinate Legislation Committee in this session. I have received no apologies, so I hope that Gordon Jackson is going to appear.

The first item on the agenda is a discussion of the Primary Medical Services (Scotland) Bill. I am pleased to welcome from the Scottish Executive Lorna Clark, who is the bill team leader, Jane Martin from the bill team, and Elizabeth Clarke from the office of the solicitor to the Scottish Executive.

I believe that Lorna Clark and her team are going to give a short introduction to summarise what the bill does, how it relates to existing legislation and, most important for the committee, tell us about the negative procedure with regard to the regulations in the bill. The committee will then ask some questions.

Lorna Clark (Scottish Executive Health Department): Thank you for inviting us to the committee today.

To set the scene briefly, the bill is the result of more than two years of negotiation between the Scottish General Practitioners Committee of the British Medical Association, the NHS Confederation in Scotland and the four United Kingdom health departments to create a new contract for general medical services—GMS. The primary legislation is enabling and much of the detail of how the contract will work in practice will be set out in secondary legislation.

The bill does two things: it creates a new duty on health boards to provide primary medical services, and it goes on to create a framework for the discharge of that duty. Separating those two elements can make it easier to navigate the bill.

The duty to provide primary medical services falls on health boards, which have four means by which that duty can be discharged. First, they can use section 17C arrangements, which members might be more familiar with as PMS or personal medical services. Those are local arrangements that are agreed between the health board and the individual practice. Secondly, the health boards can use the GMS contract, which is the new, nationally-negotiated contract that will be substantively the same throughout Scotland. Thirdly, if they deem it appropriate for their area, the health boards can provide services directly by employing general practitioners or other health care professionals. Fourthly, the health boards can use a different type of contract—a health board contract—that will allow them, for example, to contract with existing GP out-of-hours co-ops to provide out-of-hours services in areas where GPs have opted out of that responsibility. It is important to remember that whatever option the health board chooses, the duty to provide primary medical services remains constant.

I have read the *Official Report* of last week's Subordinate Legislation Committee meeting and the letter from the clerk, from both of which it seems that the committee is concerned about two issues: why the provisions are in secondary legislation rather than in the primary legislation; and why we have chosen the negative rather than the positive procedure for the main provisions. I will go through our reasoning and then discuss it in more detail with the committee.

The structure of the bill follows closely the format of existing legislation. The detail and powers of the existing GMS arrangements are found in section 19 of the National Health Service (Scotland) Act 1978. Section 19(2) of that act contains broad regulation-making powers and the bulk of the existing GMS regulations are made under that section. The bill follows those broad parameters. The bill will insert new sections 17J to 17O into the 1978 act and those sections will set out the regulation-making powers and flesh out the technical and administrative detail of the new arrangements.

The bulk of the existing regulations are subject to negative procedure and, to date, we have found that that offers the right balance between the need for flexibility, so that ministers can make any necessary changes to the regulations, and giving Parliament its due place in relation to scrutiny.

The current regulations contain a lot of detail about existing arrangements and the new regulations will contain a lot of detail about how the new contract will work in practice. Inevitably, some of that detail will have to be changed as the contract beds down and we get more familiar with it. Putting the detail in regulations permits the Parliament to scrutinise what is being done, and gives ministers the flexibility to make changes

more quickly than would be possible if everything were included in the bill. The regulations are not going to be static.

The committee has already examined changes to the existing GMS regulations. Anyone who was on the committee during the previous Parliamentary session will remember that the regulations are a complex document that has to be amended often as matters progress. It is important both that the Executive can amend the detail of what will be a complex document without always having to resort to primary legislation procedures, and that the committee will have the chance to scrutinise the regulations.

With one exception, the regulation-making powers that ministers are proposing to take under the bill are subject to the negative procedure. The exception is in section 7 on ancillary provisions, where we make it clear that the orders mentioned in section 7(5)—orders that might change primary legislation—and orders made under section 7(3) should be subject to the affirmative procedure. Given the nature of those potential orders, it is appropriate that they should be subject to more detailed scrutiny.

We propose that the rest of the regulation-making powers should be subject to the negative procedure. That follows the current arrangements, where the existing GMS regulations are pretty much subject to the negative procedure. In the past, that arrangement has worked well in balancing the opportunity for Parliament to scrutinise the changes with allowing ministers to respond quickly to any need for change or amendment.

We are aware of the suggestion that some of the regulations in the bill should be subject to the affirmative procedure in the first instance, and then changed to the negative procedure thereafter. We are not convinced of the need for that. We intend to make the draft regulations available before the primary legislation completes its passage through Parliament. That will give MSPs and other interested parties the chance to study the draft regulations while it is still possible to amend the bill. We are confident that that will not be necessary and that any outstanding concerns will be addressed when people have sight of the regulations.

I will say a little about when we hope to make the regulations available. We understand the wish to see the regulations quickly. The elements of the regulations that concern dispute procedures and listing arrangements for doctors who provide primary medical services are being developed on a Scottish basis to reflect Scottish structures. The Minister for Health and Community Care gave an undertaking that the Health Committee would have drafts of those elements of the regulations before stage 2, which is scheduled for around the middle of November.

The rest of the regulations are being developed on a UK basis to reflect the fact that we are implementing a UK contract. We are bound to proceed on that basis. We will supply drafts of the regulations as soon as we can. I hope that the committee understands that, because they are being developed on a UK basis, we do not have the same control over them as we do over the Scottish angles.

I repeat the minister's assurances to the Health Committee that we are working hard with our counterparts in the rest of the UK to ensure that the regulations are available quickly and that we will share the regulations with the Parliament at the earliest opportunity. We will do all that we can to ensure that we have a working draft of the key elements of the regulations for stage 2 and certainly before stage 3, but we are to some extent bound by the UK procedures.

The Convener: I was happy to hear about what the minister said to the Health Committee about providing the regulations at stage 2. You are correct to say that we are considering the balance between primary and secondary legislation. On a constituency note, I spoke to some rural GPs at the weekend, who have much concern about what will happen in rural areas out of hours. That will be controversial, which makes me worry, because I am concerned that GP hours might not be discussed, as they are not dealt with in the bill. How will that fairly controversial issue be dealt with in the Parliament and in committee structures?

Lorna Clark: It will be up to GP practices to decide whether to provide out-of-hours services, so we need to build in an element of choice for that. One aim of the contract, the bill and the regulations is to define more clearly what a GP must do. The regulations will set out essential services that all practices are required to provide; additional services that we expect the vast majority of practices to provide, but which some practices might opt out of; and enhanced services for which the responsibility is on health boards.

