EDUCATION COMMITTEE

Wednesday 23 November 2005

Session 2

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EDUCATION COMMITTEE
21st Meeting 2005, Session 2

CONVENER

*Iain Smith (North East Fife) (LD)

DEPUTY CONVENER

*Lord James Douglas-Hamilton (Lothians) (Con)

COMMITTEE MEMBERS

*Ms Wendy Alexander (Paisley North) (Lab)
*Ms Rosemary Byrne (South of Scotland) (SSP)
*Fiona Hyslop (Lothians) (SNP)
*Mr Adam Ingram (South of Scotland) (SNP)
*Mr Kenneth Macintosh (Eastwood) (Lab)
*Mr Frank McAveety (Glasgow Shettleston) (Lab)
*Dr Elaine Murray (Dumfries) (Lab)

COMMITTEE SUBSTITUTES

Richard Baker (North East Scotland) (Lab)
Rosie Kane (Glasgow) (SSP)
Michael Matheson (Central Scotland) (SNP)
Mr Jamie McGrigor (Highlands and Islands) (Con)
Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Dr Jenny Bennison (Royal College of General Practitioners Scotland)
Robert Brown (Deputy Minister for Education and Young People)
Dr Helen Hammond (Royal College of Paediatrics and Child Health)
Ronnie Hill (Scottish Commission for the Regulation of Care)
Morgan Jamieson (Scottish Executive Health Department)
Dr David Love (British Medical Association Scotland)
Ms Jane O'Brien (General Medical Council)
Peter Peacock (Minister for Education and Young People)
Jacquie Roberts (Scottish Commission for the Regulation of Care)
Maureen Verrall (Scottish Executive Education Department)

CLERK TO THE COMMITTEE
Eugene Windsor

SENIOR ASSISTANT CLERK
Mark Roberts

ASSISTANT CLERK
Ian Cowan

LOCATION
Committee Room 4

Scottish Parliament

Education Committee

Wednesday 23 November 2005

[THE CONVENER *opened the meeting at 09:30*]

Subordinate Legislation

The Convener (Iain Smith): Good morning, colleagues, I welcome you to the Education Committee's 21st meeting in 2005. We have a long agenda ahead of us this morning. We will mainly be dealing with the Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Bill, but before that we have a number of statutory instruments that were carried over from a couple of meetings ago while we awaited a final report from the Subordinate Legislation Committee, which we have now received. The instruments are all before the committee. Before I ask whether we have anything that we wish to report on the instruments, I ask members whether they have questions on any of the issues that the Subordinate Legislation Committee raised. I think that Lord James has a couple of points.

Lord James Douglas-Hamilton (Lothians) (Con): They may be matters on which we wish to report. The first point is whether we can seek clarification from the minister about whether, in cross-boundary disputes, the home or host authority would attend an additional support needs tribunal. That has not been made altogether clear in the guide to parents. It is a technical point, but it might be worth clarifying.

Secondly, my understanding is that, currently, either the local authority or a parent can challenge the tribunal's decision on a point of law in the Court of Session. In the letter that he wrote to me on 24 June, the then Deputy Minister for Education and Young People, Euan Robson, promised that details would be set out in the rules and procedures for the additional support needs tribunals and in the guide to parents. However, those details do not appear to be made clear in either the Additional Support Needs Tribunals for Scotland (Practice and Procedure) Rules 2005 (SSI 2005/514) or the guide. Could we raise that by letter? Again, it is a technical point. In his letter, the deputy minister said:

"The Rules and Procedures for the Additional Support Needs Tribunal, which are currently out for consultation, sets out further detail on this matter. It is intended that the guide for parents on making a reference to the tribunal will contain this information. In addition, at the time of the tribunal's decision the parties involved in the reference will be informed of their right to refer the matter on a point of law to the Court of Session."

It would be helpful to parents if clarification was given on that.

The Convener: Are colleagues content that we write to the minister and ask for clarification on those two points?

Members *indicated agreement*.

The Convener: If there are no other questions on the points that the Subordinate Legislation Committee raised, I will go through the instruments to ask whether the committee wishes to report on them.

Additional Support for Learning Dispute Resolution (Scotland) Regulations 2005 (SSI 2005/501)

The Convener: Does the committee agree to make no comment on the regulations?

Members *indicated agreement*.

Additional Support Needs Tribunals for Scotland (Practice and Procedure) Rules 2005 (SSI 2005/514)

The Convener: Does the committee agree to make no comment on the rules, subject to the letter that Lord James has asked us to send?

Members *indicated agreement*.

Additional Support for Learning (Placing Request and Deemed Decisions) (Scotland) Regulations 2005 (SSI 2005/515)

The Convener: Does the committee agree to make no comment on the regulations?

Lord James Douglas-Hamilton: The first point that I raised related to these regulations. It would be a great help if that could be clarified.

The Convener: Subject to that point, does the committee agree to make no comment?

Members *indicated agreement*.

Education (Additional Support for Learning) (Scotland) Act 2004 (Transitional and Savings Provisions) Order 2005 (SSI 2005/516)

Education (Additional Support for Learning) (Scotland) Act 2004 (Consequential Modifications of Subordinate Legislation) Order 2005 (SSI 2005/517)

Additional Support for Learning (Co-ordinated Support Plan) (Scotland) Amendment Regulations 2005 (SSI 2005/518)

The Convener: Does the committee agree to make no comment on the instruments?

Members *indicated agreement*.

Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Bill: Stage 1

09:35

The Convener: This is the second and final day of oral evidence taking as part of our stage 1 consideration of the Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Bill. We have three panels of witnesses this morning. The second panel will be representatives from the Scottish Commission for the Regulation of Care and we will hear from the minister later this morning.

The first panel of witnesses are various representatives of the medical profession. I am pleased to welcome Morgan Jamieson, national clinical lead for children and young people's health in Scotland at the Scottish Executive; Dr David Love of the British Medical Association Scotland; Ms Jane O'Brien, head of standards and ethics at the General Medical Council; Dr Jenny Bennison, deputy chair of policy at the Royal College of General Practitioners Scotland; and Dr Helen Hammond from the Royal College of Paediatrics and Child Health. I welcome you all this morning and thank those organisations that have submitted written evidence. I am happy for you to make brief opening remarks in support of your written evidence.

Dr Helen Hammond (Royal College of Paediatrics and Child Health): We are happy to give evidence to the committee. We will stand by the submission that we made.

Morgan Jamieson (Scottish Executive Health Department): I did not make a written submission and I did not come prepared to make any statement at this point. I am happy to interact with the committee, if that is satisfactory.

Dr David Love (British Medical Association Scotland): Thank you for inviting us to give evidence. I start by placing on record our concern about a statement in paragraph 11 on page 4 of the bill's policy memorandum. It states that organisations including the British Medical Association expressed no problems

"in relation to the principles of joint inspection for services for children."

That is quite incorrect. The BMA expressed considerable concerns both in previous written submissions to the Executive and in our submission to the committee. Our main concern is about the possible threat to the doctor-patient relationship that is posed by the bill. That

relationship is founded on confidentiality and we have grave concerns about that.

We are concerned that the wide-ranging powers that are proposed in the bill cover not only child protection issues but other services to children. The considerations in those two contexts could be quite different. We need to bear in mind that the bill covers a wide age range; it covers not only small children but 17-year-olds, who are young adults and who could be legally married with small children. The legislation would apply to them too and we need to bear that in mind as we consider the implications of the bill.

Ms Jane O'Brien (General Medical Council): Thank you for inviting the GMC to give evidence. We have made our main points in our written submission. It might be helpful to explain that the GMC exists to protect patients and serve the public interest, which we do through licensing and regulating doctors. As members know, we give advice to doctors on good practice, which includes advice about confidentiality. We accept that new powers might be necessary to allow access to records in some circumstances, but we think that such powers should be used cautiously with minimum intrusion on privacy. The bill could be substantially improved to better reflect those ideas and to protect individuals' rights.

Dr Jenny Bennison (Royal College of General Practitioners Scotland): We stand by our written submission as well as supporting the BMA's submission.

I will be brief. We would like to have had more time for proper formal consultation, so that we could have sought our members' views, because agreement has to be reached with the health professionals who are involved if the inspection process is going to work. We also think that the powers that are proposed in the bill should be openly declared to Scotland's public, including Scotland's children and young people, who should have been allowed to give an opinion on the bill.

The Convener: I thank you all for your opening remarks. Members may now ask questions. If members want to ask a specific organisation a question, they should say so; otherwise any member of the panel may answer it. Fiona Hyslop looks keen to ask questions.

Fiona Hyslop (Lothians) (SNP): I have a general question. Are the witnesses comfortable with the bill being fast tracked? The bill has been introduced to the Parliament with a condensed timeframe so that pilot joint inspections can continue. Are you satisfied with such a way of proceeding? Would you prefer there to be a delay so that the many concerns that you and others have raised can be reflected on? I would like to hear your views on that basic issue.

Dr Love: We fully support the view of the Royal College of General Practitioners. There has been a very short timescale in which to consult members, hold discussions and get feedback. It would be extremely valuable to hear how general practitioners in particular would react to the bill being passed, but we have not had the opportunity to find out what their reactions would be. I firmly believe that there should be a much longer consultation period. The Royal College of General Practitioners representative said that we need to seek the views of the public, patients and young people, but the timescale has not allowed that to happen.

Fiona Hyslop: Does that mean that the process should be delayed? It is perfectly possible for the Parliament to delay it. We must weigh up the Executive's desire to move forward, the fact that inspections are being put on hold as we try to get the legislation in place and the need for consultation. I address my remarks to the BMA in particular. Most general practitioners will have no idea about the proposals. Therefore, if the bill becomes law—which it could easily do by the end of the year—could its provisions end up being counterproductive precisely because of the rush that there has been? The Executive and the Parliament will have to judge whether the rush to pass legislation is worth the risk.

Dr Love: I am in no doubt that passing the bill quickly and as it stands will be counterproductive. There should be a delay for further consultation and feedback.

Dr Bennison: I agree with what has been said. The danger is that the health professionals who are involved will feel defensive about the proposals if the bill is rushed through and that it will be more difficult to communicate effectively with them. The pilots showed that individual interviews with the professionals who were involved were the most useful way of finding out what had happened. Interviews will be less helpful if a doctor feels very defensive about somebody marching into their premises and taking records off their shelves without the permission of the patient.

Ms O'Brien: We would support the views that have been expressed. We are also concerned that the bill is not clear in a number of areas. It will be difficult to explain properly to the public—including children, but also their parents and carers, whose records may also be accessed in the scheme—exactly what the purpose of the legislation is, which it is essential to do. Child protection services and children's services more generally are constantly confused and it is difficult to understand the documents that have been produced—even when one tries hard to do so. I think that child protection was considered and then wider services were covered, but that has not

been properly reflected in the bill. The bill will create rather than prevent more confusion. It is, of course, difficult for us to judge what the knock-on effects of a delay might be—that is clearly for members to do.

09:45

Dr Hammond: I suppose that I am a bit torn. I understand the concerns of my colleagues representing other professional bodies, but I doubt whether we would get a different view by delaying the process. There is merit in having wider consultation with young people and parents, which need not take a long time. I understand that some of that is already under way. Again, consultation should be more about helping people to understand the process than about changing the process. It should be about ensuring that they truly understand what we are trying to do before the bill is passed and inspections take place.

However, I think that there is a need for urgency. I suppose that paediatricians recognise that more than our colleagues do because we have been involved in many of the very difficult cases that have led us into the audit and review and the child protection reform programme. We have also been involved in the momentum building up to the inspection process in the implementation of the framework for standards and the pilot inspections. Therefore, paediatricians would like to get on with the process, although we do not want undue haste, which would derail it. There is a difficult balance to be struck.

Morgan Jamieson: I align myself with what Dr Hammond just said. It is important to emphasise that, unlike the other panel members, I do not speak on behalf of any particular body or group. I am here in my own right and by the committee's invitation, although I speak as someone who was medical director at Yorkhill for a number of years, where I dealt with the handling of case records and confidentiality issues.

There is a tension in the bill process and a natural and proper desire to progress it. We are very aware of the child protection issues that have arisen, even within our own land, and there is a desire to have services that are robust and that work in an effective, interagency manner. We need to progress that. My emphasis would be on taking through the bill. I am not exposed enough to the workings of the Parliament to know how undue the haste has been over the bill.

Fiona Hyslop: Very.

Morgan Jamieson: I cannot comment on that, but I take note of what has been said. I certainly share the desire to get the bill properly in place, but alienating a large sector of the professions while doing so would clearly create problems. There is a need to ensure that people are on board, although I am not sure that I necessarily share the concerns that my colleagues have about some matters.

Fiona Hyslop: Just on the broad parameters, there are obviously three elements to the bill: the child protection inspections; access to information for children's services inspections generally; and the power for the general social work inspections. Do you think that the medical professionals would be more comfortable with the bill's provision on access to medical records if it referred only to child protection and was pushed through to allow joint inspections for child protection purposes? Is the concern caused by the widening of scope to include general children's services inspections? Would it have been better if the bill had been presented in the first instance as being about only child protection inspections?

