The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 30 October 2012

Session 4

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HEALTH AND SPORT COMMITTEE
29th Meeting 2012, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)
Derek Feeley (Scottish Government)
John Matheson (Scottish Government)
Michael Matheson (Minister for Public Health)
Alison McInnes (North East Scotland) (LD)
Alex Neil (Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 4

Scottish Parliament

Health and Sport Committee

Tuesday 30 October 2012

[The Convener *opened the meeting at 09:30*]

Draft Budget Scrutiny 2013-14

The Convener (Duncan McNeil): Good morning and welcome to the 29th meeting in 2012 of the Health and Sport Committee. As usual, I remind everyone present that mobile phones and BlackBerrys should be switched off, as they can interfere with the sound system.

Agenda item 1 is our continuing scrutiny of the Scottish Government's draft budget 2013-14. I welcome our final panel of witnesses. We have Alex Neil, Cabinet Secretary for Health and Wellbeing—welcome, cabinet secretary, to your first meeting of the Health and Sport Committee in your new role. We look forward to working with you over the future period. From the Scottish Government, we have John Matheson, director of health finance and information, and Derek Feeley, director general health and social care and chief executive of NHS Scotland. I offer the cabinet secretary an opportunity to put some remarks on the record.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): Thank you, convener. It seems that every time that I get a change of ministerial portfolio, you end up as the convener whom I report to. However, it is a welcome development.

Since the Government was elected, our record of achievement has not only led the way in the United Kingdom in, for example, improving patient safety and massively reducing waiting times, but it is recognised internationally as innovative and aspirational in its scope and potential for improving health and healthcare. All that has been undertaken in the context of the most dramatic reduction in public spending ever imposed on Scotland by the UK Government. Within those constraints, we continue to deliver on our manifesto commitment to pass on the Barnett consequentials to health.

Resource funding will increase by £293 million in 2013-14 and national health service territorial boards will receive allocation increases of 3.3 per cent in 2013-14 and 3.1 per cent in 2014-15, which will be directed towards front-line services. That means that the core budgets of our territorial health boards will have been protected in real terms in each year of the spending review period.

The core health capital budget will be supplemented by identified revenue-to-capital transfers of £320 million in the spending review period. Further investment in improving the NHS estate will be available through delivery of revenue finance projects, equivalent in capital terms to an additional £750 million of investment. That means that there will be over £2 billion of capital investment in the NHS estate over the spending review period.

In delivering our NHS healthcare quality strategy ambition of effective care, we have made significant improvements to health and healthcare outcomes for the people of Scotland. We have made a significant contribution to the marked reductions in mortality rates for the three big killers: cancer, heart disease and stroke. The Scottish Parliament has passed world-leading legislation to introduce minimum pricing for alcohol. The national keep well programme of inequalities-targeted health checks has successfully engaged more than 180,000 people, and we have rolled out our detect cancer early programme, which aims to increase the early detection of cancer by 25 per cent.

We must be bold enough to visualise the NHS that will best meet the needs of the future in a way that is sustainable, then make the changes necessary to turn that vision into a reality. The key priorities for 2013-14 will be, first, to develop a shared understanding with everyone involved in delivering healthcare services; secondly, to secure greater integrated working; thirdly, to prioritise anticipatory care and preventative spend; fourthly, to prioritise support for people to stay at home as long as appropriate; and, finally, to take action to ensure that people are admitted to hospital only when it is not appropriate to treat them in the community.

That is a brief overview, convener; I hope that it gives you a flavour of the direction of travel that we intend to pursue. I will be delighted to answer any questions from the committee.

The Convener: Thank you. Our first question is from Dr Richard Simpson.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Thank you, cabinet secretary, and welcome to the Health and Sport Committee.

In your opening remarks and in the letter that you sent to the convener, you paint a really quite rosy and optimistic picture. That is slightly paradoxical, given that you opened today by referring to the largest public sector cuts that have ever been imposed, which is the case for the rest of the UK as well as for Scotland.

The health service in England is said to be facing cuts over the spending review of £20 billion, which is a massive amount. The equivalent cuts

here would presumably be in the region of £2 billion and yet you have painted for us again this morning a highly optimistic picture of a health service that is delivering—in fact it has delivered—and will be able to deliver all your aspirations. That is all well and good, but we know from Audit Scotland, for example, that three health boards last year were lent funds—that is in paragraph 24 of the "NHS financial performance 2011/12" report from Audit Scotland. We also know that there are high-risk efficiency savings—that is in paragraph 41, exhibit 8 of that report. Indeed, in the case of NHS Lothian, 62 per cent of the efficiency savings are regarded as high risk.

In your letter to the committee, you said that the local development plans were on track at the end of September to deliver the financial balance laid out in the local development plans and their efficiency savings. With regard to the three boards that were lent funds, why was that not reported until we got the Audit Scotland report? When will the money be repaid by the boards? Will it be this financial year or the next or some other time? The boards are all on track to have a zero balance at the end of this year and yet they have those loans.

I have significant concerns about the budget situation. I will illustrate that by saying that, having exposed the waiting list games in NHS Lothian—we await with interest the Audit Scotland report on waiting times—we now know that Lothian is about to offer 500 patients treatment abroad so that it can meet its targets. The capacity problem, in Lothian at least, is significant. If it is significant for Lothian, I wonder how significant it is elsewhere.

NHS Borders is offering patients treatment in England—not just for procedures that are never available in Scotland, which would be appropriate, but for other procedures that one would normally expect to be performed in Scotland. In the last full year for which we have statistics, we learned in an answer given in the Westminster Parliament that 8,000 Scots were treated as in-patients in England and 17,500 Scots were treated as out-patients in England.

The Convener: Can you get to your question?

Dr Simpson: That does not include accident and emergency. Will the cabinet secretary comment on those points and will he undertake to ensure that increased transparency in financial reporting is put in place, as Audit Scotland has called for, to ensure that the committee can scrutinise the NHS finances as we would wish to?

Alex Neil: I am delighted to answer. First, I refer to the beginning of Richard Simpson's remarks regarding the savings of £20 billion in cuts in the NHS south of the border. Those cuts were introduced by Andy Burnham, the Labour health secretary and then kept by Andrew Lansley and now Jeremy Hunt—the Tory health secretary south of the border.

I will not get into a macho competition with the south of the border on who can make the biggest cuts to the NHS. Unlike those south of the border, we do not intend to tear up the NHS. We intend to keep it as an integrated, fully equipped, well-manned and high-outcome service that is free at the point of use. If the people south of the border want to destroy the NHS that is entirely up to them, but the NHS in Scotland will adhere to and continue to build upon the founding principles on which it was established in 1948.

My second point is on the Audit Scotland report. All those transfers of funds were reported. They are already in the public domain. They were always in the public domain. Audit Scotland's point was that the way in which we put them in the public domain should be more obvious; it should be more glaring. We are happy to look at that to see how we can do that, but it is not true to say that the information was not in the public domain. The information was in the public domain and I will hand over in a second to John Matheson, who will give you chapter and verse on when and where the transfers were reported.

Let me also make the observation that Audit Scotland is the auditor of the three health boards that are referred to in the report that Richard Simpson mentioned. Audit Scotland signed off those accounts. Clearly, as the auditor, Audit Scotland would not have signed off the accounts if it had thought that there was a major problem, so we need to see the issue in context.

Thirdly, on the Audit Scotland report, the amount involved is less than 0.1 per cent of the £11.5 billion or so that we spend on the national health service every year. The procedure whereby we vire resources within the national health service at the end of the year was endorsed by the Public Audit Committee when it was convened by Hugh Henry, who said that that was the right thing to do. Unlike south of the border, where health trusts are profit centres, the health boards in Scotland are cost centres and are part of a national health service. We do not have 14 separate health services under each of the health boards; we have a national health service. Therefore, we allocate and, if required, reallocate resources as and when required.