Additional services provisions will include the times of day at which a GP is expected to provide a service. Putting out-of-hours services in that context, rather than making them separate, made more sense to us because some GPs will want to provide those services and some will not. Separating out-of-hours services from the rest of the responsibilities and duties was not a sensible way forward. It was better to put those services with the bulk of what GPs do. The principle that some parts of the contract are mandatory, so that all GP practices must provide them, will be in the legislation, but the detail of what that means will

be in the regulations, so that we consider all the functions of GPs as part of a package.

The Convener: How will the issue be raised in the chamber? Will discussion relate merely to the use of regulations and take place in the Health Committee and this committee? As the issue is not in the bill, will the Parliament be able to discuss it?

10:45

Lorna Clark: The Health Committee and the Finance Committee discussed the matter substantively when they took stage 1 evidence. The Finance Committee's stage 1 report to the Health Committee mentions out-of-hours services and the Health Committee questioned us heavily on the principles behind out-of-hours services and how those services would be provided. I expect the Health Committee to reflect that in its stage 1 report, which will be debated in the chamber. The full Parliament will have opportunities to debate the principle of allowing GPs to opt out of providing out-of-hours services and to ensure that the Executive is clear—as we are—about how to progress that. Substantive debate has already taken place on out-of-hours services and I expect that to continue throughout stage 1.

Christine May (Central Fife) (Lab): I am new to the Parliament and to the committee. You said that the bill would contain a statement that some general medical services were mandatory. Could a section be inserted that said that other services were discretionary, which might leave something in the bill that provided an opportunity for that matter to be debated, without our having to wait for a committee report or for somebody to raise the issue by means of another device?

Lorna Clark: Almost by definition, the fact that a section deals with mandatory terms suggests that other terms exist. The section that says what the contract will cover gives GPs the opportunity to provide services that are not essential and services that might not even be primary medical services. The bill gives us scope to debate what the essential services will be and what other services GPs might provide.

Christine May: To which section are you referring?

Lorna Clark: Proposed new section 17N of the 1978 act deals with other mandatory contract terms. It allows us to make regulations that deal with

"the manner in which, and the standards to which, services must be provided",

variations in contract terms and

"circumstances in which … the contract may be terminated".

When boards draw up contracts with individual practices, they will say that the mandatory contract terms—on the essential services that must be provided—are defined in the regulations. Proposed new section 17N will give us scope to put other terms in contracts, such as additional services, essential services or other matters that local health boards and practices think are needed in contracts.

The Convener: I will make a point about proposed new section 2C(5) of the 1978 act that also relates to proposed new section 17K(1) of the 1978 act. The committee thinks that the definition of primary medical services is important. As you will have seen from our letter to you, we wonder whether an illustrative list—not an exhaustive list—would be useful. What are your ideas on that?

Lorna Clark: Our concern is that an illustrative list quickly becomes a prescriptive list. If a provision is not in the illustrative list in the bill, the danger is that people will say, "The service is not in the bill, so it is not appropriate for us to provide it."

Primary medical services involve complex medical practices that do not fit easily into a neat legislative box. We hope that we are creating primary legislation that will stand for some time, but medical practices evolve all the time. The increasing prevalence of a different skill mix in practices is changing the balance between what is delivered in secondary care and in primary care. The new contract is practice based, so it will increase the move from secondary to primary care.

We need the flexibility to take account of that and to ensure that we are not hide-bound by primary legislation and therefore stopping good, innovative local practice. In general, what primary medical services are will be decided by custom and practice, as at present.

The existing legislation does not contain a detailed description of what we currently mean by "general medical services". Traditionally, everybody knows what we mean—it is what we go to our GPs to get. Because we are moving into new areas, we thought it important to have a backstop provision under proposed new section 2C(5) of the 1978 act. Should we deem it necessary, that provision would allow us to say that something does or does not come under primary medical services. That means that a health board can be told either that it has or that it does not have a duty to provide a service. If we were to include a list in the bill then, as medical practice evolved, we would have to go back and go through a lengthy process involving consultation every time we wanted to make a change. If such changes could be effected under

secondary legislation then, as things changed, we would have more flexibility to allow services to be provided in a different way.

In addition, if such a list were to be included in the primary legislation, health boards might be put under pressure to provide something under primary medical services even if they did not think that appropriate. If those powers came under secondary legislation, we could move much more quickly. For example, someone might argue that liposuction should be available as a primary medical service. Most people would say that that was not appropriate. If we had the regulation-making powers, we could move quickly to advise boards that they did not need to provide that service as a primary medical service. It is about flexibility, and the difficulty is to do with agreeing a neat definition that fits into a primary legislation box. We think that a definition of primary medical services would be much easier to cope with, and to change with the flexibility that is required, if the definition-making power rests in secondary legislation.

Christine May: I have some sympathy with that view, having been involved in the joint future group discussions, which involved a joint committee between a local authority and a health board. Those discussions got badly bogged down in discussing what was permitted for each party. However, that view applies only if we accept that an illustrative list will become a prescribed list. Is there some way of making it clear that an illustrative list is literally that? Could such a clarification be put either on the face of the bill or in a footnote? Could that be done by some method whereby we would not necessarily have to revise the legislation when and if we wanted to amend what was on the list?

Lorna Clark: It is our experience of primary legislation over the years that, if a list is included in a bill, it becomes much more difficult to argue that something that is not on that list should be included in the scope of the legislation.

Mr Stewart Maxwell (West of Scotland) (SNP): On the other hand, it would be much more difficult for anybody to argue that liposuction should be included if it were not on such a list in the bill. The coin is two-sided, is it not?

Lorna Clark: Someone might want to develop a minor surgery practice in primary care as the practice gets more experienced and gets more professionals in. It might be difficult for the practice and the board to provide a certain type of minor surgery in a given area, however, if it is not included on the list. Patients might want that surgery to be provided by their GP, with whom they are familiar and who is closer to them. There are two sides to the issue, and we must get the balance right. If such services are covered by secondary legislation, it is easier to be reactive and to cope with things changing as medical technology progresses.

The Convener: I think that Mike Pringle had a point to raise.

Mike Pringle (Edinburgh South) (LD): No—I think that the point about sample regulations has been covered.

The Convener: I think that you also had a point about trialling.

Mike Pringle: Yes. The committee's view was that it might be helpful to both the Executive and the Parliament if powers were trialled while there was still time to lodge amendments. We were therefore going to ask what time frame the Executive had in mind in that regard. I thought, however, that you had already answered that point.

Lorna Clark: Some of the regulations will be available by mid-November, in time for stage 2 consideration. We hope that the vast majority of regulations will be available by then. We are not being as positive about that as we might, because of the UK dimension, but we expect to get the bulk of the regulations out so that people can look at them while the bill is being considered. Should members decide to lodge amendments to the bill, it may be possible to see the regulations in time for that.