Dr Love: That is undoubtedly true. Much of the anxiety has arisen because of the lack of clarity about children's services and about how wide the inspections would be. There is confusion about the child protection bit of the bill and the children's services bit. Many of the justifications for overriding the need for patient consent have been made on the back of child protection issues. However, such arguments simply do not apply to the audit of children's services in general, where there might be no child protection issues. That situation has caused us a considerable problem in reacting to the bill. It would certainly ease the process if the bill was simpler, which is not to say that we still might not have reservations.

Dr Bennison: I agree with that.

The Convener: I will follow up on what Fiona Hyslop has been asking. The Executive says that the reason for the urgency of the bill is that the pilot joint inspections identified a problem in gaining access to health records, which made matters more difficult. The bill proposes one way of resolving that issue, but that obviously causes concern to some of the medical professions. If the medical professions have any alternative means of resolving the problem that would allow the joint inspections for child protection to go on, that might address some of the issues that have been raised.

Dr Love: I suspect that when the inspections took place, the interpretation of the Data Protection Act 1998 lacked clarity. General practitioners and doctors who work in hospitals are in different positions. Under the act, general practitioners are data controllers. Achieving clarity about our duties in respect of consent has taken a long time.

In the past year or so, after taking expert legal advice about the interpretation of the act, we have agreed with the Scottish Executive Health

Department a code of confidentiality on access to health records, which deals with when consent can be sought, when implied consent can be used and when access without consent can take place. That was agreed after an extremely long and painstaking process. Having agreed that code of confidentiality, I would have thought that it could be the basis on which records were accessed.

GPs now have much greater clarity about their duty to share information when child protection is concerned. Perhaps a year or two ago, that was unclear. It is now much clearer and GPs are clearer about their obligation to share information when child protection concerns arise.

Dr Hammond: I echo that. In the past two or three years, a huge shift has taken place—GP colleagues, mental health colleagues and paediatricians now feel much more comfortable about their responsibilities. We have been helped enormously by the chief medical officer's letter and note of last year and by a document from the Royal College of Paediatrics and Child Health on doctors' responsibilities in child protection, which involved GMC colleagues, the Royal College of General Practitioners and the defence bodies.

On a positive note, there has been a big shift in the profession's willingness to share, and understanding of the need to share, information in child protection practice. I certainly think that we would not want to do anything that got in the way of continuing that progress. The professions need to understand the information sharing that is involved in joint inspection and the difference between sharing information for joint inspection and sharing information in practice. That is one issue that we must deal with in the coming months.

Morgan Jamieson: Working at an organisational level, I can understand why general practitioners working as individual data controllers do not face some of the issues with the same regularity as does a medical director for a whole organisation, who faces them almost day to day. That perhaps explains why I may have found it easier to come to terms with the confidentiality issues, because I understand that information can legitimately be shared for reasons beyond simple health care under implied consent or even without consent, in some circumstances. I imagine that most of the work was done under implied consent, because there was some public understanding that child protection was one of the legitimate reasons for sharing information.

Fiona Hyslop: I will explore a couple of issues. The bill refers to registered medical practitioners and we have a variety of representation. Do you understand that term to cover nursing staff and health visitors? We have received written evidence that expressed concern about who the medical practitioners who will share information are.

What is the status of the General Medical Council's agreement entitled "Confidentiality: Protecting and Providing Information"? If that is embedded or accepted and operating well, why did problems arise with pilot inspections? Were they caused by the data protection issues that we have heard about? If that code is working well and you think that it could be the bedrock for sharing information, why do we need the bill and why did the inspections encounter problems?

Ms O'Brien: It would help if I responded to the second issue first. The GMC's publication is guidance—it is not binding or statutory. There is an awful lot of guidance out there. There is guidance from us, from the UK Department of Health and from the Scottish Executive Health Department. All the guidance tries to advise doctors on how they can best serve patients' interests while keeping within the law. Two main issues arise in relation to the law: the Data Protection Act 1998 and the common law or article 8 of the European convention on human rights. Those measures interlink, as the first data protection principle is that processing must be fair and lawful, but that is just a start, so we must consider common law or human rights law requirements at the same time, although some people consider them separately.

Our guidance lays out the circumstances in which doctors may disclose information, which are if there is a statutory duty to do so, if consent has been given or if there is an overriding public interest. We usually say that the public interest test is one of proportionality, so we do not, as the Scottish Parliament information centre briefing suggests, allow disclosures without consent only in relation to serious crime. That is not true; the test is a great deal more subtle than that. We ask doctors to take into account the invasion of privacy and any harm that might be caused to the individual, for example, whether the police will come knocking on their door in the morning, whether they will lose their job, and other situations that might arise from the disclosure of medical information. Doctors must also take into account the public interest in having a confidential medical service that people trust, so that they can share information freely with their doctor on the understanding that it will not go any further. That trust may be eroded by individual breaches of confidentiality. Doctors are asked to weigh those issues against the benefits of the disclosure. In some cases, the issue might come down to whether the disclosure is necessary to protect someone from death or serious harm; in other cases, where the likely implications for the individual are minimal, the threshold might be much higher. That is what our guidance tries to explain.

Fiona Hyslop: So the guidance certainly does not cover disclosure for inspection for improvement or quality assurance. I assume that the national health service code is similar.

Ms O'Brien: It is good practice to seek consent for disclosures of that kind, as people do not routinely expect them. If somebody goes to their doctor and the secretary needs to type a referral letter, that falls under the patient's expectation of how their data can be used or shared. However, if a disclosure is not directly necessary for the patient's individual care, or if the patient cannot be expected to foresee the disclosure and there is no statutory power to disclose the information, we expect consent to be sought. If consent cannot be sought or is withheld, we expect the doctor to make the public interest test. Disclosure may well be justified in those circumstances.

We support the need for legislation, but it must be used sparingly, because doctors have to make a difficult judgment in the public interest test, with the threat that if they make the wrong judgment, they could have to appear before the courts or the General Medical Council. If the public will, as expressed through Parliament, is that there is a public interest in the inspection process and that inspectors must be able to get records, it seems reasonable for them to have that power. However, it should be used only when other measures that we would prefer for policy reasons, such as obtaining consent, fail. We should not say that we do not need to seek consent or listen to objections that people may have. We should not just rush straight to disclosure because that is easiest and we have the power to do so.

Dr Love: I make it clear that the code of confidentiality to which I referred was not the GMC guidance; it is a code that is now part of general practitioners' contractual obligations under the new GP contract. GPs must abide by a code of confidentiality that relates to visits to the practice to assess various elements of performance under the contract. That code was not in place when the inspections took place in which problems were encountered, so we now have a totally new situation.

10:00

Mr Adam Ingram (South of Scotland) (SNP): The Executive has made available to all interested parties a draft protocol on sharing medical information, which covers the ground that we have been talking about. What is your assessment of that protocol? To what extent does it marry with the codes that you mentioned?

Dr Love: The protocol is helpful up to a point, but it does not satisfy all our concerns. One of the major differences is that, under the code of confidentiality—which is largely driven by the Data Protection Act 1998—patients have the right to opt out and can say that they do not want their medical records to be accessed. The bill seeks to remove that right. A 17-year-old who is married with children will have no right to say that he or she does not want their records to be accessed, whereas under the current code of practice, they have the right to prevent access.

Of course, the protocol is only a protocol. What will be important is what is in the bill and the regulations.

Mr Frank McAveety (Glasgow Shettleston) (Lab): Given your combined expertise and knowledge of your field and others, why can we not come up with a protocol that we can believe in?

Dr Love: The code of confidentiality is a protocol that was agreed and signed up to by the Scottish Executive and general practitioners, so a protocol exists.

Mr McAveety: There are concerns expressed in the written evidence. North Lanarkshire Council's submission recognises the safeguards, but equally it acknowledges the crucial debate about child protection. In the past decade, many inquiries have shown critical failures in processes, with A not sharing information with B and information not being picked up early enough. After all those bitter experiences, why are we still anguishing over the matter?

Dr Love: We think that information is best obtained by interview. The information in medical records is limited because they are kept for different purposes and are concise and abbreviated. The inspectorate has found that it can glean much more from constructive discussion than it can from inspecting medical records. That will continue to be the case and it is our preferred approach.

Morgan Jamieson: It is important to note that the phrase "child protection" is used in two slightly different contexts. There are individual cases in which we are concerned about the safety of a child at a particular moment—they are live cases, if you like. People throughout the professions understand that any barrier to sharing information in such cases should be removed. Ultimately, we have a duty to do what is right for the child and we should not regard the law as being a barrier to proper sharing of information about the care of individual children.

I do not completely share my colleagues' views, but the problem that we are here to discuss is inspection of services that come under the child protection banner. I do not think that the imperative to share information on individual cases can necessarily be extended to an imperative to

share such information when we inspect services and when we consider whether we have good structures in place. I am not dissociating myself from approving much of the plan, but it is important to distinguish between the two banners under which we consider the use of information.

Ms Wendy Alexander (Paisley North) (Lab): Morgan Jamieson has just made the second helpful observation of the day. We are trying to strike a balance in an incredibly difficult area and there is a difference between the generality of the inspection of children's services and individual case conferences.

I have a question for Jane O'Brien. It is a United Kingdom-wide question and I think that she is the member of the panel who is most qualified to answer it. As we have deliberated on this difficult issue, the committee has been preoccupied with how similar legislation has developed in the rest of the UK. Although the situation in England is different, I have a couple of questions about the General Medical Council's approach there.

The inspection provisions of the Children Act 2004 are slightly different to those that apply here. Nevertheless, the regulatory body, the Commission for Healthcare Audit and Inspection—which I had never heard of—which was created under the Health and Social Care (Community Health and Standards) Act 2003, created a right for people in England and Wales to access and remove health records. That includes access to personal records relating to the provision of health for or by NHS bodies or to the discharge of any functions of the NHS. Bodies conducting joint reviews may therefore access information including personal records without requiring the express consent of individuals. That has largely been done with consent, however.

When the Health and Social Care (Community Health and Standards) Bill was being considered at Westminster two years ago, did the GMC object to those powers being given to the regulatory body, the CHAI?

Ms O'Brien: The CHAI has now helpfully decided to call itself the Healthcare Commission, which is a more handy term. Yes, we did object. We had lobbied—principally with respect to the debates going on in the House of Lords—to secure more safeguards. We did not wish to remove the powers altogether, but to provide further safeguards. The predecessor body had to demonstrate that there was an overriding public interest—it had to justify that in accessing people's records. We were concerned about the phrase "necessary or expedient", which we felt might be opening the door too widely to inspectors rushing in.

We received an assurance from ministers, which is recorded in *Hansard*, that there would be a code of practice, to which regard would be had in all inspections. The code of practice was drafted following the passage of the bill. The GMC was involved in writing the code and in establishing the practice that consent should be sought first and that if that failed, if the consent was not safe, or if there was some other reason, the powers under the act could then be called upon. Things would not happen the other way round, however.

That is how we have proceeded under the new legislation in England. The powers are similar, but one big difference is that there are criminal offences for inspectors or employees of the Healthcare Commission for improper disclosures. No such provision appears in the bill, as far as I can see. The only offence in it would be non-compliance with the requirements to disclose information.

Ms Alexander: Which you welcome, presumably.

Ms O'Brien: We think that the arrangements should be corrected, because of the importance of the rights that the bill will give to intrude on people's privacy. It should be reflected that responsibilities go with that.

Ms Alexander: That was very helpful. The notions of objecting in principle and of joint working on a code of practice might offer us a route that could commend itself at a later stage. I am grateful for your explanation.

Lord James Douglas-Hamilton: Do you accept that a balance needs to be struck between the interests of child protection and patient confidentiality? Would you feel reassured or happier if there was a sunset clause somewhere in the bill; that is, a clause to the effect that, if the legislation works perfectly well, it can simply be renewed, but if there are substantial problems, it can be re-examined and readjusted as appropriate?

Dr Love: I am not persuaded about the need for urgency. Mention of sunset clauses raises the spectre of recent happenings at Westminster—which, I must confess, I do not understand. It would be preferable to get the legislation right and to address the problems that are raised, rather than try to rush legislation through with the backstop that we could change it if it proves unworkable. I would have thought it preferable to try and get the legislation right in the first place. It seems always to be more difficult to change legislation once it has been passed than to influence and change it before it is passed.

Lord James Douglas-Hamilton: The proposal that is before us is to introduce an accelerated procedure in the interests of child protection. If that principle were accepted by the committee—it is quite likely that it will be—would you be happier if

the legislation were reviewed in the light of experience one year down the track?

Ms O'Brien: We would welcome that, particularly if that were to happen in conjunction with removal from the bill of some ministerial powers to make regulations.

We feel that the bill does little more than say that there will be joint inspections and that regulations will be made to say how the inspections will work, but how that will happen has not quite been worked out yet. If some of that freedom were cut back a bit so that we understood that disclosures would be made for the purposes of the inspection process and not for other purposes, and that they would be made to members of the current inspection bodies and not to other people, that would reassure us. A reviewing clause could be used to say that if we need wider powers than are in the bill, we can come back to the matter, rather than have such a free hand, as is in the bill at the moment.