For two of the three boards that were mentioned, the specific reason for viring funds was cash-flow implications arising from building projects, such as the new Victoria hospital in Kirkcaldy. Not just in the health service but across all departments, every Government vires resources and is perfectly entitled to vire resources, particularly in the final quarter, to ensure that we do not end up with a massive

underspend that must then be sent back as a cheque to the Treasury. I make absolutely no apologies for that clever and intelligent management and use of resources, nor do I accept in any way that we have not reported these matters, as we have done for years, in the public domain. I further emphasise that we did that in the way that was endorsed and recommended by the Parliament's Public Audit Committee. We have adhered to every one of those rules.

We will accept the Public Audit Committee's recommendations to make matters even more transparent; we are happy to do that. However, there is a difference between making something more transparent or more obvious and not reporting it. We have reported it. As auditor of the three boards, Audit Scotland knows that.

Richard Simpson's final point was about people being treated outwith Scotland. That is always very much a last resort, which will be done only if it is absolutely clinically essential. Clearly, our job is to ensure that the capacity exists in Scotland. Until this year, anyone who required a procedure such as a transcatheter aortic-valve implantation for a heart condition had to have that done furth of Scotland. Under this Government, the TAVI procedure has been introduced in Edinburgh, so people can now have the procedure in Scotland without having to travel down south. It remains our strategy to treat people outwith Scotland only as a last resort. You should not always believe every word that you read in the newspapers, even those as reputable as the *Evening News* and *The Scotsman*.

I ask John Matheson to quote chapter and verse on when we reported those virements.

The Convener: Before he does so, I point out that the matter relates not only to Audit Scotland. In evidence, the Royal College of Nursing, the British Medical Association, Unison and Professor David Bell have highlighted at previous committee meetings the lack of transparency in health budgets over a period of time. We have had a raft of evidence raising that issue, including papers from our budget adviser. I hear the cabinet secretary's robust defence, but I think that it is important to address the issues in the broadest terms.

09:45

John Matheson (Scottish Government): I will start with some introductory comments. We have regular contact with boards on the financial issues that they face, and we get into detailed discussions with them. We do not automatically give them support; rather, we look to ensure that any issue that they have is transitional and will be managed on a recurring basis so that we have confidence that they have financial sustainability.

As the cabinet secretary said, two of the three boards that Audit Scotland highlighted had double running costs associated with a move into new premises. I will focus on Forth Valley NHS Board as an example. We got a reassurance from that board that it had a sustainable financial plan. In its finance report for the four months to the end of July 2011, it talked about a potential overspend of £3 million and a worst-case scenario in the region of £10 million to £12 million. It entered into detailed discussions that involved the chief executive and me about how that issue could be resolved, and we offered it support, which was primarily funded from capital receipts generated from hospital sales within Forth valley. That was money that was going to come in in later years in Forth valley, and the board would repay that support.

In the finance report to the board for the nine months to the end of December 2011, it was highlighted that non-recurrent transitional costs of £4 million and non-recurrent support of up to £6 million had been received. We still tried to keep the pressure on the board to minimise any financial issues that it had, which was why we capped the level of support that we were willing to offer it. There is a repayment profile for the board that takes it up to 2015-16. It is on target in its financial position in the current financial year, as are Fife NHS Board and Orkney NHS Board.

We will, of course, consider transparency and see how we can be more transparent. For example, I meet a lead official in the Royal College of Nursing on a quarterly basis to discuss financial matters. We share the monitoring returns from each individual board with the RCN at its request to try to be as transparent as possible in the information that we provide.

The context is important. We are talking about 0.1 per cent of the total health budget. We are trying to enable boards to plan for the future in a sustainable way, but also to manage the reality of the current pressures in a controlled and effective way. That is what we have done with the three boards.

The approach is not new. Just after the turn of the millennium, NHS Lothian received support from the Scottish Government in recognition of the double running costs with the move to the new royal infirmary. Even in the current financial year, Dumfries and Galloway NHS Board has returned £4 million to the Scottish Government and asked that it be banked and carried forward for two or three years. We will do that on its behalf. It will then receive that money back to cover the double running costs with the move to the new Dumfries and Galloway royal infirmary.

Alex Neil: Derek Feeley will supplement that a bit.

Derek Feeley (Scottish Government): We are very keen to be transparent, and if there are issues that the committee wants to bring to our attention, we will respond to them favourably.

I would like to supplement what John Matheson said. There is one thing that we already do. John Matheson gives a finance report to the Scottish partnership forum, where the Government and the management side of the NHS and the trade unions in the NHS, including the BMA and the RCN, meet. Therefore, they regularly hear financial reports from John Matheson. That is a unique feature of the NHS. We openly share such information with our partnership colleagues.

If there is more that we can do, we will do it.

The Convener: I remember NHS Argyll and Clyde selling the family future. From my personal experience, that is not a sustainable position.

Dr Simpson: Tayside, too, got into real financial difficulties. Our concern is seeing the future and whether there will be problems. Thank you for the explanations that you have given. At least we know that the loans are related to capital issues in which double running is required, so we can be clear about that.

I return to the cabinet secretary's robust defence and his suggestion that we are different in Scotland and that we face a different situation. I accept that his party and mine have moved the health service in Scotland down totally different lines compared with the health service in England. That has been the choice of the Scottish Labour Party and the Scottish National Party.

However, despite the cabinet secretary's comment that we are not going to have cuts in Scotland, we have lost 2,500 nurses. Forth Valley, whose financial situation has just been mentioned and which serves a population of only 180,000, has lost 50 nurses in the past year. That is a very substantial cut and, as I have repeatedly indicated in the chamber, we cannot have a situation in which we do not recognise that the loss of 2,500 nurses has front-line consequences. If that kind of unreality continues, we will be in significant trouble in a year or two.

One of the streams that was mentioned in the letter to which I referred was workforce planning. Cabinet secretary, will you provide us with the most up-to-date workforce plans setting out the posts that will be lost this year? I have been unable to obtain that information through a freedom of information inquiry. Grampian replied, highlighting my use of the word "axed" in my FOI request—I do not care what the thesaurus says; the posts have been axed—and denying that any posts have been axed. That sort of response from a health board does not provide the sort of transparency that allows this committee or indeed any MSP to operate. Will you give us those workforce plans and, furthermore, acknowledge that 2,500 posts have been cut and that that is putting the system under massive pressure?

Alex Neil: I am happy to deal with all those points. First, however, I want to give you an example of the kind of financial pressures that we are under. The £45 million that NHS Lanarkshire has to fork out a year for the rip-off private finance initiative costs of Hairmyres and Wishaw is making a huge dent in the Lanarkshire budget, and we are having to pick up the PFI tab and all its consequences. I do not think that those who supported PFI are in a very strong position to criticise the national health service's budgetary position.

As for nurses, I want to make three points. First, there are in total more qualified nurses working in Scotland today than were working in the health service when we took over five years ago. Secondly, if you look at the number of nurses per patient and per bed, you will see that we are far better staffed with nurses than any other part of the United Kingdom. We have in general a very good staffing position in relation to nurses in comparison with the rest of the UK. Thirdly, we need to recognise that the national health service is being reconfigured. Last year, Dr Simpson himself said that he accepted the shift in the balance of care that

"could result in a reduction in the number of acute beds."—[*Official Report*, 8 June 2011; c 430.]

By definition, we are moving more towards day surgery and moving away from hospitalisation to treatment in the home. That is why in recent years there has been a 30 per cent increase in the number of community nurses in Scotland.