The Convener: Can you give us a bit more detail about which regulations will be involved?

Lorna Clark: There are two primarily Scottish elements to do with the different structures that pertain in Scotland. They involve the disputes procedure, which is set out under proposed new section 17O of the 1978 act, and the new listing arrangements for GPs performing primary medical services, which arrangements are set out under proposed new section 17P of the 1978 act. We will have those regulations ready in time for the start of stage 2. The rest of the regulations are being taken forward on a UK level. It is to do with which areas have specific Scottish structures and which areas can be dealt with at a UK level to reflect the UK contract.

The Convener: Could you tell us a little bit about the other side of the coin? Will Westminster be trialling other powers?

Lorna Clark: I will need to confirm where things are with the regulations at Westminster, which tends not to have the same level of scrutiny as we do, because it has very different procedures. We are working on having the regulations relating to Scotland ready for about November, and we hope that the bulk of the regulations for the UK as a whole will be available then, but we can check on that and come back to the committee with regard

to exactly when England expects to have its regulations ready for its parliamentary process.

The Convener: That would be useful for the lead committee.

Christine May: I have a question about proposed new section 17E(3A) of the 1978 act. That section authorises ministers to make regulations that require payments to be made. What payments does the Executive have in mind? Who would be required to make those payments? Why are you suggesting the method that is outlined in that new section?

Jane Martin (Scottish Executive Health Department): New section 17E(3A) states:

"The regulations may also require payments to be made under section 17C arrangements in accordance with directions given for the purpose by the Scottish Ministers."

That would permit the Scottish ministers to direct, for example, that GPs providing primary medical services under a section 17C arrangement could receive seniority payments in accordance with a national scheme in much the same way as their fellow GPs performing primary medical services under the national GMS contract.

On retrospectivity, regulations currently provide for any moneys paid to GPs in error, whether or not they relate to a retrospective period, to be recovered. The bill does not amend that.

Christine May: If there is a provision in the bill giving ministers that power, do we need to make regulations?

Lorna Clark: No—not if it is directions that are involved.

Jane Martin: The bill brings the regulatory framework for section 17C arrangements into line with the regulatory framework that is proposed for the new GMS contract. Essentially, that creates a level playing field, so that GPs who go for one contractual option and not another are not penalised.

Christine May: We raised a point about an illustrative list in relation to proposed new section 17K(1). Would your response on the question of an illustrative list in relation to proposed new section 17E(3A) be the same?

Lorna Clark: Yes.

The Convener: So many of the bill's provisions are covered by regulations. Would the affirmative procedure be more appropriate than the negative procedure for some of them?

Lorna Clark: In deciding whether provisions should be subject to the negative or the affirmative procedure, we examine the particular regulation-making powers involved in each case.

We did that as we drafted the bill. We considered how such powers work at the moment, as most of the proposed powers are similar to powers that are in place now. We made our decisions on a case-by-case basis. There are elements of section 7 that we thought would make the affirmative procedure appropriate, given what the orders might do. For the regulations elsewhere in the bill, it seemed that the negative procedure was most appropriate. The important thing, however, is to consider each individual power and to determine what the appropriate mechanism is, rather than to say that because there are many regulations, surely some of them must be suitable for the affirmative procedure. To summarise, we looked at each power on its own and decided on the best way of dealing with it.

The Convener: Could I ask you to comment on new section 17K(1) in particular?

Lorna Clark: Those provisions allow us to make regulations specifying what services a GMS contract must provide—basically, essential services. Under the contract negotiations, we have agreed definitions of essential, additional and enhanced services for the present time.

We want to put those definitions in regulations so that we have the power to change them, if we decide that we need to, as things bed down. There are quite well-agreed definitions for each of those types of service. The provision of essential services is basically the routine, day-to-day management of patients and the treatment of patients who are ill, or who believe themselves to be ill. If the committee were interested, we could send it the full definitions that we have for each type of service. They are listed in the contract document that was published in February.

We believe that, as the new contract beds down and medical practice changes, we will need the flexibility to revisit those matters through regulation. We will give the committee the chance to consider any such regulations through the negative procedure, but we will not put those definitions in the bill, because we might want to act more quickly than we would be able to if everything were dealt with in primary legislation.

11:00

The Convener: If an instrument subject to the affirmative procedure were to be used, there would be no problem with revisiting such matters. Why would an affirmative instrument, as opposed to a negative instrument, create a lack of flexibility?

Lorna Clark: We have considered how we have done things in the past and how our approach has worked in the past. We think that what we have done so far has provided an appropriate level of

scrutiny, without taking up a huge amount of our time or the committee's time. Given that that approach has worked reasonably well in the past, we have been keen to continue with it. What we are seeking to do is not that different from what we have been doing—it is about using powers in a similar way and following existing precedent. That will give us flexibility and will still enable the committee to examine matters and to consider whether we need to make changes. We are building on what has worked well in the past.

Christine May: On particular sections, would you be open to an argument about whether it might be more appropriate for the relevant instrument to be subject to the affirmative procedure rather than to the negative procedure, or to be subject to the affirmative procedure in the first instance and subsequently to the negative procedure? We are talking about a restructuring of primary medical care services to take them much more closely into areas that used to be social care or—to take the example of sports facilities—community-related health care. Given that that is the case and that changes in the regulations might well have an impact on local government regulations, for example, it might be more appropriate to use the affirmative, rather than the negative, procedure in the first instance.

Lorna Clark: We are always prepared to consider the committee's views. Although we can always re-examine matters, I reiterate that, at present, we are not minded to change our position, which is that most of the regulations would be better suited to the negative procedure.

Christine May: Okay.

The Convener: I want to move on to deal with new section 17L. Stewart Maxwell has a few points on subsections (1), (4) and (6).

Mr Maxwell: You might have answered my question already, but I want to clarify the timetabling for introducing the regulations that relate to section 17L(4), which deals with the effect of a change in the membership of a partnership. I think that you have already indicated that only regulations that relate to sections 17O and 17P will be drawn up by stage 2, which means that regulations that relate to section 17L(4) will not be drawn up by stage 2.

Lorna Clark: We hope that they will be, but we cannot make a firm commitment. It is our intention to do all that we can to ensure that those regulations are drawn up, but we cannot be as positive as we can be with other regulations, because of the United Kingdom dimension. Although stage 2 remains the target that we are working towards, we cannot make the commitments that we have made on the regulations that relate to sections 17O and 17P, which are completely under our control.

Mr Maxwell: That clarifies the situation; thanks for that.