The Convener: I will expand on that slightly. A balance must be struck between the primary legislation and the regulations and draft protocol. Do you think that the current balance is wrong? Is there not enough in the bill about the parameters and limitations of the proposals and rather too much about regulation? The Executive would counter that by saying that it has done things that way deliberately in order to allow easier amendment if practice does not work as intended. In other words, is the balance right between being able to move quickly to correct something if the process goes wrong and the need to state clearly the parameters in the bill?

Ms O'Brien: We understand the need for legislation not to tie hands too tightly and to allow some powers to make regulations that can be changed relatively easily. However, we were pleased to see the proposal to use the affirmative procedure in that respect.

We would prefer to see more detail in the bill. As I said, a list of inspection bodies is given in the bill, followed by a power that I imagine it is intended would be used if a new inspection body were created, but the bill does not say that—it leaves open the power to add other bodies to the list. We would be reassured if, rather than there being such wide-ranging powers, those freedoms were slightly curtailed with a view to amending the bill or regulations if they prove to be insufficient.

Dr Love: The question of urgency is closely related to child protection and prevention of further episodes of abuse. That is being addressed by the change in attitudes to which other speakers referred. We are talking about making a retrospective review and, I hope, experiencing a learning process as a result. Although that is important, I am not sure that it is that urgent compared with the proactive steps that we should all be taking to try to prevent child abuse.

Lord James Douglas-Hamilton: Given your concerns that there might not be enough safeguards at present, are you prepared to suggest amendments to include what you believe should be in the bill? I appreciate David Love's point that it is necessary to get the bill right in the first place.

Secondly, it would be very useful to know in detail your thoughts on best practice, which might lead to a code of conduct.

10:15

Ms O'Brien: We would certainly be happy to have a go at the amendments. I have to say that the GMC is not expert in parliamentary drafting, but we would be happy to give you our best shot with an explanation of what we intend. Likewise, we will offer any advice that we can on best practice. We might usefully work with colleagues on that because operational experience and understanding how things work on the ground will be key aspects.

Morgan Jamieson: I have just a brief observation to make. "Urgency" is clearly a relative term and I probably sit somewhere in the middle ground in that regard. Clearly, the bill does not have the urgency of some of the anti-terrorism legislation that seeks to respond to an immediate threat. Equally, we cannot be casual about getting proper legislation and a proper system in place. I do not know that I totally share my colleagues' views. There has been a shift in the process of sharing information on an individual child. People have reinterpreted their freedoms and responsibilities in that regard. I still think that the issue is about finding out how systems do not work properly together. There is plenty of evidence that we are still well short of an ideal situation in that regard. We cannot be casual about introducing processes to understand that, because things often fail at system level.

Dr Hammond: I want to back up that point. The information that has been gleaned from the pilot inspections reinforces Morgan Jamieson's view. There is urgency for us to look properly at our systems.

Dr Elaine Murray (Dumfries) (Lab): We took evidence at last week's meeting from Her Majesty's Inspectorate of Education and from the Social Work Inspection Agency. It became clear in their evidence that the powers already exist, as you said, to undertake investigations on a child, which could involve the release of medical records without parental consent but which would not involve the release of medical records relating to

relatives or carers without their consent. However, if the general environment of a child gave a GP cause for concern, that could be discussed with other professionals. Am I correct in that interpretation of the current situation?

Morgan Jamieson: If the records of a family member were pertinent to a child's safety, that circumstance would override the confidentiality duty towards other family members as well.

Dr Murray: At last week's meeting, Jan Warner thought that that was not the case.

Dr Bennison: The relatively recent advice that came out after the Caleb Ness inquiry was that we should take into account the records of other family members. If there is a case conference about a child at GP practice level, we now pull out all the information about other family members as well.

Dr Murray: So that power already exists in practice. The bill's policy memorandum says that the proposed powers would be

"to share information (on an anonymised basis and under prescribed conditions) with other inspectorates, if this information is necessary for the conduct of their service specific inspections."

That is slightly different from sharing medical records and so on. Currently, you can release information about individuals without their consent if you feel that that is necessary to protect a child. What, in that case, is the concern about sharing information "on an anonymised basis" for the purpose of an inspection?

Dr Hammond: Having worked in the past in paediatrics in adoption, I know that anonymising records is a huge administrative task, which also makes records extremely difficult to read. There are difficulties then in linking up the records of different agencies.

Dr Murray: The policy memorandum suggests that information be shared

"on an anonymised basis and under prescribed conditions".

Is the problem for the medical representatives that that is not clear in the bill?

Dr Hammond: My understanding is that the information would be shared by linking the named records of the children in the different agencies, then the information that is collated for the process of inspection would be anonymised. However, to anonymise the records in the first place to ensure confidentiality—

Dr Murray: I was quoting directly from the policy memorandum, which states that the proposed powers would

"share information (on an anonymised basis and under prescribed conditions)".

Fiona Hyslop: Last week, Graham Donaldson said that it would be impossible to allow discussion "on an anonymised basis". He went on to say:

"Once we are dealing with cases, all the information that we hold on file is deliberately anonymised".—[*Official Report*, *Education Committee*, 16 November 2005; c 2760.]

That happens after the event. I think that there is a lack of clarity.

Dr Murray: We must pursue the matter with the minister. Much of the detail is not in the bill, but will be provided in regulation, so would a commitment by ministers to hold early consultation on the regulation—if that were possible—help to allay some of your fears?

Morgan Jamieson: It is difficult to truly anonymise information. One can remove a name or a number, but patients' details often contain enough information to allow them to be identified. True anonymisation avoids most issues of confidentiality and certainly takes one out of the scope of the Data Protection Act 1998 because, if information is no longer identifiable, it is no longer covered by that act.

There are two problems. The first is that to achieve full anonymisation is quite challenging; the second is that, under the protocol, at least one or two inspectors would have direct access to the identifiable records. Those records would be anonymised when they were subsequently shared as part of the wider consultation, but—

Dr Murray: Concerns have been expressed about the police seeing medical records, for example.

Morgan Jamieson: I appreciate that.

Dr Murray: In the evidence that he gave last week, Graham Donaldson said:

"the interface between medical and other services is critical in child protection. If we cannot explore that interface, the inspection process cannot pursue what it has to pursue in the necessary depth. Therefore, the level of confidence that we could provide would be severely restricted … Giving false assurances could do more harm than good."—[*Official Report*, *Education Committee*, 16 November 2005; c 2765.]

He felt strongly that, unless the sharing of information was a possibility, the child protection inspections would not achieve what we all feel they ought to achieve. What do you think of that view?

Dr Love: If consent is obtained for the information to be shared, we have no problem—that is perfectly okay. The problem arises when information is shared without knowledge or consent. I am not convinced that a case has been made or that there is any evidence to back up what Graham Donaldson says.

Dr Murray: But you would already be prepared to share information without obtaining consent in a case in which you were concerned about a child.

Dr Love: Of course. However, given what the inspections set out to inspect and assess, the information that would be obtained by looking in a GP record would be very limited. Much more information would be obtained by talking to the GP and to the other professionals who were involved in providing services to a child. The evidence of previous inspections is that that is more illuminating. I think that there is a misconception about what information is kept in GP notes and how much that might help the inspection process.

Ms Alexander: I will come in on that point and will try to—or will invite Morgan Jamieson and Helen Hammond to—make the case for the sharing of such information. In addition to the cases that Elaine Murray helpfully identified, there is inspection of child protection services and the wider services that relate to the protection of children. The challenge that we face concerns the inspection of child protection services. There are 50,000 children in Scotland on the at-risk register and it is simply not possible to offer the same level of support to all the children who are on that register or who are likely to be on it in the future. Most inspections of child protection services have suggested that the most vulnerable children receive insufficient support. The question is whether sufficient support can be provided to those children without access to medical records being granted.

I have talked to paediatricians at my district general hospital and I know that they feel that they have a better handle than anyone else on the non-accidental injuries that affect a very small number of children. They would want any social work department assessment of their services to be aware of the frequency and incidence of the non-accidental injuries that affect a subset of the children who are on the child protection register, in order that support of sufficient intensity could be given to that small number of children now and in the future. How can we devise a policy and legislative framework that allows, in the assessment of child protection services, identification of the children who are most at risk? Can we do that without access to information on that subset? The medical records in such cases will be critical in establishing the degree of risk. I invite Morgan and Helen to comment on that.

Dr Hammond: Paediatricians as a body would certainly feel that they probably had more information about the most vulnerable children than their colleagues in general practice. That is not in any way a criticism of those colleagues; we are doing different tasks. Our health visitor colleagues would probably come in behind us.

My colleagues and I feel that to inspect services properly we have to have a 360° look round. In doing so, we learn a lot about the paediatric care and general practice care of the child from the health records, but we also get an insight into the communications with other agencies that have been involved at different stages of the child's life; for example, social services, education services or the police. In a similar way, by considering the records of the other agencies, we can get a view of health services involvement. That two-way communication is vital in the protection of children.

I do not agree with what a colleague said about the value of considering the case records because doing so is enormously valuable. If we consider any of the inquiries or audit reviews, the tracking of the chronology of events from the raising of the first concerns about the child right through to successful protection—we hope—or unsuccessful protection is critical in allowing us to identify where things went wrong or went well so that we can improve our services. Without joint consideration, we will not be able to do that. The pilot inspections demonstrated a gap and demonstrated a willingness and desire—certainly among paediatricians—to contribute to the process and to make it more effective for children.

Morgan Jamieson: We have just heard the views of someone who has spent her life working at the front line. I am happy to endorse what Helen Hammond said.

Fiona Hyslop: There seems to be confusion over what we mean by health records. I can understand the sensitivities of GPs about confidentiality of medical records, but under the same umbrella we are talking about case records for health visitors and nursing staff. Are you concerned about confusion in the bill over medical records and case work records, and over who is covered?

Dr Hammond: There is a lack of clarity that will have to be rectified. Every case record for the child—whether from the health visitor, the school nurse, the GP, the paediatrician or anybody who has been involved in care of the child—has to be accessed in some way so that a chronological picture can be put together.

Mr Kenneth Macintosh (Eastwood) (Lab): The different health records are listed in the protocol. I am not sure whether that is the appropriate place for them.

I want to ask David Love in particular about the code of confidentiality. The code was not drawn up with specific reference to either children's services or child protection. Why not? What does the code apply to?

Dr Love: It was drawn up primarily with the quality of outcomes framework and the new GP

contracts in mind. An annual visit to the practice would assess the robustness of disease registers to ensure that the treatments that GPs claimed to deliver were actually being delivered and to ensure that targets were being reached. Some of that information can be checked only by checking medical records.

Mr Macintosh: The code of confidentiality is to help which inspectors or which visitors?

Dr Love: It is to help the health board.

Mr Macintosh: So the code is to help the monitoring or auditing of GPs' practices.

Dr Love: Yes.

Mr Macintosh: Only one protocol has been drawn up by the Executive—the protocol for child protection. We do not yet have the protocol for children's services, which might be more rigorous. How does the code of confidentiality compare with the child protection protocol? That protocol says that the information that is shared must be proportionate. It is quite prescribed—things can be done only in limited circumstances. How does it differ from the code of confidentiality?

10:30

Dr Love: I could not say how the protocol differs line by line, but I can think of two important differences. First, under the existing code of confidentiality, the patient has a right to opt out and to refuse to have their records accessed for the purpose in question. I am trying to remember the second important difference.

Mr Macintosh: I will give you a chance to think about that. However, under the code of confidentiality, when the health board goes to look at a GP practice, the permission of the patient who is being considered must be asked for.

Dr Love: In general, we rely on implied consent, making patients aware of the possibility of what might happen and explaining things to them in the practice through leaflets and so on. They are given the right to withhold their consent.

The other major difference is that records are accessed by a medically qualified person.

Mr Macintosh: The members of the inspection teams will be qualified to be in inspection teams, but not everyone in them will have medical qualifications. That is a concern.

Dr Love: No—only one will have medical qualifications.

Mr Macintosh: Would you be concerned about the others sharing the information?

Dr Love: Yes.

Mr Macintosh: I think that information must be made available under the protocol along the lines that you have suggested. That medical records might be looked at for audit purposes must be publicised in GP practices and elsewhere.

Dr Love: Yes.

Mr Macintosh: Does not that involve the same sort of implied consent?

Dr Love: Yes, but people have a right to withhold that consent under the code of confidentiality.

Mr Macintosh: Right. So the main difference is that a person can opt out under one but not under the other.

Dr Love: Yes. I am particularly thinking about 17-year-olds, who are covered by the bill. They have no right to opt out, whereas an 18-year-old has.

Mr Macintosh: I want to clarify something. Obviously, there is a separate protocol for children's services. Could the code of confidentiality that currently exists or the protocol be modified? What could be done to reach an agreement about what would be acceptable to doctors, medical professionals and the inspection teams? The protocol has been drawn up by the Executive, but could you agree to a similar document in the same way that you have agreed to the code of confidentiality?