Nevertheless, we must be absolutely sure that we have the right number of nurses with the right skills mix throughout the health service, irrespective of the department that they work in or their hospital or whether they are working in the community or the acute sector. That is why, with our partners in the trade unions such as Unison, the RCN and others, we have developed the world-leading workforce planning tool, which has been 90 per cent implemented and will be 100 per cent implemented in the first quarter of next year. We will make that tool, which has been agreed with the trade unions and the RCN as the proper way to plan our workforce, mandatory for every board in Scotland from next April and it will ensure that we have the right numbers and the right skills mix, that the nurses are in the right place at the right time and that we can reduce substantially more our reliance on bank nurses. Indeed, we

have already eliminated our reliance on agency nursing, and I believe that that is the way forward.

I have to say that conducting a debate on the basis of raw numbers is a very juvenile way of planning the workforce. However, speaking of raw numbers, I note that they have increased in the past five years.

The key thing is to ensure that we have the right number of nurses and that they are in the right setting, whether it be acute, community, or accident and emergency; that they have the right skills mix; and that we de-layer the management structure to ensure that maximum resources go into front-line nursing. That is exactly what we are doing. As I said, the workforce planning tool will be mandatory from April next year. That is the way forward rather than just bandying about numbers.

The Convener: Again, it should be borne in mind that we are talking about the evidence that we have received. Audit Scotland highlighted a significant cut in the number of nurses in that area. That is an indicator that we are moving. In 2009, we had 58,428 nurses; by 2013, that will drop to 56,100, which is the loss of a couple of thousand nurses. I recognise that we will see an increase of more than 1,000 people who are involved in personal and social care.

We received other evidence that was not so much about the squeeze. Unison talked about the non-filling of vacancies and the increased pressures that are being put on professionals working in the hospital sector. Is that issue being dealt with? I am talking about day-to-day pressures. You highlighted the level of planning, and I think that we can see that, but there are fewer nurses and more people in personal and social care. However, there is a question about what is happening every day when people are not being replaced and vacancies are not being filled when, at the same time, nurses' overtime is being cut back to keep costs down. All that puts pressure on and, as you say, no one is measuring the quality of the patient experience and the risk to the reputation of the health service. We have heard horror stories about care for the elderly in the acute hospital sector. What is going on here?

Alex Neil: I will make two or three points in response to the very reasonable issues that you have raised, convener.

First, on vacancies, at the moment there are 900 vacancies for nursing positions in Scotland. Because of the controversy over numbers, I have been taking a close look at the profile of the vacancies as well as the numbers profile. I have been checking that boards have not been prolonging the length of time for which vacancies have gone unfilled for budgetary reasons. I am absolutely satisfied that the figure of 900 vacancies is fairly reasonable given the totality of the levels of employment of nurses in the national health service.

If we take your figure of 56,100—

The Convener: It is not my figure; it is Audit Scotland's figure.

Alex Neil: We need to remember the distinction between the number of employees and the full-time equivalent, and we can see that 900 is not an unreasonable level of vacancies to have at any one time. However, I have sought assurances and I am keeping the situation under constant monitoring, to ensure that no board is using vacancies as a way of saving money. It goes without saying that nursing vacancies should be filled at the earliest opportunity. If a nursing vacancy is advertised, that means that we need that nurse. The time that is taken to fill the vacancy should not in any way be prolonged. Vacancies are being filled in the normal time.

The Convener: Will you share that information with the committee?

Alex Neil: No problem. As I said in our bilateral meeting last week, if the committee feels at any time that it does not have the information that it should have—financial or otherwise—let me know and we will provide it. We have nothing whatsoever to hide. As Derek Mackay said, we believe in total transparency.

You referred to pressure points. There is no doubt that there are sometimes pressure points; for example, the overall level of sickness absenteeism in the national health service is higher than we would like. Sometimes that absenteeism can create pressure points, which have to be dealt with. The point of the workforce management and planning tool is to deal with those pressure points. The tool is 90 per cent applied already throughout the NHS in Scotland. That will be 100 per cent by the spring of next year; after that, the tool will be mandatory. That should ensure that pressure points are identified early on and are therefore dealt with more speedily than in the past.

10:00

The Convener: You said that everybody was happy with the evaluation of that tool.

Alex Neil: Yes. We have involved Unison, the RCN and others.

The Convener: When people come along and give us evidence, it is important that we test it with you.

Alex Neil: I will hand over to Derek Feeley to give you some supplementary information. However, my understanding from talking to other

people, such as international medical visitors to Scotland, is that the tool that we have developed is seen as the leading workforce planning and management tool in Europe, as far as health service provision is concerned.

Derek Feeley: Just to confirm, we have developed the tool in partnership. The RCN can speak for itself, but my understanding is that it has been advocating the use of the tool beyond Scotland. For example, it would like to see it being used in England, where it is not in current use.

The tool is about trying to identify the pressure points to which the cabinet secretary referred and that you, convener, were keen that we understood. We need to identify those pressure points and translate that information into the staffing numbers that are required.

The tool will not be a panacea—we are not pretending that it is—and we have other things in place. For example, we have introduced the one-year guarantee scheme, and we have the internships in nursing to ensure that people get good experience while they are waiting for permanent posts. It is easy to overlook those opportunities for nurses as we have become accustomed to them, but they are unique to Scotland.

I will pick up on something that Dr Simpson said in his opening remarks, because it is important to acknowledge his comments about these matters. The quality of healthcare in Scotland is good. It is safer, infections are down, hospital standardised mortality is down, waiting times are low, and care experience is high and being sustained. No one is pretending that there are no pressures, but the NHS is performing well and we expect it to continue to perform well.

The Convener: In a previous evidence session, John McLaren challenged us all—politicians and Government—on the issue of the top health target of raising healthy life expectancy. Healthy male life expectancy is down a year and a half in Scotland, up three years in England and up four years in Wales. The top target has not been met and no one has done anything about it.

Derek Feeley: I have seen John McLaren's presentation of those figures and it scared me a bit, too. I immediately asked my resident expert on these matters, the chief medical officer, whether those figures are right. Harry Burns has explained to me that they are an artefact of the way in which the data is collected. We will get that explanation to the committee.

The Convener: John McLaren did give us a caveat, so we look forward to further information.

Drew Smith (Glasgow) (Lab): On that issue, John McLaren made a point about the accuracy of the information that we had. However, if raising healthy life expectancy is genuinely our top target, it leads us to question why we do not have better information—although I do not know if that question is going too far off course.

Alex Neil: It may also be a feature of how other people collect their information—it might not be as robust as ours. We will provide you with the detail, because it is fairly technical and complex.

Drew Smith: That is useful, cabinet secretary.

Bob Doris (Glasgow) (SNP): At last week's evidence session, I asked witnesses whether they would want to reallocate some of the real-terms increase in the revenue budget to health boards and, if so, how they would do so and what their priorities would be. If I recall correctly, only two of the witnesses responded. Unison said that it would have greater efficiencies in accident and emergency units, and it mentioned Ayr and Monklands hospitals. I did not ask Unison to clarify what it meant just in case it was going to suggest that we close those hospitals—that is clearly not a priority for the Scottish Government. The voluntary sector said that more money and more of the change fund should be allocated towards it, funnily enough.

Given that we can see what financial support the Scottish Government is delivering to health boards, what representations have you had to reprofile your spending priorities? We could not really get anyone to take up the question at committee, but when we consider the draft budget we must take such issues seriously.

Alex Neil: To be honest, apart from general comments from people about delayering management and, without being specific, other issues of that nature, we have not had any information. I have only been in the job for five or six weeks, but I have not received any detailed proposals from anyone on reprofiling the budget, either for this year or any of the next two years.

It might be useful if I explain where we are with the budget. Obviously, we made a manifesto commitment to pass on all the Barnett consequentials to the national health service and we have done that.