It seems unlikely that the circumstances with which section 17L deals will change once the definitions have been made. The policy is straightforward. Why has the issue not been dealt with by provisions in the bill? Why have you decided to use subordinate legislation to deal with such matters?

Lorna Clark: Are you talking about the impact on a contract of a change in the membership of a partnership?

Mr Maxwell: Subsections (1), (4) and (6) of section 17L seem to be relatively straightforward. I cannot imagine any circumstances in which there would be a change. If you accept that the policy with which those subsections deal is clear, why cannot you just include the relevant provisions in the bill?

Lorna Clark: Section 17L(4), which deals with the effect of a change in the membership of a partnership, is a good example to use. The contract that we create will be a rolling contract. We do not want the health board and the practice to have to renegotiate the contract at the end of every year. We know from experience that partnerships change—GPs leave and new people come in. We do not want to reach a situation in which, every time there is a change to the partnership, the contract ends and the board and the practice have to go through the procedure of negotiating a new one.

However, we want to ensure that we have provision to deal with a change that is so significant that it means that the partnership is no longer the same body that signed the original agreement. The situation is not as straightforward as one might think. The policy on what would happen with a change in the membership of a two-person practice is quite straightforward, but what might suit a two-person practice, in relation to the impact of a change in the membership of the partnership on the contract, might not be equally suitable for a practice with seven or eight people.

We are discussing with the GPC the detail of how that will work. I think that we will end up with a list of criteria that say that, if a practice is of a certain number, a change in so many members of the practice might lead to a change in the partnership. With a bigger practice, there might be a more appropriate percentage, such as half the members, for example. The issue is complex, because practices vary considerably in size and what suits one practice will not suit another.

As the years progress and we become more familiar with the situation, we might find that we have to change our initial view of what constitutes a significant change to a partnership. We might find that a change in one of the three members of a practice has a significant impact and that it would therefore be appropriate to change the regulations to bring down the number of people who need to change in a partnership before we consider that it is no longer the same body as it was. The issue becomes more complex when one considers how such a provision might be worded in primary legislation. The result is a long, complicated list, which we think would be more appropriate to include in secondary legislation.

Mr Maxwell: I appreciate what you say about the possibility of the situation changing. I understand that the initial view—that a change in one of the three members of a partnership would not be a problem—might alter, although I am not sure that I agree with what you say on that. However, I am not sure that I accept that taking account of practices of different sizes adds to the complexity of the issue. There must be a finite number of members that a joint practice can have, so it should be possible to define clearly what happens in those circumstances. After all, that is what you intend to do in the subordinate legislation. If that is possible in subordinate legislation, you should still be able to deal with it in the bill.

Lorna Clark: The fact that the bill will allow more than just GPs to be members of a partnership might mean that it is appropriate for the contract to come to an end if the GPs in the partnership change but not if the nurses or the practice managers—who can now be part of the partnership—change. The area is complex. We will have to see how things work in practice. Although we might think that a change in practice manager is not significant at the moment, we might find that, in practice, it is significant and we might want to govern far more closely any change to who sits at the centre of the administration of the contract. Given the complexities of the contract and of who can hold the contract, flexibility will be important, at least in the first instance, to ensure that we get the right balance between prescription and giving practices the chance to roll forward without having constantly to renegotiate the contracts.

Mr Maxwell: I will accept that what you have said is reasonable. Given the importance of the area with which section 17L deals—one could say the same about every area with which the bill deals—why should a negative instrument be used? That question has already been asked.

Lorna Clark: We need to take account of the flexibilities that we will need, what we will need to bring back to the committee and how we might need to change things. We are always happy to listen to committee members to see whether we need to change things, but I reiterate that, on the individual powers, we think that we have the right balance between the positive and negative procedures.

Mr Maxwell: My final question is on section 17L(6), which includes the phrase

"within such period as may be prescribed".

That also applies elsewhere.

Jane Martin: It applies to section 17D.

Mr Maxwell: That is right. Do you feel that the transitional period should be specified, rather than being left open? Surely there is a rights issue, although perhaps not a European convention on human rights issue. Should people have a right to know what the transitional period will be? Should the period be specified in the bill rather than being left open ended?

Jane Martin: The Executive's view is that the specification of the period should be a matter for subordinate legislation. As Lorna Clark has said, that will give us the necessary flexibility to change the period, should that prove necessary, in the light of experience and good practice as the new GMS contract and the resulting impact on the section 17C arrangements bed in in Scotland. The question is not whether an individual can supply a service; we are setting out who can put their names to the contract, which is different from who can be employed to perform the services directly.

The move to the practice-based contract is a major change and we want to ensure that everyone who is a signatory to the contract understands the rights and responsibilities that go with it. We believe that that aim is best served by ensuring that signatories have a recent connection with primary medical services. The most obvious example of a group that might be covered by section 17C is practice managers. There is nothing in the bill or the regulations that we are drafting to prevent a practice from employing a practice manager who has not previously performed such a role or who has not performed it recently. However, we have reservations about whether it would be appropriate for such a person to be a signatory to the contract until they had spent some time in the role and understood what was involved.

We might also use the power to bridge the gap between contracts. For example, if a practice manager is part of a section 17C pilot contract that comes to an end on 1 May, but the substantive section 17C contract is not agreed until 1 August, nobody would argue that the practice manager should not be a signatory to the contract.

However, to return to my earlier point, if a practice manager is new to a role, we would want them to gain some experience before becoming a signatory to an important contract.

Mr Maxwell: Are you saying that, even if you define the transitional period in the secondary legislation, the likelihood is that it will change?

Jane Martin: What we are saying on this point is consistent with what we have said about many of the other provisions. We need to see how a lot of the provisions bed down as the contract is implemented across Scotland. We believe that a subordinate legislation power made under the negative procedure allows us the appropriate flexibility to cater for that while ensuring that the Parliament has a level of scrutiny over what we are doing.

The Convener: I am sorry to keep pestering you on this point, but I think that it is important. We have already heard about a considerable number of changes, even in this morning's small debate. You have also mentioned the importance of trialling, but that will be fairly limited, as the issue will come back to the lead committee in November.

You have talked a little bit about the constraint that you are under within the UK context. However, you then argue that you want the regulations to be made under the negative procedure, not the affirmative procedure. I find it difficult to join up those two perspectives. I would be interested to hear what other committee members feel, but I am coming to the conclusion that, if you do not intend to make more affirmative instruments, we should make a big plea to you for a longer period for trialling. As you keep saying, you have to see how things will pan out and further trialling would enable you to do that. There could be considerable changes. I would like to hear your views, and those of committee members, on that.

Lorna Clark: By trialling, do you mean our giving you sight of the draft regulations?