Dr Love: That is possible, yes.

Ms Alexander: I want to ask about 17-year-olds. I understand that there are around 9,000 teenage parents in Scotland each year. Let us assume that 3,000 of them are aged between 13 and 17. It is, of course, possible that in excess of 3,000 of those young people are mothers or fathers of children who are the subject of concern or are on the child protection register. If we leave things as you suggest, not only would 17-year-olds be able to deny in their own right access to medical records, but they could deny access to their children's medical records. Obviously, that cohort has parenting anxieties and challenges and, as I said, some of their children will be on the register. A risk is associated with that. In your scenario, how would things pan out for teenage parents and their right to deny access to their children's medical records?

Dr Love: My main concern was about 17-year-olds, not their children, and my main concern about teenagers is particularly to do with sexual health issues. Are we going to inhibit that group from going to their GPs to seek sexual health advice? For example, will we inhibit them from going for the morning-after pill because they will know that information will be accessible to an inspection team? We could end up with a scenario in which they are assured of that greater

confidentiality by getting the morning-after pill from a pharmacist rather than by going to the GP. I suspect that pharmacists' records will not be inspected. That would mean that other sexual health issues that need to be addressed will not be addressed. Our great concern is that that group may be deterred from going to their GP for help.

Ms Alexander: I was just asking whether an unintended but inevitable consequence could be that those who are parents withhold consent—

Dr Love: Well—

Dr Hammond: Presumably not for the child's information.

Ms Alexander: No, just their own.

Dr Love: Just their own? Yes.

Dr Bennison: Of course, it would still be the case that records and information would be shared where there were concerns about the child.

Ms Alexander: Sure.

Dr Hammond: I am concerned that, at times, we muddle the purpose that lies behind the inspection of services and that which lies behind the delivery of care to young people. Obviously, the issue of young people being put off from taking up sexual health services is a subject that is close to our hearts. Indeed, better sharing of information on young people who are at risk is a big issue in itself. We have done a lot of work on the subject—a good example is the healthy respect programme in Lothian.

We need to be clear with young people from the beginning of their contact with services that there may be circumstances in which information will have to be shared—for instance, if we perceive a young person to be at a significant level of risk. That way of working is beginning to work. We have had to deal with the real concerns that child protection procedures can put off young people from accessing services from any source. Those concerns relate to sexually transmitted disease and pregnancy services.

The issue, which is a real one for us in practice, is not one that affects the inspection process, in which the sharing of information is done for a very different purpose. That sort of information sharing does not lead to services interfering in young people's lives; it is about ensuring that services are good and robust and that they deliver the care that young people need.

Ms O'Brien: I completely endorse that. It is important that the public are given a clear explanation of the purpose that lies behind access to records. The public should understand that, except in extremis—when a serious risk is perceived—the provision will not impact on the care that they receive or on any other aspect of their life.

As I understood it originally—I am not so sure that I understand it now—disclosure is made for the purpose of monitoring and improving the quality of the services that are provided and not to intervene in an individual child's treatment, care, education and so forth. An exception to that is made when the child may be at risk of serious harm. Clearly, one always has to act in those circumstances. If that is explained clearly to people, the vast majority would say that they were happy for their records to be accessed.

However, there is a big danger that a rumour mill could get going. People might say that, if the police have access to GP records, individuals should not tell their GP that they are taking ecstasy on Saturday nights, because taking E is a criminal offence and no one knows where the information might end up. Misinformation can spread if we do not make things absolutely clear, and that could be really dangerous in relation to the objectives that all of us are trying to attain.

Morgan Jamieson: I echo those final comments—that is not to say that we disagree about most things. There is a need for clarity. Part of the consensus around the issue is that people need to understand the purpose and limits of the provision. In many ways, the bill reinforces confidentiality; it puts a wall around the way in which the process is handled.

In the mind of a 17-year-old, is there really a huge difference between their records being accessed for the purposes of a health services audit or for the purpose that we are discussing? Surely a 17-year-old would not discern any difference. In the context of the present code of confidentiality, to what extent have 17-year-olds either used their opt-out or not come forward for sexual health advice?

Dr Love: The code has not been in operation for a terribly long time, but the fact remains that such people have a right to withhold their consent, which the bill will take away from them. That is a fundamental difference.

Ms O'Brien: Another difference is that the joint inspection will take the matter outside the health care world and into the world of youth justice and, less controversially, into social care. If people are unaware of or misinformed about that, that could be a danger, because it would be perceived to be different from the health board inspecting records for the purpose of providing health care. As a teenager, I would have felt a bit concerned—in fact, I would have been horrified—if I had been told that my teachers or the police would be told about my sexual health. We must guard against any such rumour milling.

Dr Murray: That point is important, because there is a lot of misinformation. If a GP thought

that a child or young person had been abused, they would already share that information, because they would feel that that was in the child or young person's best interests. I return yet again to the policy memorandum. It says that information will be shared with other inspectorates, so it will not be shared with policemen, head teachers of schools or anybody of that sort. Information will be for an inspection by Her Majesty's Inspectorate of Education and the name of the child involved will probably not be attached. In discussing the bill, it is important that we do not put such misinformation into the public domain, as it could be dangerous. I certainly understand your concerns.

Do you accept the need to undertake the inspections? Do you think it important that the inspections should take place? What in the bill or regulations would reassure you that the measures would not lead to confidential information about individuals ending up with people that it should not be with?

Dr Love: We would like two major things to happen. First, we would like an attempt to be made to gain consent. I recognise that that might be inappropriate when particular concern is felt but, in general, consent should be sought. That would remove all our anxieties.

The other issue—it may be irrational—is that it would be a great help if only a medically qualified inspector looked in the medical record.

Dr Murray: What do you understand by the term "medically qualified"? Does it mean a doctor?

Dr Love: The understanding in the code of confidentiality is that such a person would normally be a doctor.

Dr Murray: So you would be happy if a doctor accessed the records and shared the information with the other members of the inspection team.

Dr Love: Yes—on an anonymised basis.

Dr Bennison: Another point is about the offences. It would give some reassurance if, as in England, a person who inappropriately shared information gleaned in an inspection was committing an offence. At the moment, the proposal is one-sided.

Fiona Hyslop: I will pursue the concerns about police involvement in sharing information. In the Lothians, all pregnant women are asked whether they are misusing drugs, for the clear purpose of dealing with concern about child protection and the baby's health. If women say that they are misusing drugs, that information shows that they are committing a crime. However, because of their trust in the confidentiality of the medical profession, they do not expect that information all of a sudden to be rushed off to the police.

If we are to give people reassurances, we must recognise that joint inspections not of live cases, but of historical cases, can throw up things. We know that it is expected that police on secondment would be part of an inspection team. What access would they have to records? I understand the argument that a medical professional should have access and that information should be anonymised, but if the police secondee to an inspection team accessed records for the purpose of considering general service improvement and came across something that was of concern and should lead to individuals being charged for a criminal offence, would that be problematic? Should that be dealt with explicitly to give the reassurance that people seek that the police will not have inappropriate access to records?

How can we treat the issue of police involvement in the inspection team to give the reassurance that personal information will not be abused and that confidentiality will be maintained? How can we protect children in future? What role should the police have in joint inspections, what access should they have to information, and what should they be allowed to do—or not be allowed to do—with the information that they have access to during the joint inspections?

10:45

Dr Hammond: My understanding is that the police are joint partners in an inspection, just as they are, in a sense, joint partners in work with children and families. Only if a child was identified through the inspection process as being at risk of immediate harm would an action follow in relation to that child. My understanding of the bill is that such a case would go back to the operational team, not that an individual inspector would take any action in relation to that child and their family. The case would be referred to the services that should be acting to protect the child, to ask them to look at the case again and to take appropriate action. It would not be a case of using records to identify people who, as in the example that Jane O'Brien gave, committed a criminal offence by taking ecstasy on a Saturday night, and of that leading to police action. However, we need clarity on that if the bill is to work.

Fiona Hyslop: What happens if the records show that somebody has been involved in an offence against a child? That is not about protecting a child now but about charging someone with an offence retrospectively. That raises an issue—I am thinking of consent—and is where things get difficult. Parental consent may be sought for access to records, but those records may lead to a criminal charge. One can see where difficulties could arise. Parents who might have been involved in an offence are exactly the sort of

people who would not want to give consent, as that might uncover the offence. In such cases, access to records without the parents' consent may be required.

Dr Hammond: I do not think that I am the right person to answer that specific policy question. In practice, however, if it came to light that a perpetrator might have access to other children and that therefore other children might be at immediate risk of harm, action would have to be taken in the way that we described: the case would be referred to the practice teams to take the matter forward.

Fiona Hyslop: We cannot pretend that the police will have no role. That is the difficulty. The reasons for involving the police may be the right ones, but they might colour everybody else's approach to sharing information.

Morgan Jamieson: I would like to make two comments in a slightly different vein but on the same subject. First, personally I am not at all unhappy that it should be a medical practitioner who looks at the medical records. If that gives people a greater sense that a safeguard is in place, I personally do not have a problem with it.

My own suggestion was related to the situation in which a general practitioner or paediatrician has a real concern about something highly confidential in someone's records. They may not be able to deny access to those records but they should at least have the opportunity to explain to the inspector why they are very concerned about the nature of the information. It might be helpful if that were contained in the protocol.

Secondly, I fully agree that consent is the ultimate high ground: getting consent relieves one of almost all other responsibilities, in a sense. However—although I do not work close enough to the coalface to be sure about this—my understanding is that it would be difficult to get consent in all cases. In some it would be easy, but in others it would not. I do not think that we could have a system that works on gaining consent half the time and on consent being refused the rest of the time. There has to be equity.

Unless one can handle access to records in a way that is totally based on consent, one should totally rely on due process. We should not arrive at a system in which people take consent where they can get it, but if they cannot get consent, they go for the legal process. We should have an equitable way of handling access to records across the board.

Dr Love: In relation to child protection, those arguments are persuasive. However, we are talking about a bill that covers children's services and although the arguments are persuasive in certain circumstances, they are not persuasive where there are no child protection issues. That is one of our major concerns.

Mr Macintosh: Are there no penalties for inspection teams? Are there any examples of situations in which inspectors are penalised if they breach confidentiality?

Ms O'Brien: There are penalties in the Health and Social Care (Community Health and Standards) Act 2003. I can send you the—

Mr Macintosh: Therefore, social work inspectors are—

Ms O'Brien: No; I mean inspectors who are employed by the Healthcare Commission, so the penalties would be in relation to health records.

Mr Macintosh: Do you mean care commission inspectors?

Ms O'Brien: I am talking about the Healthcare Commission in England and Wales.

Fiona Hyslop: Last week, the Social Work Inspection Agency seemed to suggest that, although the measures are about child protection in the first instance and children's services generally, it is interested in developing the power to access records so that it covers mental health issues and perhaps elder abuse. Obviously, child protection is the number 1 issue that we are considering, but would that be a welcome progression or would you have concerns if the bill was the start of something a bit wider and deeper?

Dr Love: We would have the same concerns, or possibly even more concerns, if the powers in the bill were extended to the inspection of other services. In fact, we have had an assurance that there is no intention to do that. A power to access records of patients who suffer from mental health problems without their knowledge or consent would be of great concern to us.

The Convener: As there are no more questions, I thank the witnesses for coming and for their helpful evidence on what is a small but complicated bill.

10:51

Meeting suspended.

10:57

On resuming—

The Convener: Our second panel of witnesses are representatives of the Scottish Commission for the Regulation of Care, which is commonly known as the care commission, to give it its weekday title rather than its Sunday one. We have with us Jacquie Roberts, the chief executive, and Ronnie Hill, the director of children's services regulation. I

thank the witnesses for their written evidence. I give them the opportunity to make additional comments before we ask questions.

Jacquie Roberts (Scottish Commission for the Regulation of Care): Our written evidence speaks for itself. The care commission's role in relation to the bill will lie in considering children's services in general and in checking child protection procedures and policies for many children in Scotland. The bill's main purpose is to allow us to check whether agencies are working together effectively for the protection of children. It is clear that, without access to health records and health personnel, the checking of the systems is incomplete. Graham Donaldson, on behalf of all the agencies, could not give an assurance that the checking system is complete or that the systems are set up for the protection of children.

Dr Murray: We had a lot of discussion with the previous witnesses about confidentiality, which is an obvious concern among many medical professionals. In the course of your inspections of premises, whether in the private, voluntary or public sector, do you ever get access to medical records?

Jacquie Roberts: The Regulation of Care (Scotland) Act 2001 allows us to access medical records through either a medical practitioner or a registered nurse—so not just through a doctor.

Dr Murray: When you are informed of the contents of medical records, how do you ensure that they remain confidential and that the information goes no further?

Jacquie Roberts: We have strict rules and guidelines for our personnel on maintaining confidentiality. The 2001 act allows us to access such information only in rare circumstances—in cases in which we have reason to be very concerned about the provision of care for an individual.

11:00

Dr Murray: Is it necessary for you to get consent from the individual concerned? I appreciate that, in some cases, they may not be able to give consent.