We have also done two specific things for the next two years. First, we have ensured that there is a real-terms increase in the budget allocated to the territorial boards as they are primarily—but not exclusively—involved in front-line services. That means that next year, with a deflator of 2.5 per cent, the boards will get an average increase of 3.3 per cent, which is a real-terms increase of 0.8 per cent. The year after that, with the deflator still at 2.5 per cent, boards will get an increase of 3.1 per cent, which is a real-terms increase of 0.6 per cent.

Secondly, we have shifted money from resource into capital. Clearly, there are major capital works that we must ensure happen so, as well as shifting more than £300 million over the next three years, we also have the £750 million non-profit-distributing programme. I have already announced the go-ahead for the new Royal hospital for sick children in Edinburgh, which is a long overdue project that has been wished for for many a year. There is a new neuroscience unit in Edinburgh and a range of other things, too.

Despite the massive cuts imposed from London, we have made very good use of our resources. Over the four-year budget, our efficiency savings, which will not in any way undermine our clinical objectives, will accumulate to almost £1 billion. Every penny of that is going back into front-line services.

Bob Doris: Okay. I note that you did not say how any particular group has asked you to reprofile the heath budget, but I will move from the general to the specific.

Yesterday, I met staff at the Greater Glasgow and Clyde NHS Board's psychological services. They have an interest in pushing forward the targets for children's access to psychological services. Only a year or two ago, the waiting time to get clinician-led psychological support was one or two years. The waiting time is currently at 29 weeks. That is still not good enough, which is what the clinicians would say, too, but there has been dramatic progress in the correct direction.

The board has prioritised a budget line for that particular area, which is an example of how we start to get the results that are required when a health board sets its budget in correlation with the health improvement, efficiency and governance, access and treatment—HEAT—targets. The Scottish Government has set out a series of priorities. How do you monitor health boards to ensure that they are financially prioritising those targets? The issue is about not only the money that is given to health boards but how they then prioritise the agreed targets.

Alex Neil: A great deal of monitoring goes on. For example, I meet—and my predecessor met—all 22 health board chairs regularly, and Derek Feeley meets the chief executives once a month. There are also a lot of bilateral meetings. John Matheson meets his finance counterparts on the boards regularly, and John Connaghan, who is in charge of workforce development, meets his human resources counterparts regularly too. There is also monthly reporting on a range of performance indices.

I will pull that information together at ministerial level to produce my own internal monthly management information report. It will have a number of sections, but the most important one to me will be on treatment outcomes. That information is core to how we decide on the success or otherwise of a health system, so I want to look at it regularly. Obviously I will not look at every treatment outcome every month, but I want to look closely at outcomes and their costs, and benchmark them against the best to see how we are doing on treating cancers, heart disease, stroke and all the rest.

A lot of the work is already being done, so to some extent the report will be a collation exercise. However, I assure members that we get regular reports on cancer and heart disease treatment waiting lists, HEAT targets and a whole range of other things. Members would need only to look at my ministerial box of an evening or a weekend to see how many reports we get from all around the health service in Scotland on meeting performance and outcome targets.

Bob Doris: I have one final question on that subject.

It is not only the financial budget that local authorities set to achieve the HEAT targets and the Scottish Government's variety of priorities that is important. The outcomes are important, too—the budget is the input. NHS Greater Glasgow and Clyde did not dramatically increase the financial resources that it put in, but it achieved quite a dramatic improvement, so it is not always about the amount of money that is put in. If we organise our services correctly, we get a quality output.

Do you monitor the money that is put into specific budget lines across the 14 health boards and compare the outputs? If one local authority is performing well in a particular area and another is not, it is important that best practice is shared. We need to ensure not just that we monitor the money that we put into health boards but that we get the outcomes that we desire. Is that monitoring done as standard?

Alex Neil: Absolutely. The emphasis on targets has been changing. As you know, the HEAT targets have been consolidated into 16 targets, and we are carrying out further reviews to see whether they need to be updated or changed in any way to reflect the dynamic situation in the health service.

The current situation can be compared with the many targets that existed previously. One can set too many targets and end up not achieving any. The fact is that we look at the outcomes, and we are much more outcome-orientated than ever before. It is the outcomes that matter.

As the minister who is in charge of the health service in Scotland, I am keen to look at a lot of things such as finance, staffing and all the rest. I even look at what the Opposition parties are

saying to see whether there are any good ideas, although I have to say that I have not seen a lot recently.

I look at all the outcomes and the costs and we benchmark the outcomes so that we can get a clear picture of how well we have done historically, how well we are planning to do in the future, and how well our outcomes compare with the best.

John Matheson wants to add something about the relationship between outputs and inputs.

John Matheson: I have just a couple of points. In financial planning, we do not want surprises. With regard to the draft budget for 2013-14, the boards welcomed the outcome and also the fact that the uplift was what they were expecting, as they had been drawing up their financial plans on that basis. The spending review has been helpful in giving boards some assurances about what to expect in the next period.

The boards want as much as possible to go into their baseline, so we have been putting more resources in at that end. For example, we have put in an additional tranche of access moneys directly into the boards' baselines.

The cabinet secretary is right to say that we have been focusing, and getting the boards to focus, on outcomes and outputs. We have tried to move away from a micromanagement approach in which we give boards smallish allocations for specific targets. We have succeeded in bundling allocations around themes such as primary care, early years, mental health and so on. That gives the boards local flexibility, which is important, as to how they use that resource, provided that they deliver the required outcomes and outputs.

10:15

Derek Feeley: We explicitly connect finance and performance. The local delivery plan that every board is required to construct contains both its commitments to meet its HEAT targets and its financial profiling. When the cabinet secretary conducts annual reviews with boards, as he did yesterday in Fife, we talk about performance and finance together. We do not talk about the two things separately. Likewise, in the mid-year reviews that officials do with boards, we talk about both performance and finance.

I will say two other things that might give Mr Doris a bit more comfort. We have done specific benchmarking of boards, looking at what they spend against their outcomes, in a number of areas including mental health and theatre utilisation. That enables us to ensure that we get value for the spend. We have also started to develop some tools to help boards to make assessments. For example, the integrated resource framework is a tool that is intended to help boards to look at what they get for the investment that they make. Quite a lot of effort is going into that.

The Convener: I think that Mr Matheson hit the nail on the head when he said that, in financial planning, we do not want any surprises. The evidence that we have received is all about that. Are we planning properly for a shrinking budget? I think that we are already there as a committee, but there are a number of potential surprises. There is a £1 billion maintenance backlog. I understand that some of that work just involves a lick of paint somewhere, but some boards are having to use revenue funding because they do not have capital funding, including in your constituency, cabinet secretary.

We have a recent report from Audit Scotland—I came across it just last night—on planning for a legal decision on equal pay. I think that the situation might have been turned upside down. That is no surprise, because local authorities have been involved in it for many years and it has cost us an absolute fortune. Equal pay is therefore a factor, and many thousands of people are involved in the issue.

When we look at efficiency savings, again Audit Scotland is saying that people have not identified where that money is going to come from. There is a risk that boards might not make the savings.

We are looking at the robustness of what is happening in the health service. As we heard last week from the RCN and the BMA, the worst thing that we could do is to not plan for eventualities and to see services collapse. I think that that is where we are. There are still many surprises lying in there, or there could be.

Alex Neil: I would not describe them as surprises, convener. We do scenario planning. If we take the backlog as an example, it was the subject of a full review earlier this year, under my predecessor, and there is now a fairly advanced estate strategy operating in the national health service. It would be a lot easier to implement if all the surplus properties were bought up in the market but, because of the condition of the economy, properties that might have sold quite quickly a few years ago are not now moving as quickly. However, we are clear about the matter. We know where the risks lie and we look at contingencies where they are required. In life, we inevitably get the odd surprise, but—

The Convener: It is a big number, cabinet secretary.