The Convener: As I understood it, the powers were to be trialled and you were to consider two important aspects of the new arrangements. When Mike Pringle asked what would be happening, you said that two sections would be looked at in the Scottish context and that you would come back with information for the Health Committee in November.

11:15

Lorna Clark: We have agreed that, before the Health Committee starts its stage 2 deliberations, we will give committee members sight of as much of the regulations as we can. We are committed to giving them sight of the regulations on disputes and on listing, because we have control over those. We are working as hard as we can, and encouraging our colleagues elsewhere in the UK to work with us to our timetable, to ensure that as much as possible of the overall package of regulations is available for stage 2. When the Health Committee considers whether it needs to amend the primary legislation, it can do that in the knowledge that it has the chance to look at the secondary legislation and see exactly what that says on such matters as the prescribed period of time and definitions of various services.

Because the contract is a UK one—and ministers are committed to taking forward the UK contract as far as they can—I cannot guarantee that we will have everything ready for the stage 2 debate, but we will do our utmost to ensure that we do. We are constantly in contact with our colleagues elsewhere in the UK and are stressing the importance of ensuring that as much of the subordinate legislation as possible is available before or during stage 2. That will ensure that the Parliament has the opportunity to examine what we are saying in the detail of the regulations and to consider whether that satisfies members' concerns about the balance between primary and secondary legislation.

We will get as much information to you as we can before stage 2. Some things may take slightly longer, but we are working to ensure that as much as possible is available for stage 2 so that members can study the detail and see whether they think that it satisfies their concerns or whether more should be put in the primary legislation. At that stage, members will still be able to influence the primary legislation, because it will still be going through the parliamentary process.

Christine May: I appreciate what you are saying about getting to a position where the bill can go forward from stage 2 to its conclusion. You have explained quite clearly why you have put some things in the bill and why you would rather not put other things in. However, I am more interested in how things will operate in practice once the bill is enacted. I am interested in the sustainability of the measures that have been put in place to allow the legislation to be amended as necessary.

Whether the regulations should be subject to the affirmative or negative procedure may be a debating point between us, but my view is that regulations are frequently used by those who would prefer not to see any change to existing practice as a method of enforcing adherence to old working practices. We are dealing with a matter that crosses a number of different departments, so there will be issues about how various budgets are structured and how they are accounted for.

I remain concerned that using the negative procedure will allow changes to be made that will make it more difficult for primary and social care to be delivered in the way that I believe the policy intends it to be. I know that policy is not a matter for this committee, but the structure of instruments is, as we must ensure that the policy can be implemented. Although I hear what you are saying, I have seen regulations used in practice to generate exactly the opposite effect from that which was intended.

Lorna Clark: Whether we use the negative or the affirmative procedure, we must consult on changes to regulations before we bring them to you. We need to take on board other people's views and present any proposed changes to the Parliament so that everyone can comment on them. As for the bedding down and implementation of the contract, an awful lot of work is going on to ensure that all the relevant parties are involved in considering how the contract will work in practice.

This is slightly outwith the scope of the Subordinate Legislation Committee, but a lot of working groups have been set up across the NHS to bring on board all parties that are interested in the contract, to consider how it will work in practice, exactly what it means for health boards on the ground and how other parties will be involved. A huge amount of work is going on to ensure that the contract beds down properly. We think that that, coupled with the way in which we develop the legislation, will allow us to take account of what people on the ground are telling us needs to be done. It will also give us the chance to consult and it will provide an opportunity for parliamentary scrutiny, so that any future changes can be debated and implemented in the best way.

As I said, we are always happy to consider further the points that you have raised about regulations, but at the moment we think that we have got the balance just about right.

Mr Maxwell: I agree with what the convener said about the balance between affirmative and negative instruments and I am sure that you understand where we are coming from, so I shall not labour the point. However, I have a couple of comments to make.

You have reiterated the point that you are following previous practice. I do not necessarily agree that just because something was done before it is a good idea. Perhaps this is the perfect opportunity to reassess and improve practice. That goes back to the point about the affirmative procedure versus the negative procedure. Perhaps we should be beefing up the procedure slightly rather than just doing things in the way in which they were done before.

Throughout your presentation and your answers to our questions, you have talked about what is bound by Westminster legislation. You said that the fact that the GMS contract is UK-wide means the Executive can guarantee to introduce only sections 17O and 17P, because of what is happening at UK level. Would it have been better if the bill had been Scottish and had not been introduced on the coat tails of a UK bill, which is causing such a delay that you cannot guarantee that the Health Committee will see the regulations before stage 2? There are inherent problems in considering the bill without all the necessary information because of the drag effect of having to wait for Westminster. Why is the Executive not doing the whole thing and bringing its own bill to the Health Committee and the Parliament in the fullness of time so that the legislation can be considered properly?

Lorna Clark: We are not just talking about Westminster; we are talking about every country in the UK. During the past two years, we have proceeded on the basis that ministers, the Scottish General Practitioners Committee and the health community wanted a contract that was the same throughout the UK. Part of the reason for that is to facilitate moves around the country so that a GP working in England who is interested in moving up to Scotland will not be put off by the fact that the contract in Scotland is radically different. All along, the policy has been for a UK contract.

The BMA branches representing the four countries have had discussions to see what suits the UK. The issue is not that we are bound by Westminster; it is about the UK moving forward together on the same basis to ensure that GPs have parity of treatment no matter where they are working in the UK. Ministers think that that is an important principle. The principle imposes some constraints, but the outcome will be worth it when UK GPs are treated in the same way wherever they are. We are not waiting for Westminster; we are part of UK-wide discussions and we have to ensure that every part of the UK is ready to move forward.

The way in which the Scottish Parliament works means that our timetables are slightly tighter than those at Westminster. To some extent, that gives us power to say to Westminster that we need to make progress because we have to make sure that the bill undergoes the proper scrutiny. The ministerial principle is that a UK-wide contract is the best thing for GPs in Scotland and that is why we are acting on that basis.

The Convener: I have no problem with a UK-wide contract and I can see the importance of it. However, I take issue with the fact that our time scale is being squeezed, which is affecting when we get to see the detail of the regulations. That is

important to us because so much of the legislation is in regulations and not in the bill.

Lorna Clark: The situation in Scotland is no different from the situation elsewhere. We are all committed to implementing the contract on 1 April 2004. That means that the primary and secondary legislation must be implemented by that date in all four countries. Because the Scottish Parliament allows more scrutiny of secondary legislation than might be expected elsewhere, the issue is more pressing here. However, if we are to make progress on a UK-wide basis, as we are signed up to do, we have to make sure that the regulations are as far as possible comparable throughout the UK. Because there is a ministerial commitment to introducing the contract on 1 April 2004, we have to make progress and get the regulations ready as soon as we can.