Jacquie Roberts: Indeed. There are cases in which it is difficult for people to give consent, but our understanding is that we would obtain consent to access records.

Mr Ingram: Is the system one in which there is implied consent and somebody can opt out, or is it a question of your asking for consent in your inspections?

Jacquie Roberts: It was envisaged that there would be an investigation when things are going wrong. That is why we are expected to get consent from the individual or their advocate. The bill is about more generalised inspections of the way in which services work together; it is not concerned with the investigation of individual cases. The provisions of the 2001 act are about the investigation of either the care of an individual or the provision of a service in one particular registered service. The 2001 act and the bill have different purposes.

Mr Ingram: Do you think that implied consent with an opt-out is a reasonable approach? As we have heard, that is similar to the approach of the national health service code of confidentiality. Will the two marry together quite well?

Jacquie Roberts: Yes. I always think that it is a good test if children, young people and their parents understand what we are trying to do. We are trying to test whether the system works to protect children and whether people communicate effectively with one other. If we give children and young people the reassurance they need that they or their friends are protected and the system is working, they will understand the idea of implied consent. The protocol states that health boards must make it clear why not just medical records but health information are being made available for inspection or audit purposes.

Since the 1970s, there have unfortunately been many cases in which things have gone seriously wrong simply because agencies were not communicating effectively and sharing information. The bill is groundbreaking because it will empower the various agencies that have a responsibility to inspect and to provide scrutiny to share information with each other. If we cannot reflect that and demonstrate it in our inspection and scrutiny, how can we expect child protection systems to work effectively?

Lord James Douglas-Hamilton: I have a couple of quick questions, the first of which is an elementary question. Where do the inspections of the Social Work Inspection Agency begin and end and where do your inspections begin and end? Do they ever overlap? Will you give us a short note on that, if you feel able?

Jacquie Roberts: Do you mean a written note?

Lord James Douglas-Hamilton: Yes, unless you can give the answer straight away.

Jacquie Roberts: The Social Work Inspection Agency began work only in April this year and it has concentrated its efforts on piloting performance inspections of local authority social work services. We do not cover those services in that way. We cover the registered care services that are provided or commissioned by local authorities. We have shared interests. Mr Hill can give you examples of areas in which we are

working closely together to ensure that, rather than tripping over each other and doing the same things, we work together to examine the quality of services. An example is our work on school care accommodation and secure accommodation for children and young people.

Lord James Douglas-Hamilton: Do you have a good working relationship?

Jacquie Roberts: We do indeed. Mr Hill will add to that.

Ronnie Hill (Scottish Commission for the Regulation of Care): We are developing a memorandum of understanding, which will be a protocol that sets out exactly how we will work to ensure that, in the best interests of service users, there is no overlap and that we add value to each other's inspections.

Lord James Douglas-Hamilton: Has any thought been given to developing integrated inspections, similar to those carried out by HMIE and the care commission for early education provision?

Jacquie Roberts: The short answer is yes, we are doing that. The provision in the 2001 act has been a good one in practice in that it expected us to do integrated work with HMIE. That has been one of the successes. We are using that as a model for our work with the SWIA.

Lord James Douglas-Hamilton: Therefore, you wish no particular amendment to be made to the bill.

Jacquie Roberts: No.

Mr Macintosh: I do not know whether you heard the particular argument about confidentiality in the previous evidence session. The bill applies to joint inspection of child protection services and to joint inspection of children's services generally. Obviously, that process has not started yet, but do you make a distinction between the two? Is there a clear distinction between joint inspection of child protection and joint inspection of children's services?

Jacquie Roberts: I understand why the points were made during the previous evidence session, but one of my main concerns is that there are children who are not in the child protection system but who need to be. Unless we consider services in the round, we will not find out about such children and whether the systems in children's services generally are in place to identify effectively the children who are at risk.

Mr Macintosh: On good practice in professionals sharing information, would you expect health professionals to share information not only in the provision of child protection services but in the provision of children's services?

Jacquie Roberts: Yes, I would, because that is the only way in which we can identify the children who are in trouble and in need, whose parents might not be giving them the care that they need.

Mr Macintosh: The bill does not really distinguish between the two areas; it just talks about the joint inspection of children's services. I was trying to work out whether we could limit the medical confidentiality aspect to just child protection. However, it strikes me that there is no clear delineation between the two areas.

Ronnie Hill: I do not think that doing what you suggest would be helpful. There would be the danger of a gap opening up in relation to information that could usefully be gained through the wider children's services inspection. We should acknowledge that the protocol relates to child protection inspections. However, there is time to develop the protocol further and to consult children, young people and wider interests on it.

Underlying all this is the need for the inspectors to share and discuss properly information from all parties. Helen Hammond put it very well earlier when she referred to having a 360° view.

Jacqui Roberts: We cannot overestimate the risks to children if they are, mistakenly, not identified as being in need of child protection. That is what happened in some of the recent tragic children's cases. We need to have the facility for people to share information generally in children's services.

Fiona Hyslop: You have helpfully explained the challenges for child protection and for wider children's services. However, surely there is a difference between sharing general information that might uncover new child protection cases and sharing retrospective information about live cases. Clearly, joint inspection for child protection cases will examine specifically cases in which there is a documented problem. That is retrospective information, which we can distinguish from new information. You said that you cannot identify and communicate information for children's services generally. I suspect that such information would show up the gaps in child protection information, which could lead to identifying vulnerable children who are not on the at-risk register. On that basis, is it not possible to distinguish between consent and access to confidential information to improve matters and to prevent problems in the future, and access to information about specific, past cases?

Jacquie Roberts: My understanding is that children in need are also included in the sample. All of us know that some of the children who are most at risk but may not be identified as such are those who live with drug-misusing parents. My point is that, because of that, it is essential that we have a system that considers a broader range of

children than just those who are or have been on the child protection register. Is that the point that lay behind the question?

Fiona Hyslop: Yes. That is very helpful.

Jacquie Roberts: We put together guidance for people who work with children who live with drug-misusing parents. In fact, parents themselves have told me, "You'll need to get rid of confidentiality if you've got to protect the bairns."

Fiona Hyslop: One of our concerns about the bill relates to the relationship between those responsible for the joint inspection of children's services and the increasing number of voluntary sector providers. Even if the protocol addresses records, it will not necessarily consider the records of voluntary sector providers or the records of the children's hearings system and so forth. From your useful experience in this area, what issues do you believe the committee should be alert to? Given that the protocol is not just about joint inspections of statutory council services, but is wider and deeper than that, should a more explicit reference be made to the voluntary sector? Neither the bill nor the protocol is explicit on the subject.

Jacquie Roberts: That is a reasonable point. The independent sector now accounts for nearly 50 per cent of the provision of children's services, so it would be worth while to emphasise the important role that it plays and the need for the same rules, guidance and guidelines on confidentiality and information sharing to apply to it. We need to ensure that the independent sector knows how to access the proper child protection system when it needs to do so. We have had to work quite hard with some of the small independent sector providers to get them to understand that they, too, need to put in place a child protection policy and know when to refer a concern to the local authority, social work and police for investigation.

Fiona Hyslop: Are they aware that they may be subject to a joint inspection?

Jacquie Roberts: I think that they are.

Ronnie Hill: Yes, I think they are. There is a further opportunity to raise and develop awareness through the on-going consultation that will take place next year in connection with the overarching children's services inspection.

Fiona Hyslop: Thank you.

The Convener: As no members have further questions, I thank our witnesses for the helpful evidence that they have given the committee. I also thank them for their helpful submissions.

The Minister for Education and Young People is not due until 11.30 am; he is coming from a meeting of the Cabinet. I propose that we suspend the meeting until 11.30 am. The break will give members the opportunity for reflection. We can also have a chat about some of the issues that we want to raise with the minister.

11:13

Meeting suspended.

11:39

On resuming—

The Convener: Colleagues, we now resume the meeting with our third panel on the Joint Inspection of Children's Services and Inspection of Social Work Services (Scotland) Bill. I am pleased to welcome Peter Peacock, the Minister for Education and Young People; his deputy, Robert Brown; Maureen Verrall, head of children and families division, Scottish Executive Education Department; Jackie Brock, head of inspection and quality improvement branch, children and families division, Scottish Executive Education Department; and Andrew MacLeod, Scottish Executive Health Department.

Thank you for coming to give evidence this morning. I hope you have had an opportunity to catch up with some of the oral evidence and the substantive written comments that we have received on the bill. I invite the minister to make some opening remarks.

The Minister for Education and Young People (Peter Peacock): To be honest, convener, while I have been partially briefed on what has happened in the last hour and a half, I have not been fully briefed. However, I have a feel for what has been said and I have seen the written evidence. I do not have anything more to say. I gave evidence to you on the background to the bill a couple of weeks ago. I am more than happy just to take questions from members and to see where we go.

The Convener: I will start by asking about the consultation process. A number of the written responses that we received, particularly from organisations that are directly involved with children and young people, are critical of the lack of consultation, particularly the lack of opportunity to consult children on the bill. Would you care to comment?

Peter Peacock: I can understand that. As we discussed a couple of weeks ago, because we are seeking an accelerated process, the procedure is necessarily different from that which the Parliament would normally undertake. We have been very up front about the whole inspection regime. A huge number of professionals across the board—social workers, police, health professionals and others—have been involved in an extensive consultation on the whole inspection

system. As you know, we have piloted inspections. That has given rise to a series of recommendations on how we can make improvements.

In the background, there has been a lot of consultation on how the policy should operate. As you are probably aware, once we got close to the bill, Andy Kerr and Robert Brown attended meetings—particularly with health professionals—to explain the background to our thinking. Before we lodged all the information and the bill, we briefed Opposition spokespersons and as many people as we could about our intentions.

I accept that the timetable is accelerated, but we have gone to a lot of effort to ensure that everybody is well informed about what we are seeking to do and that they have the opportunity to respond to the bill, the regulations and the protocol, which we published in advance of the normal timescale for a bill. That was all done with the intention of enabling people to say what they want to say.

As we move through the parliamentary stages, we are still listening and reading and picking up from representations things that we can do to finesse the arrangements. We are more than willing to consider those things. We are doing what we can in the circumstances; we have covered the bases pretty well.

Dr Murray: During our evidence-taking sessions, members of the medical profession in particular have expressed concerns about access to records. One suggestion is that medical records should be inspected only by medically qualified inspectors, who can share relevant information with other inspectors, possibly on an anonymous basis wherever possible. Could that be incorporated in the bill?

Peter Peacock: The short answer is no. Remember that we are seeking to reflect in the inspection process what ought to be the actuality of service provision for children, particularly vulnerable children—children who are at risk in one way or another. Increasingly, we expect services to work together on a complementary basis; to share their practice, whether medical practice, social work practice or police practice; to effect change in services; to improve the outcomes for young people on a joint basis; and to work increasingly as a single team, not as individual professions. We aim for that to be day-to-day practice in children's services and child protection. We are seeking to replicate that in the inspection process and to take a genuinely multidisciplinary approach.

We are talking about inspection teams of professional, highly qualified, experienced individuals who are capable of making judgments, assessing and analysing information and—in the context of the arrangements that we are setting out—sharing that information between professionals to discuss issues.

It would not be right if only social workers could deal with the social work bit, only police could deal with the police bit, only doctors could deal with the doctors' bit and only health visitors could deal with the health visitors' bit. That would defeat the purpose of the overarching, joint professional view about how to proceed.

That said, I clearly understand the sensitivities around the territory of health records, but in this context it does not follow that only doctors can assess the work of doctors.

11:45

Dr Murray: I do not think that that was the suggestion. I was talking about extracting the information from the medical record. The point is that a medically qualified person would know what information was relevant and what was not. It could also be a matter of concern to patients if they thought that their medical records were going to be shared with the police.

Peter Peacock: I did not catch your second point.

Dr Murray: Teenagers, for example, could be concerned if they believed that their medical records might be shared with the police.

Peter Peacock: The principle that I was trying to set out still applies to access to records. That is not to say that one of the inspection team who accesses the records will not be medically qualified. There will be medically qualified members of the joint inspection teams—paediatricians for example—but I could not necessarily guarantee that that will always be the case.

There is a slight danger of thinking that we are always focusing on the heavy interrogation of medical records and medical files. We are talking about giving the inspection teams access to clinicians and other professionals, but particularly to those in the medical profession who are not only not entitled to give access to their files, but are not entitled to have conversations with the inspection team about what has been happening with a child. That is why we have introduced this legislation.

I do not know whether the committee got to this in the evidence that was taken last week, but the way the inspectors see it is that they will do the overarching examination of policy, systems, leadership and processes in the organisation, then hone that down to what they need to examine in more detail. Part of that will be to track some

children through the system to see how they have been treated. That would not lead to a medical situation in all circumstances, but it might well do. They might be able to resolve an awful lot without interviewing or dealing with doctors or health visitors, but there is a likelihood that they would have to do that.

The inspectors have told me that a huge amount of what they look for would be resolved if they could have quality conversations with the GP, the health visitor or whoever about what actually happened in the case, so that they get a better feel for the circumstances. The inspectors might never require to go beyond that point and to look at medical records, but then again they might.