Alex Neil: Absolutely, and I think that we are very much on top of where the risks might be.

The Convener: If we look at the big, top-line figure that covers everything from a lick of paint in a reception area to the cladding on Inverclyde royal hospital, what is the figure for the big risks?

Alex Neil: There is a detailed analysis of the backlog, which I will be happy to send you. The £1 billion figure includes, for example, buildings that have been declared surplus to requirements.

The Convener: I understand that.

Alex Neil: Clearly, they will not be a high priority in terms of backlog spend. When we boil it down and look at where we really need to spend money in the next few years, the figure is substantially lower than £1 billion.

The Convener: What is it? Does Mr Matheson know?

Alex Neil: John Matheson will give you the detail.

John Matheson: This is a good example of transparency. I know that we went down to the level of the lick of paint, but we looked at low risk, high risk and significant risk as well as medium risk, and the final figure was just over £1 billion.

I will give you one board as an example in a moment but, when we break down the overall figure into significant risk and high risk, as opposed to medium and low risk, it roughly halves. When we take account of what is in the planning programme, which includes Dumfries and Galloway royal infirmary, the new sick children's hospital in Edinburgh—the cabinet secretary mentioned it earlier—Ayrshire and Arran community hospital, and Balfour hospital in Orkney, that brings the residual figure down to just over £400,000.

Alex Neil: £400 million.

John Matheson: It is £400 million—thank you for the correction.

Alex Neil: I wish it was £400,000. [*Laughter*.]

John Matheson: I am normally quite good with numbers—the figure is just over £400 million.

Dumfries and Galloway is a good example. The gross figure in Dumfries and Galloway, as part of the £1 billion, was £61 million, of which £40 million will be dealt with through the new Dumfries and Galloway royal infirmary and £5 million will be dealt with through disposal of properties, and a backlog maintenance programme will deal with the balance. Therefore, we immediately come down from £61 million to just over £10 million for Dumfries and Galloway.

The Convener: So the money is not just for the fabric of buildings but for high-tech diagnostic equipment. Audit Scotland suggested that the latter is not included.

John Matheson: The equipment is not included in that figure. We have a separate programme for equipment replacement. That is one of the reasons why we have transferred £320 million across from resource to capital over the three-year spending review.

The Convener: Where is the figure for that equipment replacement?

John Matheson: I do not have that detail in front of me, but I can give it to the committee later.

The Convener: We would welcome that as well.

Alex Neil: We are happy to send you the detail, convener. I point out that some of the spend actually saves money. I will give you a very good example that you may be aware of, which is the electronic pen that was developed by community nurses in the Western Isles.

After doing an exercise that showed that 41 per cent of their time was spent on administration, the community nurses developed an electronic pen, which basically means that when they are out in a remote cottage or wherever, attending to a patient, and they have to write up their notes, the electronic pen automatically updates their computer so that they do not need to go back to the office to type all the notes into the computer.

The electronic pen has many other applications, but the community nurses in the Western Isles reckon that that single application reduced the time that they spend on administration from 41 to 20 per cent. As more people use the electronic pen, the unit costs come down. Therefore, the fairly modest spend on that will save a lot of time and ensure a lot more throughput for community nurses, which will make their job much more enjoyable because they are spending only 20 per cent of their time on administration instead of 41 per cent. That is a good example of where the application of technology has knock-on savings and efficiencies.

The Convener: I look forward to getting on to that preventive agenda later.

Have we established a liability for equal pay for the boards?

John Matheson: We work closely with the central legal office on equal pay. Our current advice is that there is a differentiation between the position in local authorities and that in the health service. For the past number of years, we have recognised it as a potential risk. We are not in a position to put a value on that risk, but we are working closely with the staff side in taking that forward. At the moment, it is what we have described as an unquantified contingent liability in

the accounts, so we recognise it as potential risk, but it is not possible to put a value on it.

The Convener: Has the risk increased since the decision in the Birmingham case? I note that Audit Scotland referred to an expectation that the time bar could be favourable for the health service. Perhaps you can come back to that question.

John Matheson: I am aware of that issue, and we stay close to the central legal office on it.

The Convener: That does not fill me with confidence, Mr Matheson, because the legal advice for local authorities on the issue has not been great over the years and it has ended up costing us more.

John Matheson: I will make a final point on that, if I may, convener. We stay close not just to the central legal office but to Audit Scotland, and every year we sit down with them both and come to an agreed position for the annual accounts for transparency on how we are going to report equal pay. We will continue to do that.

The Convener: We will be happy if you can keep the committee up to date in that regard.

Mark McDonald (North East Scotland) (SNP): I thank the cabinet secretary for his evidence so far. My question follows on quite neatly from comments made by Bob Doris, who pointed out that, in the first of last week's evidence sessions, the witnesses were asked how they would reprofile spend and whether there was anything that they would stop funding. At that point, the BMA flew the kite of homeopathy. I do not want to get into that debate today; I simply note that that organisation, too, has highlighted a service that might need to be looked at.

The question of what we spend money on in the health service—or, indeed, in general—has become more in vogue with recent interventions about whether we should stop providing certain services or whether we should reintroduce certain charges or elements of means testing. Is the Scottish Government doing any work on the data that lies behind not just the cost of providing a particular service but the cost saving that the service makes? In a recent briefing, for example, Optometry Scotland told me about direct and indirect savings that had been made as a result of universal free eye tests. I was actually quite shocked at the savings it identified, and I have asked it to send me a copy of the report in question, which was carried out by a number of universities.

What work is being done to ensure that we look at not just input measures and the amount of money that we are putting in but health and wellbeing outcomes and the knock-on effects and costs arising from not spending money later on?

Alex Neil: It is not just a matter of spending money; some of our measures should, when fully implemented, save the health service money. Indeed, minimum unit pricing is a very good example of that. Once we get it introduced, it will have quite a dramatic impact on not just the health budget but, for example, the criminal justice budget. As well as spending money, we must also consider measures that do not necessarily involve our spending a great deal.

With regard to spend, I could simply highlight the example of free personal care or, indeed, free prescriptions. Before they were made free to everyone, 88 per cent of people in Scotland qualified for free prescriptions. Of the other 12 per cent who did not qualify, 600,000 were earning £16,000 or less. Some might say that £16,000 is a lot of money, but it is worth remembering that people start paying income tax and making national insurance contributions at 11 per cent on earnings over £8,100 and that they pay council tax when they earn under £7,000. By the time those three taxes alone come off the top line, those who earn £16,000 are actually getting a lot less than that.

If someone goes to the doctor with an ailment and then has to fork out £7.45, which is the cost of a prescription for each item south of the border, they will, quite frankly, think twice about doing so. However, by not paying for the prescription, not taking the medicine and therefore not dealing with the ailment at the earliest possible opportunity, such a person might well have to make a greater call on health service resources. I also note that the productivity gains arising from the introduction of free prescriptions, free eye tests and so on were phenomenal when the health service was established in 1948—although I am not suggesting, of course, that they have the same impact now.

When we add the 600,000 who should have been getting free prescriptions to the 88 per cent who were already getting them and then take all that away from the total, we are left with a relatively small number. The costs of collecting prescription charges from those people were not worth the candle. Such examples show that it is better to follow the old maxim, "From each according to their ability to pay, and to each according to their need". Prescriptions are a need that I believe should be free at the point of use.

In any case, we monitor the health benefits and the pluses and the minuses arising not only from free prescriptions but from free personal care. After all, if free personal care and that kind of contact were not available, what would be the cost from dealing with the additional falls and admissions to hospital and accident and emergency? Some work has been done on that

matter, but we need to do more work on it. There is certainly no doubt in my mind that free prescriptions are the right thing to do and that the cost benefit of introducing them is a plus.