The Convener: Christine May has a point about new section 17N.

Christine May: We have laboured that point and the committee will be able to take a view on it. I thank our guests for their frank answers.

The Convener: Does Stewart Maxwell have any more points on new section 17P(1)?

Mr Maxwell: No. I could ask a question, but I think that I already know its answer, so I will leave it be.

The Convener: We thank the witnesses for attending. You will understand that we have reservations about the balance between what is in the bill and what is in subordinate legislation and about whether the negative or affirmative procedure should be used. We will discuss that and progress from there.

I would like to get a feeling for what we will say in our report on the bill to the lead committee. Today's questions and answers will be included in the report. I have made a few comments, but we must make a committee decision. Will the report reflect the summary that I just made of our reservations about the balance between primary and subordinate legislation and our concerns about whether the affirmative or negative procedure should be used for subordinate legislation?

Murray Tosh (West of Scotland) (Con): I am happy to back your hunch.

The Convener: It is not a hunch.

Mike Pringle: Lorna Clark mounted a spirited defence of the Executive's position and I understand where that comes from. I agree with Stewart Maxwell that, just because something was the procedure in the past, that does not mean that it should be the procedure in future. However, that is the Executive's view. I understand what the witnesses said, but there is no harm in making our feelings known.

The Convener: Perhaps we should identify some of our concerns, such as the time scale. The group of doctors whom I met at the weekend were concerned about the short time scale between when they heard about the bill in June this year and the contract's implementation in April next year. The time scale does not allow long for the regulations to be made available, as it is hoped will happen in November. Much detail will be in the regulations and the bill introduces many new measures. As the witnesses said, it will take time for the new structure to settle. If we do not use the affirmative procedure, which allows us to debate the regulations in the chamber, considerable issues are raised.

Mr Maxwell: I will reiterate and agree with what you said, convener. I disagree with the Executive witnesses' view that the balance is right. To use the negative procedure for virtually everything is not the way to go. Statutory instruments that are subject to the negative procedure tend to slip through with little debate. At least affirmative instruments have a higher profile.

The point about the time scale is important. There will be a terrible rush to make the regulations available and it is clear that not everything will be ready for the Health Committee at stage 2. We have also heard about what GPs told the convener about the time scale.

There is a clear difference of opinion between me and the witnesses. They have not changed their minds because of today's meeting, but we should make our view clear to the lead committee. To reiterate Mike Pringle's point, the fact that things have been done in a certain way in the past is no reason for saying that we should carry on like that. I do not think that that was a reasonable response. It may be that that is the correct procedure, but just because things have been done one way in the past is no reason for doing them in that way in the future.

Christine May: I agree with that, especially with regard to the annulment procedure in relation to sections 2C(5), 17K(1), 17N(1) and 17N(4)(b), which specify the various matters that will be subject to change. My biggest concern is that the negative procedure will be used to sustain existing practice, where that may not be what was required by the policy.

I accept that, to a large extent, the witnesses' responses concerned what should be in the bill and what should be in subordinate legislation. Some of those arguments were good and clearly put, and I can accept them, but to stick with the annulment procedure does not seem sensible.

The Convener: That is an important point and members are agreed on it. We asked about a number of aspects of the bill, but the big issue is the choice between the affirmative and the negative procedure.

Executive Responses

Title Conditions (Scotland) Act 2003 (Consequential Provisions) Order 2003 (draft)

11:31

The Convener: Item 2 on the agenda is Executive responses to our comments on instruments.

The first instrument is the draft Title Conditions (Scotland) Act 2003 (Consequential Provisions) Order 2003. Members will recall that there was an omission. I suggest that the committee draws the attention of Parliament to the order on the ground of the Executive's failure to follow proper drafting practice, as there is an omission from the preamble of the citation of a relevant enabling power. Is that agreed?

Members *indicated agreement*.

Police Pensions (Scotland) Amendment Regulations 2003 (SSI 2003/406)

The Convener: There was some dispute as to whether the regulations should refer to "a medical practitioner" or to "medical practitioners". There was also an issue with regard to dispute resolution. We all agreed that the two points identified by our legal advisers on those matters should be raised with the lead committee because there is still an intra vires issue to do with the extent of the regulations and for reasons that we outlined previously. Is that agreed? We shall obviously also include the Executive's comments.

Members *indicated agreement*.

Christine May: There is also an issue to do with consolidation, which comes up in relation to a number of other instruments. Perhaps at the end of the meeting you will allow us to discuss what we wish to do to make our views on consolidation known.

The Convener: That is a good point. Thank you very much.

Animal By-Products (Scotland) Regulations 2003 (SSI 2003/411)

The Convener: Members will remember that there were issues to do with the making and keeping of records and to do with sanctions and how they would be treated, and whether offences would be triable either way. Unless those points are taken on board, the regulations are still fairly misleading, despite the responses that we have received. We also hope that the Executive is moving towards having a transposition note. If the

committee is agreeable, I suggest that we draw the attention of the lead committee and the Parliament to the issues that we have raised and to the Executive's response. Is that agreed?

Mike Pringle: The Executive response states that it is inherent in the nature of any record that it must be kept or otherwise retained for a period of time, but there is no definition of that period. Does it mean 10 minutes or 10 years?

The Convener: Exactly.

Mike Pringle: Somebody should say what the period of time is.

The Convener: These are the type of regulations over which disputes could arise.

Mike Pringle: Absolutely. Somebody could turn up asking for records and might get the reply, "We kept them for a week and then we destroyed them, because we didn't think we needed to keep them for any longer." What could people do about that? In such a case, the records might have been kept for the required time. The problem is that that time is not defined.

Christine May: The issue of transposition notes is a recurring one, and we could perhaps take an opportunity at the end of the meeting to say what we would like to do in that regard. The Executive has said that it is considering the matter. Could all the bill teams be advised that that is the case? They might wish to amend their responses to us accordingly.

The Convener: Okay. We will come back to that.

Food (Pistachios from Iran) (Emergency Control) (Scotland) Regulations 2003 (SSI 2003/414)

The Convener: It appears from the Executive's response that we are not much further forward with the regulations. Issues are raised to do with what we understand by the term "importing". I suggest that we pass on our concerns, together with the Executive's response, to the lead committee and the Parliament, particularly in relation to the drafting of regulation 3(1)(b). The issue arises again in regulations that we will come to shortly.

In addition, by failing to revoke an instrument amending an instrument that is revoked by the regulations, the regulations do not comply with proper legislative practice.