The issue of looking at records is at the margins of, rather than central to, inspectors' thinking. Once they get to that point, irrespective of whether the inspectors who have been doing the lead work on the issues on a child are medically qualified, they are probably the right people to look at the file. I do not think that that is incompatible with the professionalism of the inspectors and the quality of the people about whom we are talking about being able to look at the records.

We should also remember that the same professionals will be looking at social work records, school records, police records and so on. I am not sure that there is anything specific about medical records that is different from the police records, social work records and school records to which they will also have access. In that sense, we want to maintain the principle that the professional inspectors should get access to those records when circumstances require.

Your second point was about the police. Correct me if I am wrong, but I assume that you are alluding to the possibility of a policeman or policewoman finding evidence of a crime on which they would be obliged to act, even if it was retrospective. You have a point there. We will think an awful lot more about that and see what we can do—in consultation with others—to ensure that neither is the teenager or young person put into a position that they would not be put into but for this piece of legislation, nor is the police officer put in that position. We will need to think it through slightly more carefully—hence the benefit of this kind of scrutiny of the process.

Lord James Douglas-Hamilton: I have a few quick questions, the first of which is on a technical point that the Subordinate Legislation Committee raised on the sufficiency of powers. Although section 8 makes a number of repeals of other legislation, it makes no provision for transitional arrangements. Is such a power needed? I imagine that it may not be and that the Executive has sufficient powers as it is.

Peter Peacock: I understand that, as a result of the question from the Subordinate Legislation Committee, we need to look again at the issue. At present, we are considering the exact point that the committee made and, if necessary, we will seek to meet it.

Lord James Douglas-Hamilton: My second question is related. What powers of direction will the minister have with regard to the recommendations that are made by a joint inspection? The bill does not appear to contain any powers of enforcement. I imagine that the minister will have sufficient powers, one way or another, but perhaps you will clarify the position.

Peter Peacock: I want to be clear whether we are talking about the powers that relate to the inspection itself or those that relate to issues that may arise from an inspection.

Lord James Douglas-Hamilton: The powers that relate to the recommendations that arise out of an inspection.

Peter Peacock: It appears that the power to direct is available to me as a minister through other forms of powers in local government and social work acts. Again, I will check the specifics of the point.

All our experience of inspections over many years, particularly in education and social work, leads me to say that when inspectors make clear their recommendations on finding a deficiency, the recommendations are invariably—and I mean invariably—acted upon by the agencies at whom the recommendations are directed. That happens irrespective of whether a minister gave a direction for it to happen.

Lord James Douglas-Hamilton: My third question relates to offences. I understand that the Social Work (Scotland) Act 1968 places the provisions for offences on the face of the bill. I also understand that that provision is being considered as subordinate legislation in this case. Would it not be more consistent with past legislation to put the offences in the bill?

Peter Peacock: The Subordinate Legislation Committee has raised the point. We are taking advice on the matter.

Lord James Douglas-Hamilton: My last question has been answered to a large extent. Should the power to require medical records to be shared with the inspection team be restricted to cases in which there is a concern about child protection?

Peter Peacock: Yes. We are clear that, in child protection terms, the way in which we want to proceed, which is by implied consent, is the right way to proceed. If the question is about wider children's services inspections, I advise Lord

James that we are still consulting on that. I can see circumstances in which it would be wrong to proceed on that basis—in fact, consent would be absolutely necessary. I am talking about circumstances in which there is no risk to the child and no lessons to be learned in that respect, but in which the wider provision of sexual health services, for example, are being looked at, which would mean that there is not the same requirement for access to medical records.

The Convener: From the responses that we have received, we can see that the issue of consensus is fairly crucial.

Fiona Hyslop: The bill is split into two main parts: children's services and social work services. In your last comment, you acknowledged the different issues that apply to consents and confidentiality for the purposes of child protection and children's services, but the bill is not drafted like that. Will you be open to amending the bill?

Peter Peacock: I am not clear that there is a problem with the bill. We are still consulting on the matter in respect of the protocol that flows out of the regulations that are attached to the bill. I am not clear that there is a problem with the bill, but I will try to ensure that that position is made clear. Our intention is not to widen access to medical records by default, in any way; we want to restrict access to when it is required for child protection purposes. I will happily ensure that we check that aspect, but as I sit here today I have no reason to believe that the problem is with the bill; the apparatus around the bill needs to be clearer.

Fiona Hyslop: One of the matters that became clear from the evidence of our previous witnesses, particularly the BMA, is that that they worry that, because most GPs will not know about the bill, it will start to unpick the fundamental issue of trust and confidentiality. They feel that hasty, ill-thought-through legislation could be counterproductive to the impetus to share information for child protection services and that we should not put up unnecessary, artificial barriers. If reassurances could be given, particularly on the face of the bill, about the differentiation between consent and confidentiality for child protection and children's services generally, that might be a helpful way of implementing what people recognise is required in law.

Peter Peacock: I will reflect on that point. I do not think that the problem is what is on the face of the bill; I think that it relates to how we clarify the protocols. However, I will reflect specifically on the point you made, to ensure that we are not sending any false signals into the system.

I completely appreciate the point that the BMA, the GMC and others made, although they take slightly different positions. There is a fundamental principle at stake in the sense that we are asking for access to both records and conversations. Gaining access to the latter is much less controversial than gaining access to records. We are very anxious to ensure that we get things right. We do not want to intrude unnecessarily, in any sense, in the proper relationship that exists between a professional and their client or patient. That is equally true of other aspects—social workers and others. We want to ensure that we have got this right.

The written evidence from the BMA and others referred to potential ways of looking at the protocol and refining it to give greater clarity. We are more than happy to look at that and have further discussions about it, because we want to get this right. We need to ensure that it is understood that the principle that we are trying to establish is that we can get access when it is necessary to do so, but that we do not in any way want to open up any wider implications for the general relationship between GPs, health visitors and social workers and their clients. That is why we want to get this right. We are more than happy to engage in further dialogue about all that to ensure that we get things right.

Fiona Hyslop: Similarly, on the parameters, do you have any concerns about NHS Quality Improvement Scotland's comments last week that lessons might be learned from the bill for other vulnerable groups, particularly those with mental health problems, regarding having access to records for future inspections?

Peter Peacock: I am crossing one bridge at a time. We have a very clear policy objective in relation to child protection, which we talked about when I was here a couple of weeks ago. We need the powers that the bill proposes in order to proceed to our objective. Our thinking at this stage has not gone beyond that. If or when we sought to embrace wider thinking about that, we would obviously come back to Parliament in that regard. However, my thinking now is purely on children's services and child protection.

Fiona Hyslop: Okay. Can I ask about the relationship with the voluntary sector? Children's services as defined in the bill refer to a section of the Local Government in Scotland Act 2003. That is the main, predominant relationship. However, as we heard from the care commission, the independent voluntary sector now provides 50 per cent of children's services. What do you see the relationship being between the joint inspectorate and the voluntary sector? In addition, the Scottish Children's Reporter Administration has submitted a written response. Obviously, that opens up a lot of different aspects. Would you like to comment on what you think the impact of the bill would be on those sectors?

12:00

Peter Peacock: There is no doubt but that with the modern provision, which is a mix of provision from the private sector, the voluntary sector and the traditional public sector direct service delivery, the inspection regime is about looking at the impact of the delivery of services, whoever delivers them. In this context, it is mainly local authorities that commission them, but the health service and others can commission them as well.

The implication is that the inspection regime applies to those who provide services on behalf of the state, albeit through the voluntary or private sectors. That is one reason why we involved the voluntary sector throughout in designing the inspection system. It has been an active participant in ensuring that the design of the system is right, and it was part of the pilot programmes. I believe that you have received evidence that the voluntary sector supports the principle.

There is still a job to be done over time to ensure that the full implications are understood by all bits of the voluntary sector—and the private sector, for that matter, although it will not be involved in children's services to the same extent as the voluntary sector. I am sure that there is a job to be done in terms of broader education. However, the voluntary sector organisations that have been involved are fully aware of the measures and are enthusiastic that they will help to deliver improved services in future.

The Convener: Before I call the next question, I welcome four members of the National Assembly of the Republic of Serbia who have joined the committee this morning. I hope that you are enjoying the proceedings. I look forward to meeting you later in the day.

Mr Macintosh: I return to confidentiality. The BMA said that, in conjunction with the Scottish Executive, it drew up a code of confidentiality that governs the way in which it is audited by health boards. It wishes that the protocol was more closely aligned with that carefully negotiated code. The key difference between the code of confidentiality and the protocol is that, under the code, all patients have an opt out. In doctors' practices, information is displayed that states, "Information about your medical records may be shared for the purposes of audit. If you do not wish this to happen, please draw it to the attention of the practice."

The code has not been in use for long, and the opt out has not been used to a great extent, but the BMA was exercised by the removal of that right from 16 and 17-year-olds. Introducing such a measure would improve the implied consent that you believe already underpins the system, and probably would not impinge on the work of the inspectorate teams. It certainly bears consideration. What are your thoughts about that situation, which I had not heard of before today?

Peter Peacock: Let me check one thing with officials.

I would have to give that further thought. There were several parts to your question. As I understand it, the code of confidentiality was negotiated as part of the GP contract and relates to how the outcomes of GPs' work are reviewed. I believe that the system operates on the basis of implied consent, so on that point there is no broad distinction. We envisage a system similar to that which you describe: adverts in GP surgeries that state, "This process is under way. If you have a particular objection, make it known to the practice." Some, but not all, of the BMA's points about the protocol are the opposite of what we are seeking to achieve. We will try to ensure that the protocol covers as many of the points as it possibly and reasonably can.

The issue that I was thinking through with officials, and which I will have to think through further, is that if a child or young person said, "I understand that this is going to happen and I definitely do not wish to be part of it," their views would be held in high regard. I suppose that the question is—again, I will have to think it through and come back to the committee—whether there are circumstances in which, notwithstanding that, the inspection team continues to think that something about a particular case gives rise to the need to access information. As I sit here today, I cannot say that there might not be such circumstances.

At the end of the day, as the committee will remember, the process is one of checking that all the policy, practice and good leadership that has been set in place at a high level is working on the ground for kids. I will come back quickly to the committee on the point if I can. I want to check with inspectors whether those circumstances might pertain. They might not—the inspectors might feel that there is plenty of evidence from other sources about practices to attest that what they are thinking is confirmable. I will have to check that small point before I can give a definitive answer.

Mr Macintosh: I appreciate that. As I said, we heard the evidence only today. It is quite clear from the protocol that health boards will make information available in their patient information leaflets. We are talking about a similar process.

If particular, live, concerns are raised about a case, would the case be referred anyway to whoever needs to be involved, on the ground of child protection issues? Irrespective of the bill,

surely a decision would need to be taken about the overriding issue of patient confidentiality. If so, we would be talking about the retrospective audit of the inspection process.

Another issue that we did not get the chance to explore with the BMA is what is to be done about very young children. A 17-year-old can give their permission, but how is the permission of an eight-year-old to be sought? Will the parents be asked for their permission? What will happen in terms of the code of confidentiality to which GPs are operating at the moment? Lessons might need to be learned in that regard. That said, they may not skew the results or findings of an inspection programme.

I have one other question, which follows on from the point that Elaine Murray raised on the police and the restrictions on inspectors. Again, the BMA suggested that it should be an offence for an inspector to breach confidentiality. The example that the GMC gave was that of the Healthcare Commission in England and Wales. We heard that the act that set up its operation includes offences that pertain to breaches of confidentiality by members of the inspectorate.

I understand that the current protocol says that all members of an inspection team have received appropriate training and that they are bound by professional, legal and contractual obligations to preserve confidentiality. A concern has been raised with regard to the police. Have you thought about the introduction of offences to underpin the inspectorate's contractual, legal and professional relationship?

Peter Peacock: The short answer is no. There is a point of distinction between the concerns that were raised about the police and inspectors generally. The point that I made earlier about the police related to the specific obligation on police officers.

Mr Macintosh: They have two obligations.

Peter Peacock: Yes. We need to be careful that we do not just bracket all that together.

We have not thought about the issue. In terms of access to files, there is nothing in other pieces of legislation that would result in the prosecution of an inspector if they breached confidentiality. The evidence that I have gathered from my inquiries into these matters tells me that no complaint has ever been made about an inspector breaching confidentiality. The route is not one that we would want to go down. Obviously, I will reflect on the matter and look at anything the committee says on the subject. That said, the route is not immediately attractive.

The Deputy Minister for Education and Young People (Robert Brown): The issue is also bound by things to do with the potential for dismissal, employment sanctions and so forth and perhaps several liability things as well. Regardless of the criminal side, there are already a number of major sanctions in the unlikely event that something like that happened.

The Convener: I will pursue the point slightly. One of the concerns that a number of bodies have raised in their responses is the balance between what is on the face of the bill and what is left to regulation, protocols and so forth. I wonder whether there needs to be a reference on the face of the bill to the duty of confidentiality and to the use of sensitive information received in the course of an inspection being for the purpose of the inspection only. That would provide security for all parties involved, including children and young people, and ensure that the process is robust.