10:30

Mark McDonald: Another issue that has already been raised today is the transparency agenda, on which I welcome your remarks thus far. The committee has identified that £341 million is being transferred from health budgets to local authority budgets, so I guess that the committee's question is about how closely that money is scrutinised once it has gone to local authorities. Within an £11 billion health budget, £341 million might seem small beer, but the sum involved is still substantial in and of itself.

A perhaps linked issue is the change fund. We did not take oral evidence from Age Scotland, but its written evidence indicates that it has concerns about how certain local authorities administer the change fund, which may not be spent along the lines intended. How closely do you monitor the use of NHS resources once they are transferred to local authorities, either directly or through the change fund?

Alex Neil: We monitor that use very closely, and John Matheson will be able to give detail on the monitoring processes that are in place.

It is early days yet for the change fund, and we will carry out an evaluation of the fund and how it has worked after its first year. However, there are clear guidelines on what change fund money can be spent on. To give just one example, 20 per cent of the money has to be spent on carers support.

At the right time, once the fund has been fully up and running for at least a year, we will undertake a proper evaluation, which we will also share with the committee. Obviously, when people tell us that the change fund is not being used for certain things, we talk to the people concerned to find out what is going on.

Ultimately, we will do a full-scale evaluation of the change fund once it has been up and running for a reasonable period of time. We will ensure that people follow the guidelines, and we make it very clear what the money can be spent on—for example, we prescribe what money must be spent on carers support—within those guidelines.

The flow of money from the health service to local authorities is obviously something that we keep a close eye on. John Matheson will spell out the detail of how that is audited, but at the end of the day it is all audited by the Auditor General because it involves a flow of money within the public sector. A very good example is the £1 million that NHS Lanarkshire recently gave towards the cost of a refurbished car park in the centre of Airdrie, where there is a need to accommodate additional footfall from the new health clinic that has been built. NHS Lanarkshire can clearly ensure that the £1 million was spent on the car park because the car park is physically there, so that is a good example of where it is fairly obvious that the money has been spent for the intended purpose.

I ask John Matheson briefly to outline the detailed audit process for ensuring that the money is spent where we said that it would be spent.

John Matheson: For the £341 million that relates to resource transfer, the accountable officer is still the chief executive of the individual board and the responsibility remains with them. As we said in the previous discussion, there is a need to focus not just on the money but on what the money is intended to deliver, so discussions about the effective use of such moneys would also focus on where the delayed discharge position is going within the individual board area. Over the next two or three years, more aggressive targets will be brought in on delayed discharges.

Another important point is that there needs to be partnership between the health board and the local authority—and indeed, in the context of the change fund, the third sector as well—so that plans are brought forward in partnership.

The accountability relationship for the core resource transfer money sits very clearly with the health board, and that is picked up through the audit process. However, it is important that we focus not just on the money but on what outcomes and outputs we are expecting that money to deliver and that we ensure that they are delivered.

Alex Neil: Looking forward to the establishment of the 32 partnership boards for the integration of adult health and social care, it is very important to have an integrated budget made of money flowing from the health board and the local authority into those partnerships. Ensuring that the money is spent properly will obviously require specific audit and monitoring arrangements.

Mark McDonald: There is obviously a question around the public sector pension changes. I understand that there was a vote on the issue in Westminster last night. I am aware that there is a letter from the Chief Secretary to the Treasury, which states that, if we attempt to do something different in Scotland, the money will be clawed back. Do you have any data on the implications for the health budget if we follow the calls that some are making to resist passing on the changes to health service professionals? Could the data be provided to show the impact on the health budget of the clawback?

Alex Neil: It always depends on how many people join or stay in the pension fund. If we picked up the tab for all the additional contributions and everyone stayed in the pension fund, it could go as high as £80 million a year for the health service in Scotland. A more realistic figure might be slightly less than that, but our potential exposure is up to £80 million a year.

We think that the pension reforms and the way in which they are being imposed is absolute madness of the first order. It is important to have high morale right across the public sector workforce, and issues such as pensions, productivity, pay, and efficiencies should be matters for negotiation, not imposition, except in the most extreme circumstances in which we cannot get a negotiated settlement. The proposals are extremely ill thought out, and the way in which the Westminster Government has gone about them is draconian.

If we could do something differently in Scotland, we would be keen to do it, and we are talking to the BMA and others about the possibility of that. However, I would not like to raise any expectations because of the strictures that we have been put under by Danny Alexander, who is certainly not living up to the spirit of devolution when he says that, if we choose to do something different in Scotland, the Westminster Government will take the money off us and the money will have to come out of front-line services. That is where we are at.

Mark McDonald: Just to clarify, the top-line figure of £80 million that you mentioned would be the cost of covering the contributions. The equivalent would be clawed back, so the overall cost would be £160 million once the clawback was included. Is that correct?

Alex Neil: I think that is probably right, although Danny Alexander has not spelled out how it would actually work. All he has said is that he will keep back £80 million from the Scottish Government's budget, if it is £80 million. Although we are keen to do something different, we cannot lose £80 million from front-line services in the health service in Scotland.

Gil Paterson (Clydebank and Milngavie) (SNP): I just want to go back to a point that the cabinet secretary raised earlier. I do not want to go into the detail, but you spoke about prescriptions and the effect on individuals. When I was collecting evidence for my palliative care bill, I came across issues around that and I would be happy to share them with you. It would be very interesting for you to understand the exact impact on individuals.

I have a question on preventative spending which, by its very nature, means that we spend money upfront, now, but do not see the benefits for a considerable length of time. What progress is the Government making on preventative spending that it can share with the committee?

Alex Neil: A core part of what the health service does is around preventative and anticipatory spending. One issue that does not involve us spending a lot of money is minimum unit pricing, which is a preventative measure. The detect cancer early programme is also a preventative measure. The reasons behind the integration of adult health and social care are to do with prevention as well as treatment. Therefore, a lot of what we are doing is preventative; it is not always described as such, but it has a huge preventative element within it. The change funds are obviously dedicated prevention funds and we will use the lessons that we learn from them to look at how we can do more on prevention and allocating funds specifically to prevention.

I also want to emphasise anticipatory spend. One of the first things that I did when I became the Cabinet Secretary for Health and Wellbeing was to ask Derek Feeley and his colleagues to prepare an implementation plan on data mining, data management and microtargeting. The techniques are very similar to those that are being used by Barack Obama in his campaign and, indeed, in all the campaigns now in the States. The health service collects a lot of information about people through our general practitioners. I have been told that, every year, doctors will be seen 6 million times by patients in the national health service in Scotland. A lot of data are collected and, with modern techniques, we can use them to try to anticipate particular conditions, who are the most vulnerable people and so on. The people in Stirling are probably the most advanced in Scotland in pulling together data from all the different agencies, and they are now finding that the data are used for preventative spending, as they can identify problems before they arise and anticipate them.

Tonight, I will be at a meeting involving the chief medical officer, the new chief constable for Scotland and Kenny MacAskill, the subject of which will be how we can pull together so that we identify people with drink, drug or mental health problems, for example, before they get into the criminal justice system and how we try to prevent them from getting to the point at which they commit crime. That kind of activity—the tools are now available to do that kind of work—is a revolution in preventative spending, prevention and anticipation. We are looking at and will apply every technique and way of doing things. It is not a matter of doing things ourselves; the real benefit of this approach is in doing things with our colleagues in local government, the police service, the Scottish Court Service, across the entire public sector and in the third sector.

Gil Paterson: A wee while ago—perhaps around six or nine months ago—Harry Burns came to the committee and informed us about interventions with women who lead challenging lives. There was a support team for pregnant women, which intervened not when the baby was born—I would have expected that to happen, but that is the old-fashioned way of doing things, right or wrong—but as soon as it was identified that the woman was pregnant. The outcomes and the benefits for the children and the mothers were quite dramatic. To put another hat on and talk about pounds, shillings and pennies—in old money—the health service also benefited enormously from the aftermath of that compared with what would normally happen in such circumstances. That is a really good outcome from preventative spending.