Mr Maxwell: I thought that we had asked the Executive about the problem with the definition of importing. The response that we received was about marketing, which is not what we asked about. If the Executive is talking about marketing, but the regulations talk about importing, there is a problem. Its response suggests that there is a difference between what the regulations say and what they mean. It is important that we deal with the matter. I think that the Executive has made a bit of a mistake.

The Convener: I agree.

Christine May: It is noticeable that these regulations and the Food (Peanuts from Egypt) (Emergency Control) (Scotland) Regulations 2003, which are a similar type of instrument, have been drafted in a way that is not the norm for the Food Standards Agency Scotland. It might be appropriate to say to the lead committee, and perhaps to the agency, that such a departure from the norm has led to enormous problems. The agency might wish to consider going back to its previous style.

The Convener: As we have now started a dialogue with the Food Standards Agency, I think that it would be constructive, hopefully for both sides, if we were to raise that point with it.

Christine May: I would be happy for that to be done informally, if that is an appropriate way of doing it.

The Convener: Yes, it might be better to do things informally in this case. We could emphasise again that the whole issue around importing and marketing is still not clear from the answer that we have been given. The matter might arise in other regulations, and we could just end up asking the same question.

Christine May: I expect that there will be other nuts from other places.

Mike Pringle: If somebody is importing a product such as pistachios, it might be very difficult to analyse whether there are any problems with them at the point of origin. It is much easier to analyse them at the point of importation. Despite that, the situation is unclear. I can understand why we are being told that it is easier to analyse the product when it gets here, before it is released.

The Convener: In which case—according to the regulations—the pistachios should not have been imported in the first place.

Mike Pringle: I understand that.

Christine May: Under the regulations, it is not down to the importer to inspect and test the product; it is down to the member state concerned.

Mike Pringle: I realise that. There is considerable confusion.

The Convener: Those points are all agreed, so we will move on.

Road Works (Recovery of Costs) (Scotland) Regulations 2003 (SSI 2003/416)

The Convener: Unfortunately, there appears to have been an error in the drafting of our question to the Executive on these regulations. We have therefore not received an answer back. However, our question is the same as the one that we asked for the Road Works (Reinstatement) (Scotland) Amendment Regulations 2003, the answer to which we have. I recommend that we draw the attention of the lead committee and the Parliament to these regulations and the point that we made.

Murray Tosh: Should we still insist on an answer to the point that we intended to make, even though that might not fit the cycle for handling matters? Perhaps it is an issue that could go to the lead committee.

The Convener: We could do that, but I am reminded that the question is exactly the same as the one that we asked for the Road Works (Reinstatement) (Scotland) Amendment Regulations 2003 (SSI 2003/417), the answer to which we have.

Christine May: I am pleased to see that the definition of standard axles does not include the phrase "per annum", but relates to the anticipated life of the road. I am sorry—I have jumped ahead to the next statutory instrument.

The Convener: We are agreed that, because we asked the same question on the Road Works (Reinstatement) (Scotland) Amendment Regulations 2003 (SSI 2003/417) as we did on these regulations, and because the answer is the same as the one that was given on those regulations, we will not lose anything. That would cover Murray Tosh's point.

Murray Tosh: Yes, that is right. Perhaps it was pressure of work rather than obtuseness that meant that the Executive was not able to relate the letter to the committee discussion of the instrument in question.

The Convener: The legal adviser mentioned that.

Road Works (Reinstatement) (Scotland) Amendment Regulations 2003 (SSI 2003/417)

The Convener: We move on to consider the next road works regulations. Christine May mentioned the big issue to do with the 125 million standard axles, which was in the second question that we asked. Surprise, surprise—that is not a per annum figure; it is cumulative.

Christine May: It relates to the full 20 years of a road's life.

The Convener: In the light of that answer, the Executive will introduce an amending instrument to correct the defect that we highlighted. We will also raise the failure that we identified in our first point with the lead committee and the Parliament. Is that agreed?

Members *indicated agreement*.

Food (Peanuts from Egypt) (Emergency Control) (Scotland) Regulations 2003 (SSI 2003/418)

The Convener: These regulations are very similar to the Food (Pistachios from Iran) (Emergency Control) (Scotland) Regulations 2003 (SSI 2003/414). The points that we raised were very similar to the six points that we raised on the regulations on pistachios. Is it agreed that we draw the regulations on peanuts to the attention of the lead committee and the Parliament on the same basis as we did the regulations on pistachios?

Members *indicated agreement*.

Advice and Assistance (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/421)

The Convener: As Christine May has highlighted, the regulations are the first instrument in relation to which we have encountered a big consolidation issue.

Christine May: The National Health Service (General Dental Services) (Scotland) Amendment (No 2) Regulations 2003 raise the same issue.

The Convener: We will have the debate and try to resolve the matter now, if that is okay with Christine May.

Christine May: Okay. There is a rule of thumb, or good practice, on consolidation. It seems that a common thread—that good practice slips—has run through all our deliberations to date. Although I appreciate that work on the major bills that are coming through occupies bill teams, that is not necessarily a sufficient excuse for not consolidating regulations. I would like some advice on what it might be most appropriate for the committee to do. Should we write a letter to the Executive, or should we pass the issue on to a committee or to the Parliament?

The Convener: In the first instance, we can write a letter to the Executive; we can take it up from there.

Members will note that the regulations that these regulations amend have been amended seven times, which is too many times. We can highlight that specific instance. Are there any other points?

Murray Tosh: I would not be hugely unsympathetic to an argument about disproportionate work load at any given time, but I wonder why the principal regulations were not consolidated at the fifth time of amendment. I suspect that the reason is that the Health Department was handling major legislation at that time. I also suspect that when the eighth, ninth and 10th amendments take place, the Health Department might be handling major legislation. We have been discussing health legislation for the past four years. If we accept that reason, it will always be a reason for not consolidating regulations. There has to come a point at which the Executive says that there is permanent revolution in the field of health and the Health Department will always be legislating so it will do what it has to do to get regulations consolidated, even if that means additional resources. Otherwise, the Executive will have to tell us that there will be a year when there is less legislation to consider and it is able to consolidate everything.

11:45

Mike Pringle: That leads me to ask whether the department has enough staff. From what Murray Tosh has said, it seems that it is doing legislation all the time.

Murray Tosh: The Executive will immediately say that it does not have enough staff.

Mike Pringle: I understand that, but maybe we should ask whether it is a serious issue. Is it a personnel problem? Is it a question of recruiting experienced people? Legislation is highly technical; does the Executive have enough people that are well trained in that area? I do not know the answers to those questions.

Christine May: I look forward to cross-party support when the supplementary budget estimates for employing more staff come through.