Peter Peacock: I am happy to consider whether there is merit in making it clear in the bill that inspection must operate within a confidential net or framework. I will come back to you on that, or make our thinking on it known during the stage 1 debate.

I was not clear whether you were asking about whether the protocol itself should be statutory.

The Convener: The issue is making clear in the bill or in regulations what status the protocol will have in relation to the bill and regulations. That is, it should be made clear whether the protocol will just be a guidance document or whether it will have statutory backing.

Peter Peacock: The bill establishes the broad position and regulations establish the framework that will be in the protocol, which will not be statutory, I understand, in the strict sense. However, we are listening to what people are saying about that and I will be interested in what the committee says about it when it reports, having heard all the evidence and reflected on it.

We dealt with the Education (Additional Support for Learning) (Scotland) Act 2004 and the code of practice that flowed from it by making it clear to Parliament that we would be happy to consult the committee about the detail. I am prepared to say to you today that I am more than relaxed about consulting the committee in the same way about the protocol for this bill before ministers approve it in regulation. I am happy to make that offer straight away. I do not think that that will be a difficulty. It might provide reassurance that the protocol will receive scrutiny in public.

The BMA talked about the potential of splitting the protocol into a statutory and a non-statutory bit, because it recognised that part of the benefit of the protocol being non-statutory is that it can be flexible and can adapt quickly without having to come back through parliamentary processes to be changed, which it would otherwise have to do,

even for comparatively minor changes. We are reflecting on all that, but my instinct is that the right balance is to have the protocol's parameters strictly defined in regulation but leave it freer to be adapted as appropriate. However, I am equally content to ensure that Parliament has a place in that, so that there can be public scrutiny of the protocol beyond the consultation.

The Convener: With the old phrase "have regard to the protocol" being included somewhere, so that inspection teams must have regard to it.

Peter Peacock: I am happy to consider that.

Mr Ingram: You have answered a few questions from my colleagues about the concerns that the Subordinate Legislation Committee expressed, and I want to ask another. Can you clarify the use of what appears to be a very wide power under section 2(1), which is for ministers to direct any

"person or body … to participate in the conduct of an inspection"?

That is in addition, of course, to the inspectorates that are laid out in section 1(6). Why do you need such a wide power? How do you intend to use it?

Peter Peacock: The intention behind the power is to allow associate inspectors to be included in the inspection team, as is current practice in other forms of inspection. As you are probably aware, it is not only educationists who are involved in schools inspections, and there are similar arrangements for other kinds of inspection. Not only for joint inspections, people are brought in from other disciplines because they have particular insights, expertise or life experience. The principal purpose of the power in section 2(1) is to allow that to happen. Maureen Verrall might have something to add to that.

Maureen Verrall (Scottish Executive Education Department): In the pilot inspections, a consultant paediatrician was involved as an associate inspector. Section 2(1) will give ministers the power to appoint associate inspectors, but section 2(2) will give ministers the power to restrict the powers of associate inspectors. That means that the power to appoint associate inspectors is not a broad, sweeping power to appoint just anybody who would then have all the powers of inspectors. The associate inspectors will have restricted powers.

12:15

Fiona Hyslop: Are you still convinced that it is right to include in the bill the provisions dealing with social work services?

Peter Peacock: You are referring to part 2.

Fiona Hyslop: Yes. Are you convinced about that, bearing in mind the oversight when the Social Work Inspection Agency was established? Another piece of legislation is having to be bolted on. Those who are affected have not had a fair opportunity to be consulted properly, as the bill is being rushed through. Moreover, it is difficult for the Parliament to give the bill the scrutiny that it deserves. Attention has, quite rightly, focused on the child protection provisions. On reflection, do you think that a stand-alone bill would have been justified, which could have allowed proper consultation of those affected?

Peter Peacock: No. We are where we are in relation to part 1. The bill is an appropriate vehicle for the provisions in part 2 because we have recognised that we do not have sufficient clarity about the powers that we require for the Social Work Inspection Agency. In a sense, that is the least controversial bit of the bill. We seek to bring social work inspection, in the broader sense, more into line with the practices of education inspectors in inspecting local authority functions. Our proposed approach is quite different, but it is very similar to the way in which education inspectors operate. We want to ensure that we have the powers—the absolute cover—to allow that to work.

The fact that we are using the vehicle of the bill will not stop you scrutinising our proposals—you will scrutinise them and I am sure that you will raise legitimate questions about them. We will try to ensure that we answer your concerns satisfactorily. However, it would not be right to keep the proposals for another piece of legislation in the future. It is not clear to me when another opportunity might arise. We are anxious to get on with this work now.

Fiona Hyslop: I will move on to specifics. Much of the written evidence that we have received discusses the confusion over terms. What is a "medical practitioner" for the purposes of the bill, for example? A variety of phrases are used about health records and medical records. You will of course wish to ensure that the records of health visitors and nurses and so on are covered. Having seen the written evidence that we have received, do you think that amendments could be made to clarify exactly what is meant in such instances?

Peter Peacock: We think that we have got it right with those terms, but I am happy to reflect on that concern. If there is any dubiety, we want to ensure that things are clear. I cannot give you a guarantee about what we will do, but we will certainly examine that point.

Fiona Hyslop: Another point of detail, but also of principle, is the age issue. The bill states:

"'child' means a person under 18 years of age".

Could you reflect on your policy reasoning for that definition? There are also concerns about consent

and confidentiality, even if we operate on a basis of implied consent. There is the matter of retrospective access to cases—implications arise from the fact that in some cases the children involved will have grown up.

Peter Peacock: Are you referring to cases in which somebody crosses the threshold between—

Fiona Hyslop: Yes. Would you expect there to be a review at the age of 16? It would be reasonable to explore issues to do with 17-year-olds with children; they themselves will be defined as children under the bill, but their own children might also be vulnerable.

Peter Peacock: I am more than happy to look into that and to ensure that problems do not arise because of the nature of the definitions. There are different definitions relating to ages in different parts of the Scottish statute, which bring with them various obligations and rights. We will consider that point and ensure that there is nothing in the definitions that should cause a problem for what we are seeking to achieve or for individuals because of the passage of time. We will double-check that.

Mr Macintosh: One small point that was raised last week related to whether, under part 2, social work inspectors would have the power to enter private premises to inspect the services that are provided by childminders, foster carers and so on. I think that we were told that that would be looked into and that HMIE would report back on the matter. Have you had a chance to consider that issue?

Maureen Verrall: Essentially, the matter that you raise is covered in the regulations by the definition of premises for the purpose of inspection. The right of entry will apply to any premises where a social work service is provided. We hit the boundary with, for example, a foster carer's home. If the foster carer has six or seven foster children living with them, they are providing a children's social work service, but would an inspection team have the right to enter their home? We discussed that with Graham Donaldson from HMIE. An inspection team might want to enter that private residence because there are a number of foster children in it. However, the power of entry is not a broad power of entry that can be used to go into anyone's home in the area. The right of entry applies only to premises that are being used for the purposes of providing a service as defined within legislation.

Mr Macintosh: But although it is a limited power, it could apply to private houses in the circumstances that you describe.

Maureen Verrall: It could. Of course, we would never envisage a team of inspectors just turning up and demanding entry. The inspectors would meet the foster family and discuss things with them. They would negotiate and agree on where they would have their discussions or interviews. The power must be exercised only where the premises are used for the provision of a service.

Mr Macintosh: I have a more general question, which I put to HMIE last week. Is the intention of the bill to change SWIA into a body that is more like HMIE? Currently, SWIA has a consensual relationship with those whom it inspects. Although I am sure that HMIE has a consensual relationship with the bodies that it inspects, clearly its relationship is different and the system in education is more robust and rigorous.

Peter Peacock: The issue is more to do with the robustness and the rigour of inspections than it is with their consensual nature. We have learned from the thorough way in which HMIE conducts inspections of local authorities' education functions. That has given us all sorts of insights into what does and does not work and whether value is being added to local practice. We need to bring the same degree of rigour to bear in social work. The social work profession and directors of social work are keen to get that extra rigour into the process and to depart from the perception that social work inspections are not nearly as rigorous as inspections of education services.

Robert Brown: I happened to meet SWIA for a briefing session. It is clear that its intention is to share good practice and to pursue the improving agenda. We know all about that from education. It is very much at the heart of what SWIA is trying to do.

Fiona Hyslop: In its written submission, the Association of Directors of Social Work stated that the powers for SWIA in part 2 of the bill should be the same as the powers in part 1, which means that inspectors should have access to medical records. The ADSW reflected on the recent inspection in the Borders and stated that the only reason why the social work inspection team could access medical records was that one of its members, who was from the Mental Welfare Commission for Scotland, was a doctor. Changing that situation would move things even further. The ADSW has extensive experience. We are trying to work out the parameters. There are concerns that the Executive is moving too far too quickly, but there are also concerns that it is not moving far enough.

Peter Peacock: We are not thinking of moving as far as the ADSW suggests. Remember that I have powers under existing social work legislation to commission an inquiry into a specific matter if necessary. The inspection in the Borders to which you referred illustrates a different point. In that case, we used certain powers, which meant that access to all sorts of things became possible, in a

way that would not be possible with SWIA's general powers. We do not have a gap in the armoury, because we have powers that we can use if necessary. We do not think that it is right to extend the part 1 powers to part 2, because that would involve crossing an even bigger Rubicon.

Ms Rosemary Byrne (South of Scotland) (SSP): Children 1st expressed concerns about staff shortages. It acknowledged that the bill is a good one with a few difficulties that can be sorted out, but it said that joint inspections are one part of a

"jigsaw of elements necessary to implement joined-up services".

It went on to say:

"in our experience, staff shortages are currently preventing agencies from fulfilling their existing remits and from managing internal changes, and this undermines the ability of staff in the various agencies to work together and to undertake joint initiatives."

Will the joint inspections look at the problem of staffing? Will staff shortages be highlighted if they are found in any cases that the inspectors look at? Are there measures in place to ensure that there are adequate numbers of staff so that agencies can interrelate and work together before joint inspections begin?

Peter Peacock: The experience of inspection in schools and education authorities is similar to what we propose in part 2 of the bill for SWIA. There is also potential to look at staffing in individual inspections into child protection issues.

Inspectors have commented in the past when they have come across a situation in which organisations are obviously understaffed and they have made it clear when they thought that improvements were necessary, not just in staffing but in investment in equipment and premises and so on. It is not beyond the scope of inspections for inspectors to comment on that, but they do so in a balanced way. They would not talk about an organisation being short of one member of staff unless that were material to a particular situation. They comment generally on staffing matters. If something affected the operational effectiveness of the organisation in clear ways, we would expect the inspectors to comment.

Ms Byrne: I am thinking of the example of the children's hearings system. There might be a shortage of social workers in an area and the scenario might arise in which the social worker who has been working with the young person or family is unavailable and a social worker who is on call that day turns up at the panel instead; the on-call social worker cannot reflect the same insight, depth of knowledge and working relationship with the clients. That happens frequently at the moment, as it does with joint support teams in schools when a social worker who should be available is not. If staffing is not in place, none of the proposals in the bill will work well.

Peter Peacock: If inspectors come across a situation such as the one that you describe and they believe that that will impact on either the safety of the child or the operational effectiveness of service delivery, we would expect them to comment on that. That might not be due to staff shortages alone; it could be due to the logistics of the way in which people are deployed. We would expect inspectors to make comments on those kinds of material issues.

The Convener: If members have no other questions, I will finish with one. Given that the bill is being put through at a rapid pace, perhaps without the level of consultation that we normally hope for, will the minister put on record a commitment to allow the legislation to be reviewed and further consultation to be carried out with the groups affected, particularly those that involve young people, prior to the establishment of wider children's services inspections in 2008?

Peter Peacock: Do you mean that we should reflect on how the legislation operates?

The Convener: To look at whether there need to be any changes to the rules.

Peter Peacock: We will reflect on how the legislation operates in practice and if it should impact on future legislation, we will gear ourselves up for that. Ensuring that the legislation is kept under firm review is part of our thinking.

The Convener: I thank the minister and his team for coming along this afternoon.

12:29

Meeting suspended.

12:30

On resuming—

The Convener: As members know, we have limited time to consider the bill: the stage 2 debate is in two weeks' time, so we have only next week in which to consider our stage 1 report. I propose that we have a brief discussion of the key issues that we wish to cover in the report. I also propose that we discuss the draft report in private at our meeting next week in two bites. We will start the meeting by examining the draft report and considering any changes that we want to make to it. Then we will go into public to conduct the other business and give the clerks time to redraft the report. We will consider the redrafted report at the end of the public part of the meeting, so we will have two chops at the report next week.

Fiona Hyslop: Will you go through that again?

The Convener: We will start by considering the original draft report in private at the start of next week's meeting. Once we have considered any changes that we want to make, we will allow the clerks to make them while the committee deals with the rest of the business in public. Then we will consider the redrafted report at the end of the meeting to agree—I hope—the final text.