I listened to what you said earlier about caveats. A person can say anything at the beginning and the end; it is the bit in the middle that counts. People are saying that the Government has taken its eye off the ball in perhaps listening to the folk with caveats and putting up the attack on the basis of how much money is being spent now on services compared with last year. However, if there is preventative spend, the money should go down at some point because there has been front loading. My direct question to you is this: has the Government taken its eye off the ball in relation to preventative spending?

10:45

Alex Neil: Absolutely not. In fact, the family nurse partnership project to which you referred is a very good example of the innovative approach that we are taking to prevention. It is based on international research that has, in many ways, been led by our chief medical officer, Harry Burns. That research shows that a child's life chances are largely decided during the nine months in the womb and the first six months of life. There are chemical changes in the brain resulting from how the baby was treated in the womb and during its first six months of life. The research shows that that period is extremely important in deciding the life chances of children.

The family nurse partnership programme to which Gil Paterson referred involves early intervention with vulnerable young women who have become pregnant and their partners. They get a substantial support package throughout their pregnancy and the early months of the child's life. I attended the awards ceremony for the first parents to graduate from the programme. The drop-out rate is extremely low. That alone is a good indication of the success of the programme.

The programme is not just of major benefit to the mothers, partners and children involved. There are already clear signs that it is beginning to break the generational legacy of problem families. Some of the young women who have been through the programme are pregnant again and they are applying what they learned in the programme with their next child while it is still in the womb. They are still getting support from health visitors and so on.

There are clear signs that the programme is working extremely well, which is why we announced a couple of weeks ago that we are rolling it out immediately to a further four board areas, and to the entire country by 2015. It is a good example of where preventative spending and imaginative, innovative, targeted approaches can prevent problems, anticipate problems before they arise and identify the people who need this kind of service and support.

On whether budgets should start to go down as the preventative measures work through, I have two things to say. First, I am happy if budgets do not go down as long as the preventative measures have an impact on children's lives. I would rather invest the money and know that in five, 10 or 15 years' time those children will not be truants, will not end up in the criminal justice system and are doing much better at school than they would have done if they had not had that support in their early months. This is not a quick-fix approach to reduce budgets in the short term.

Secondly, where those preventative measures do release cash savings, we are reinvesting those back into other areas in the health service to improve the service elsewhere. The whole point is to keep reinvesting to ensure that we keep improving the quality and level of service provision in the national health service. It is a much bigger return on the investment but we will not necessarily reduce the budget; we will reinvest it in other priority areas where we can.

We need to look at the longer term, particularly of something like the family nurse partnership programme. The programme has many identifiable and measurable short-term advantages and benefits. Measured over a 20-year period, the benefits of the programme will be enormous, primarily because the human beings involved will be able to live a much better, more enjoyable life, free of some problems that might have occurred if they had not had that support in the early period of their life.

The Convener: I remind the cabinet secretary that he has a Cabinet meeting to go to.

Alex Neil: I have indeed.

The Convener: We still have some questions to get through. Mr Feeley wants to respond to Gil Paterson's question.

Derek Feeley: I have two brief points. First, the benefits of these measures sometimes come through quicker than we might anticipate. An example is the impact of smoking legislation. We did not think that we would start to see a difference in people's health as quickly as we did after the smoking legislation was introduced. We may get some earlier benefits.

I also want very briefly to highlight the prevention programme launched last month called early years collaborative, which is putting some of the scientific improvement techniques that we have been using in patient safety into a multiagency improvement programme aimed at reducing infant mortality, improving what Harry Burns calls attachment or the connection between the child and family and improving readiness to learn in three strands of the early years: minus 9 months—or, if you like, pregnancy—to 1 month old; 1 month to 3 years old; and 3 to 5 years old. As far as we know, this very exciting initiative is the first big public sector attempt at improving outcomes in this area.

Gil Paterson: I was more wanting to know whether you have the balls to keep all this going, given the attacks that you have been getting.

Derek Feeley: We have.

Alex Neil: Absolutely.

Gil Paterson: I encourage you to do so.

Earlier, you used the word "anticipate" with regard to things within your control in the budget. What about the things that you cannot anticipate and the other cuts that are coming down the road? What contingency plans can you put in place or what forward planning can you do to mitigate impacts on the health budget? That said, I think that the word "mitigation" is, in the real sense, meaningless here.

Alex Neil: The core of my answer would be a quotation from Nye Bevan, who talked about applying "the language of priorities". If resources get even tighter and if the cuts agenda continues into the long term, we will have to prioritise on the basis of clinical need and prioritise resources for areas of greatest need. After all, we are talking about a national health service and clinical need has to be the key criterion in the allocation of resources.

Gil Paterson: Thank you for that, cabinet secretary.

The Convener: You have just stressed the importance of e-health. Is that an indication that you are going to reverse the £1.6 million cut to that budget?

Alex Neil: If you look across the board, convener, you will find that we are spending more money on e-health. However, the spend might not come under that particular budget line; it is one of those areas that permeates a number of budget lines. The fact is that we are absolutely and totally committed to the development of e-health. Indeed, Grampian has taken a great lead on the matter, although I note that other areas are involved. Of course, e-health might just be a matter of certain simple measures. For example, when I did my first annual review, which was at NHS Western Isles, one of the senior medical people told me during the lunch break that money could be saved if St Andrew's house put in a teleconference system that everyone could use because they would not need to travel to Edinburgh as much.

The Convener: Have you really never had such a system?

Derek Feeley: We do have a teleconference system. I think that the key phrase was "that everyone could use".

The Convener: Ah, right.

Alex Neil: Although that sort of thing will not appear in the telehealth budget line, it is a very good example of it.

The Convener: I think that everyone agrees with you about the importance of pushing this agenda, but the contradiction between that view and the fact that the budget heading was being cut by £1.6 million was noted in evidence to us.

Nanette Milne (North East Scotland) (Con): In response to Mark McDonald, cabinet secretary, you mentioned the third sector. Although there is general agreement that the sector should be involved—and should be encouraged to get involved—with the NHS in providing services, is enough being done to encourage it? Can you put pressure on the NHS and local government to make faster progress in involving the third sector?

I also note that when changes to the NHS are being considered—and I am thinking in particular of the forthcoming integration of health and social care—we keep coming up against professional barriers, vested interests or whatever you want to call them. How can we approach that matter? After all, cultural change is going to be important if that legislation, for example, is to be effective.

Alex Neil: In answer to your first question, I could also cite the example of the integration of adult health and social care, in which the third sector will have a major role to play at every level.

There is clear evidence that third sector organisations can be better, more effective and more cost-effective at delivering a range of services. That is why the third sector is represented on the ministerial group on integration of adult health and social care. The third sector needs to be heavily involved, because it has huge

expertise and huge experience in the area. I am extremely keen that we involve it at every level—at local, national and regional levels, and at operational and strategic levels. You are absolutely right about the need for that.

As far as vested interests are concerned, we must take policy decisions that are based on what is best for the Scottish people. In the case of the health service, we must take such decisions primarily on the basis of what is best for Scottish patients. Although we listen to those with vested interests and take into account what they say, they cannot dictate our health agenda in Scotland.

An issue that will undoubtedly be challenging when it comes to the integration of adult health and social care is marrying the cultures of the health boards and the local authorities. It is my understanding that where the integration agenda is at its most advanced—for example, in West Lothian—that has tended to happen much more quickly and effectively than people anticipated. That does not mean to say that that will be the case across the country; it is something that we all need to work at. When we pull two organisations together to work in an integrated fashion, we need to be highly proactive in ensuring that the partnerships develop a culture of their own, to which health boards and local authorities adhere.