The Convener: Well said.

Christine May: I have a point to make on the dental services regulations.

The Convener: Before we move on to that, I just have to point out that the information has not been consolidated on the website. There are also various versions of the same regulations on the website. We should also include that point in the letter to the Executive.

We are agreed about the consolidation of the regulations and we will link that comment with the earlier point we made about consolidation.

National Health Service (General Dental Services) (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/422)

The Convener: Christine May had a point about the regulations.

Christine May: My point is also about consolidation. The principal regulations predate devolution so perhaps there is a greater imperative for consolidation in this case. I am informed that the regulations are becoming very difficult to follow. We could make that specific point in the letter.

The Convener: Taking that point on board, are we agreed with the recommendation that the regulations should be consolidated?

Members *indicated agreement*.

Draft Instruments Subject to Approval

Local Government in Scotland Act 2003 (Ancillary Provision) Order 2003 (draft)

11:47

The Convener: The order puts right an omission in the Local Government Finance Act 1992 that has arisen because of the Local Government in Scotland Act 2003. No points arise.

Victim Statements (Prescribed Courts) (Scotland) Order 2003 (draft)

The Convener: No points arise on the order.

Instrument Subject to Approval

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No 3) (Scotland) Order (SSI 2003/429)

11:48

The Convener: No points arise on the order.

Instruments Subject to Annulment

National Assistance (Assessment of Resources) Amendment (No 3) (Scotland) Regulations 2003 (SSI 2003/425)

11:48

The Convener: No points arise on the regulations.

Air Quality Limit Values (Scotland) Regulations 2003 (SSI 2003/428)

The Convener: Stewart Maxwell has some points to raise on the regulations.

Mr Maxwell: There is the obvious point that the directive said that the regulations had to be implemented by 9 September but they will not come into force until 2 October. There might be reasons for that, but it is obvious that slippage has occurred.

My main point is about part II of schedule 2. One entry in the first column of the table entitled "Target Values for Ozone" on page 14 ought to refer to a target value for the protection of vegetation, not human health. The words "human health" appear twice in that column, which makes no sense and is a clear error in the table.

The Convener: The question is which entry should be changed.

Mr Maxwell: I do not know. I am not an expert in the matter, so I do not know which is wrong. I presume that not both target values apply to vegetation.

The Convener: I am a scientist, but I would not like to hazard a guess.

Christine May: If the second row of the table applied to human health, we would be looking after humans only from May to July.

The Convener: Okay—we think that the second entry in the first column should mention vegetation.

We have noted three other errors in the regulations. One is in paragraph 1.1 of part I of schedule 5, on page 21. Paragraph 1.1(c) of schedule 3, on page 16, contains a table headed "Particulate Matter" and seems to be missing a footnote. The definition of "public" in regulation 14(15) is restricted to that regulation, but it appears from regulation 2 that it is to have that meaning for the purposes of every relevant regulation. Do we agree to ask the Executive about those five points?

Mike Pringle: Will we ask why the Executive did not meet the deadline?

The Convener: Yes.

Another important point is that the regulations are not accompanied by a transposition note. We will remind the Executive about that.

National Health Service (Optical Charges and Payments) (Scotland) Amendment (No 3) Regulations 2003 (SSI 2003/431)

National Health Service (General Ophthalmic Services) (Scotland) Amendment (No 2) Regulations 2003 (SSI 2003/432)

Christine May: The point about consolidation is raised again by both sets of regulations. We should ask the Executive about plans for consolidating the regulations and include that in our general letter.

The Convener: Apart from that, we have no points on the regulations.

Smoke Control Area (Exempt Fireplaces) (Scotland) Order 2003 (SSI 2003/436)

The Convener: No points arise on the order.

Mr Maxwell: It is a rollercoaster ride, isn't it?

Christine May: No, no, this is "Harry Potter"—the fireplaces thing.

The Convener: It is a good job that the *Official Report* cannot convey the tone of my voice now.

Food (Star Anise from Third Countries) (Emergency Control) (Scotland) Revocation Order 2003 (SSI 2003/437)

The Convener: No points arise on the order.

Criminal Justice (Scotland) Act 2003 (Transitional Provisions) Order 2003 (SSI 2003/438)

The Convener: No points arise on the order, except for the concern about the use of the singular word "power", rather than the plural. We will mention that in an informal letter.

Victims' Rights (Prescribed Bodies) (Scotland) Order 2003 (SSI 2003/440)

The Convener: No points arise on the order.

Victim Statements (Prescribed Offences) (Scotland) Order 2003 (SSI 2003/441)

The Convener: No points arise on the order, but our legal advice contains interesting background information.

Instruments Not Laid Before the Parliament

Classical Swine Fever (Scotland) Order 2003 (SSI 2003/426)

11:53

The Convener: The order raises several issues on which more clarity is needed. Precision is needed about places and lengths of time.

Mike Pringle: Article 5(1) refers to a period of 56 days. From what date will that period be calculated?

The Convener: Article 9(2) on page 5 omits the words "or other place" after the words "knacker's yard".

Mike Pringle: Are there still knackers' yards?

The Convener: I like this bit of the brief:

"Their omission from this sentence … suggests that the notice mentioned in this sub-paragraph would not be applicable where the pig had come from or been sent to the 'other place'. The Executive might be asked whether this is the intention."

Furthermore, there are some words missing in the order. Paragraph 16, in part II of schedule 1, on page 10 of the order, which is to do with the movement of pigs, does not seem to make sense.

Christine May: It is not clear from where and to where, or within what period of time.

The Convener: Finally, there is a transposition note issue.

Land Reform (Scotland) Act 2003 (Commencement No 1) Order 2003 (SSI 2003/427)

The Convener: We should ask why the title of the order that is cited in article 1 does not correspond with the order's heading. Well spotted, legal adviser. No other points arise.

Housing (Scotland) Act 2001 (Commencement No 7, Transitional Provisions and Savings) Order 2003 (SSI 2003/434)

Criminal Justice (Scotland) Act 2003 (Commencement No 2) Order 2003 (SSI 2003/439)

The Convener: No points arise on the orders.

We have raised the general issue of consolidation with the Executive. Is there anything further that members wish to raise? Christine May wanted to mention transposition notes.

Christine May: I made a suggestion about transposition notes. Whether the *Official Report* shows it or not, I will say it again: when we met for our away day, the Executive indicated that it was considering providing transposition notes. Could that be circulated to all bill teams so that, when we receive responses, they are not along the lines of "We could understand the bill, so we didn't think you needed one"?

The Convener: We will pass that on. I thank everybody for coming today, and we will see one another next week—same place, same time.

Meeting closed at 11:56.

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