Fiona Hyslop: How long will that take? How long will the clerks have?

The Convener: It depends how long the business takes. If we can agree the broad thrust of the report today, I hope that we will not have too many changes to make at the next stage. We will have to publish the report next Wednesday or Thursday to keep to the timetable, so we will not have time to have a second meeting to discuss the draft report. That is the problem; we have only one and a half bites at the cherry.

I invite committee members to comment on the issues that they want to include in the report.

Lord James Douglas-Hamilton: I will make three quick points. First, the minister promised a firm review; the question is whether that should be in primary legislation. We should address that point. Secondly, we should address the question of the code of confidentiality as opposed to the protocol. The third point is whether there should be restrictions to cases in which there are concerns about child protection, rather than more wide-ranging inspections.

Fiona Hyslop: Consent and confidentiality will be the main focus, but we must reflect on whether child protection is distinct from or a subset of wider children's services and whether it is necessary to have a common approach or—to reassure GPs in particular and because of confidentiality—to make a distinction between the two. The minister, almost right at the start, said that he wanted to pursue implied consent, whereas Graham Donaldson stated clearly—we can check the *Official Report*, as I have it here—that that was access without consent. That is fundamental. Has the minister shifted position—there is a big difference—or does "implied consent" mean that it is not really consent because it just happens to be mentioned in a leaflet or on a poster on a GP's wall?

The Convener: My understanding from the discussions that we had with officials such as Graham Donaldson was that they assumed that they had implied consent for inspections. The general implied consent relates to medical records, but Graham Donaldson was not allowing for the possibility—which the code of confidentiality has—that people could opt out of that implied consent. I think that that is the difference. The minister is suggesting that he is willing to consider the possibility of people being able to opt out of implied consent.

Fiona Hyslop: Right. That needs to be made clear and up front because it is a key point.

Mr Ingram: Would it not satisfy people if that modification were made? That was the impression we got. The other question was about medically qualified inspectors looking at health records and feeding the information back to the rest of the joint team.

Dr Murray: It sounded as if the minister was not prepared to go that way.

The Convener: I would have thought that a medically qualified inspector should be involved in looking at the medical records, but that should not necessarily be exclusive. Different professionals might look at something differently and say that something that the medical person did not think should be brought to the team's attention should be, because it would help the social worker, for example. It would be useful to have a medically qualified person look at the records because otherwise the team might not know what it is talking about.

Dr Murray: There is also the issue about the police; the minister said that he would reflect on that.

The Convener: Yes, that is very important.

Mr Macintosh: In order to make it easier for us to agree next week, we might flag up the issues rather than state that we have come to an agreement. We might or might not come to an agreement about our position. I agree that we have been discussing our concerns and I do not want to pre-empt next week's discussion, but there is a difference between being concerned and stating our position.

Ms Alexander: That might compel a change.

Mr Macintosh: That is right. I have no problem with reflecting on evidence that we have heard and flagging up our concerns, but I would not want to give the impression that the committee endorses those concerns. I shared some members' concerns, but not all of them.

Ms Alexander: I am with Kenny Macintosh. From my earlier contributions, people would get the sense that I am essentially not persuaded of the case for the degree of risk compared with the need to have 360° information, as reflected by the paediatricians and the care commission. I accept that that is my view and it might not be the view of others on the committee. All that we can do is produce a report that gives balanced consideration to the evidence that we have heard.

With regard to the committee's recommendations, it might be quite difficult to

decide whether the committee just reflects what it has heard or takes a position. In the latter case, I see no way of avoiding votes and giving a split view.

It is unfair to ask the clerks to try to resolve differences of principle through the drafting of the report. The fair thing to ask them to do is to try to reflect the evidence that was heard.

The Convener: I know what you are saying. The committee needs to highlight the issues that it thinks are most significant and that we want the minister to look at again. We are not necessarily saying that he has to come to a view one way or another.

Ms Alexander: That is a helpful steer for the clerks.

The Convener: We have already highlighted some of the issues that we agree the minister should look at again, such as how consent is determined and whether there should be a duty of confidentiality in the bill. That would be beneficial.

Fiona Hyslop: It is right that we flag up the issues and I do not think that there is any disagreement about what they are. Kenny Macintosh is right, however. We might all give different weightings to those issues, but there is common agreement about what they are. I am just concerned that we might be abdicating our responsibility, even through this rushed process, if we do not tease out the things that we agree on. Perhaps we should do that because if there are such issues, we should put them on the record.

Mr Macintosh: That is great, if we agree them. Because of the nature of next week's meeting and the drafting being done then, I am just suggesting that if we do the report in a certain way, we are more likely to be able to get through that process.

Fiona Hyslop: Yes, as long as we separate out the evidence and the key issues from the issues that we agree on. We should probably discuss now whether there are things that we as a committee agree on.

Dr Murray: We should also discuss whether we agree with the general principles of the bill, because that is quite central.

Fiona Hyslop: Last week Jan Warner said that as it stands, the bill allows access without consent, so there is an issue about whether there should be a duty of confidentiality in the bill. We probably all agree that there should be.

The Convener: That relates to the issue of what is meant by consent, whether express consent or implicit consent.

Fiona Hyslop: Should that be determined in the bill? Should the bill say something about implied consent? We should explore what express consent and implied consent are to see whether we have a consensus.

Mr Macintosh: The bill should say more about the protocols that are in place. At the moment there might be a perception that it allows unrestricted access to medical records, but it clearly does not.

Fiona Hyslop: Jan Warner thinks that it does.

Mr Macintosh: Every other piece of evidence has shown that that is not the case. There will be no unrestricted access to medical records. The bill has to make clear the restrictions on access and it should refer to the protocol. Perhaps we should consider whether the protocol should be set out in subordinate legislation. We are encouraging professionals to share information in their working practices; the inspectors also have to share information. The message that we are trying to send is that they are making professional judgments and sharing information. I did not accept the argument from the BMA that to do that would be going too far and would breach trust in doctors. I believe that it would benefit the welfare of all children and would improve children's services other than just child protection services.

Fiona Hyslop: There are different perspectives on the bill. Paediatricians see it as protecting them on issues of confidentiality, but the BMA and GPs take almost the opposite view. We have to reflect that in our stage 1 report, because we are wrestling with it. Because the bill is being dealt with at an accelerated pace, we have even more responsibility to analyse the issues. It is crystal clear that we have to share with the wider public our real concerns.

On Elaine Murray's point about the general principles, the fundamental issues are whether we are happy with the bill and the pace with which it has been introduced and whether we think it will do what is needed. It is clear from evidence that we have received that some people would prefer there to be a delay. We have to decide whether we agree.

The Convener: I accept that.

Lord James Douglas-Hamilton: We can go some way to addressing Ken Macintosh's point by stating the dilemma of how much should be in the bill and how much should be left to regulations or protocols. My preference is to have as much as possible in the bill, especially in emergency or accelerated legislation. We do not need to consider how we should amend the bill; we are just referring to the question of amendments. As long as we do that accurately and honestly, honour is satisfied. We do not have to be in unanimous agreement on how much should or should not be in the bill. We can decide that later.

Ms Alexander: It is fair to make a point about the time between stage 2 and stage 3. Although I do not object to acceleration in general, given the dilemma with which we are grappling on the regulation and code, it would be ideal if the organisations involved had more time to reflect after the publication of the report. I want to endorse the principles of the bill and I do not want to explore too deeply whether it was right in principle to have an accelerated timetable. Once the bill starts this part of the parliamentary process, there is a danger that our consideration of it will be too truncated to allow for precision of final stage amendments. It is fair to reflect that point, because we are likely to have less than a week for that.

12:45

Fiona Hyslop: We have agreed that we want to co-operate with the legislation, but what is the difference between having stage 3 on 22 December—almost Christmas eve—and having it on 12 January? How many pilot inspections will take place over Christmas and new year? It is not that members want to burn the midnight oil over Christmas and new year; it is precisely for the reason Wendy Alexander outlined, which is that it would allow a greater gap. That is not necessarily unreasonable.

The Convener: Graham Donaldson argued that to delay the passing of the legislation until after Christmas meant that he would be unable to start sending out letters about the next set of pilots until much later—he would be losing two weeks in that process.

Ms Alexander: When do the next pilots commence?

The Convener: Two pilots have been done, but there is a process in the protocol about the timing of the pilots. Graham Donaldson's intention would be to get that process under way and to send out the first letters right away. I am not sure whether it is on the day of royal assent or on the day that the bill is passed.

Ms Alexander: We have already made a comparison with England, where inspections started one year later and will be complete one year earlier than the timetable we are working to.

The Convener: I am just saying that that is the argument that has been made—I am not saying whether I agree with it. It has been argued that in order to allow the administrative processes that are required to get the inspections under way to start earlier, it is better to pass the bill before Christmas.

Ms Alexander: I have sympathy with HMIE telling us that it that it would like the issue on the agenda now because it needs to alert people, particularly health agencies, that that is the direction in which it is moving. There is now not a health board or GP out there who does not know that this is coming over the hill. However, if we are not going to move to an all-Scotland basis and if we will be doing the pilots for another 28 months—

Fiona Hyslop: No, that is not true.

The Convener: Joint inspection of child protection will go ahead immediately.

Fiona Hyslop: Is this not a case of the tail wagging the dog? It is essential that the legislation is correct. Buying ourselves another three weeks might result in better legislation. Graham Donaldson could send out letters now, saying, "Should this legislation be passed, these are the areas that we might want to go into next."

The Convener: I am not saying that I agree with what Graham Donaldson is saying—I am saying that that is HMIE's explanation for wanting stage 3 complete by Christmas. It is perfectly legitimate for the committee to say in its stage 1 report that we are not happy with the timetable and that we want longer for stage 2 and stage 3.

Mr Macintosh: There is a reverse argument, which is how much attention those who want to make their views known on the bill will pay to it between Christmas and 12 January. We are in a truncated period and, although it is frustrating, we have to come to a decision whether we accept the timetable and whether we want extra time.

The Convener: If we are going to ask for extra time, I am inclined to ask for stage 2 to start a week later in order to allow members and ministers to give proper consideration to amendments. That would have a knock-on effect on stage 3.

Fiona Hyslop: I am not convinced that anything significant will happen over that period.

The Convener: It is not me you have to convince. I am just giving the reasons why we have been asked to complete stage 3 by Christmas; I am not defending those reasons. If the committee thinks that a longer period should be allowed for amendments at stage 2 or stage 3, it is reasonable for us to put that in our report.

Lord James Douglas-Hamilton: That might be safer, because it will not make that much difference to those who have to implement the legislation—the professionals.

Mr Macintosh: I agree. Stage 2 is the problem for me, not stage 3. It is about giving people enough time.

Ms Alexander: We should be considering stage 2 amendments on 21 December.

The Convener: We are not scheduled to have a meeting then.

Fiona Hyslop: That would mean that there would be a greater gap before stage 3 as well, so we would get the benefit of extra time for stage 2 and stage 3.

Mr Macintosh: We could ponder it next week.

The Convener: It does not affect how we complete stage 1—we already have the timetable for that. I am perfectly happy for us to put it into the system that we would like at least an extra week to consider stage 2 amendments, which would have a knock-on effect on stage 3.

Fiona Hyslop: Is there anything the clerks want from us?

The Convener: We have to comment on consultation in the report. Quite a lot of criticism of that is reflected in the evidence. We can say that we note the reasons why that is happening.

Fiona Hyslop: Some organisations are concerned that the Education Committee is the first to have contacted them. I suppose that the Executive is of some concern.

The Convener: The other important aspect is that we refer to the need continuously to review the process after the legislation is implemented and to involve the stakeholders in that review. I made a point about a review in June 2007—

Fiona Hyslop: I am sure that that can be written into the legislation. Wendy Alexander might remember the Housing (Scotland) Bill a while back. I tried to lodge amendments to require there to be a statement—I think that it was a statement on homelessness. There are mechanisms to put in the legislation a requirement for ministers to report to Parliament.

The Convener: Do we wish to comment on the Subordinate Legislation Committee's report or to endorse that committee's comments?

Mr Ingram: That should feature in the report.

The Convener: We are meant to comment on the financial memorandum, although there is not much to say on that. Are we content with the financial memorandum? Have we had anything from the Finance Committee on that?

Eugene Windsor (Clerk): Just the questionnaire.

The Convener: It has not made any comments, however.

Eugene Windsor: No.

Ms Alexander: On our timetable, when are we doing the second reading?

The Convener: At present, we are due to do it in two weeks' time.

Ms Alexander: On 7 December.

The Convener: Sorry, three weeks' time. The stage 1 debate is in two weeks' time.

Ms Alexander: Stage 2 is on 14 December.

The Convener: Stage 3 was due to be on 21 or 22 December. If we delay stage 2 by a week, it means that we will have a meeting on 21 December, which is not scheduled at present.

Fiona Hyslop: But we might need to have that to have a second bite at stage 2.

The Convener: There is one final thing before members leave. Do members agree to take the draft report in private next week?

Members *indicated agreement*.

Meeting closed at 12:52.

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