Nanette Milne makes a good point, which we and our friends on local authorities are extremely conscious of. The issue will need to be worked at, and that is what we will do, to ensure that it is in no way a barrier to success on the integration agenda.

Nanette Milne: I am glad that you said that the patient was the most important focus.

Alex Neil: Absolutely.

Nanette Milne: That is what we are looking for. Thank you.

The Convener: There are some follow-up questions that we could ask, but we are aware of the time constraints.

Drew Smith: I have two brief questions. NHS Health Scotland, which is our national health promotion agency, and Healthcare Improvement Scotland would seem to be two special boards that have a particular role to play in preventative health. Why has Audit Scotland expressed concern about consistent underspending by those two boards?

Alex Neil: Sometimes they are more efficient in doing things than they anticipated. I come back to the original point. We are a national health service. Although there are 22 boards—14 territorial boards and eight special boards—when one board does not need as much money as was thought, we do not spend money just for the sake of spending it; instead, that resource becomes available to the wider NHS. I am not concerned about underspend per se; I would be concerned if the bodies were underperforming. The reality is that they have been given a budget. If they do not need the entire budget, it is far better to free up some of that money for other things. I will bring John Matheson into the discussion shortly.

We need to get out of the culture of thinking that it is necessary to spend every penny, even if that means not spending as wisely as we should. We must get out of that mindset and into a mindset that recognises that we are all part of a national health service and that we should spend the money wherever in the NHS we get the best returns for patient care, our health improvement, efficiency and governance, access and treatment objectives and all the rest of it.

Drew Smith: But does not the existence of a consistent problem suggest poor financial planning?

Alex Neil: I do not agree with that, but I will let John Matheson deal with the specific point.

John Matheson: I do not think that it does indicate poor financial planning. We need to put the figures that are being talked about in context—they are quite small figures.

We need to remember that Healthcare Improvement Scotland is a reasonably new organisation that is developing its strategy and how that strategy will be delivered. One of the key factors that I always look for is how much of an organisation's money is being spent on direct patient care services, or public services, which is where its focus should lie. That is why I was pleased to see that HIS has now co-located with the Scottish Ambulance Service in the headquarters of NHS National Services Scotland, so it is minimising bureaucracy and backroom services to do with aspects such as facilities, and is directing more of its expenditure towards the public services that it should be—and is—focused on.

11:00

Drew Smith: I will move on from a specific question to a slightly broader one. The Audit Scotland report identifies a concern around the nine boards that are relying on non-recurring funding to break even. To what extent does it concern you that that is still the case?

We might accept that those boards need to move on to make recurring savings rather than just trying to get through each year. Is it the case that they have now gone past the easy part in making the savings that they need to make, and

that in reality they will, in the next year and years, be cutting to the quick?

The Deputy Convener (Bob Doris): That is a broad question, cabinet secretary, but a brief answer would be appreciated because I am keen to let in Aileen McLeod before the evidence session comes to an end.

Alex Neil: Okay. As time goes on, it becomes more difficult to identify easy savings. The savings agenda will have been going for four years at the end of next year, and will have saved nearly £1 billion. I do not share the concern about one-off savings, but we need to recognise that, for the foreseeable future—certainly until around 2015-16—it looks as though we will continue to be subjected to spending cuts from Westminster.

Therefore, we are trying to ensure, in an innovative fashion, that we generate internally in the health service the necessary resources to provide the quality and level of service that we believe is essential in Scotland. That will remain as a combination of recurring efficiency savings and cost savings as well as one-off cost savings.

We mentioned the property portfolio earlier. If the commercial property market—or even the housing market, as some of the buildings would be suitable for housing—improves, we will get one-off capital receipts when we sell those buildings.

One of our problems in recent years has been that the property market has been so depressed that the capital receipts that we would normally have expected from surplus properties have not been forthcoming. If there is an improvement in the property market, that situation will change.

I am not concerned per se, as long as we can continue to identify the sources of funding that we need to provide the quality and level of care that Scotland needs.

John Matheson: Audit Scotland makes a fair point, but we keep a close eye on the level of dependency on non-recurring savings. We are a £12 billion organisation and, in that context, the level at which those savings sit—around £20 million or £30 million—is less than 0.5 per cent.

It is the same with efficiency savings. People will develop efficiency savings in-year and get the full-year benefit in the following year, but some non-recurring support may be required in the current year. We look at those levels on a board-by-board basis through annual reviews, detailed monthly discussions and mid-year reviews.

Aileen McLeod (South Scotland) (SNP): One of the areas of the draft budget that the committee has not yet touched on concerns health research and innovation. That area has an important role to play in maximising the outcomes for patient care by turning clinical research into clinical practice. Through the support that we give our universities, our research community and our business sector, we can improve health promotion and disease prevention, understand disease and improve diagnosis and develop better preventative medicines.

The European Commission has identified healthy and active ageing as one of its global challenges. Does the cabinet secretary welcome the support—in particular the financial support—that is likely to be forthcoming under the future European Union research and innovation funding programme for 2014 to 2020? That is of course the horizon 2020 programme, for which €80 billion has been proposed, but it depends on what comes out of the current EU budget negotiations in Brussels. Do you see an opportunity to use that particular measure to support research and innovation in that area in Scotland?

Alex Neil: One of my jobs is to chair the life sciences advisory board. As you know, the Scottish Government has designated life sciences as one of the three major target growth areas in our economic development strategy, but research and development are also crucial to our health strategy. The office of the chief scientist for the health service, Andrew Morris, has been doing a great deal of work both on the research side and with companies to try to get more of the development done in Scotland. As you know, we have had recent announcements about the successful completion of work, with companies doing clinical trials in Scotland and seeing Scotland as a hotbed for growth in the sector.

I absolutely welcome the prospect of additional funding from the European Union, given Scotland's research base and the fact that we have so many high-quality universities. Three of our universities are in the top 200 in the world—I do not think that even Germany has that—and we have particular centres of excellence such as my old university, which is the University of Dundee. It used to be a centre for training brilliant young economists. [*Laughter*.] Now it is a centre for training brilliant young medics and life scientists and it has a particularly important role in cancer research.

We will be proactive in pursuing that agenda at a European level as well as within Scotland.

Aileen McLeod: Thank you.

The Convener: As we have no further questions, I thank you and your colleagues for your attendance this morning and the information that you have provided. We might wish to write to you with some additional questions.

Alex Neil: No problem. We will be glad to provide any information.

The Convener: Thank you.

I suspend the meeting to allow us to set up for the next panel.

11:06

Meeting suspended.

11:10

On resuming—

Social Care (Self-directed Support) (Scotland) Bill: Stage 2

The Convener: Item 2 is stage 2 consideration of the Social Care (Self-directed Support) (Scotland) Bill. I welcome Michael Matheson, the Minister for Public Health, and the officials who are accompanying him: Jean Maclellan, head of adult care and support division; Craig Flunkert, bill team leader; Kirsty McGrath, from the legal directorate; and Ian Shanks from the Office of the Scottish Parliamentary Counsel.

Section 1 agreed to.

After section 1

The Convener: Amendment 1, in the name of the minister, is in a group on its own.

The Minister for Public Health (Michael Matheson): Throughout the passage of the bill, I have been keen to work with committee members to strengthen the bill where appropriate. I am therefore pleased to have followed the committee's recommendation that consideration should be given to making the principles of independent living, which are already implicit in the bill, more explicit by way of direct reference to them on the face of the bill.

I recall that Richard Simpson first raised the issue when I gave evidence to the committee during its consideration of the bill at stage 1. The committee's recommendation in its stage 1 report was based on the evidence received from groups that represent the interests of people who have disabilities, such as the independent living in Scotland project, Self Directed Support Scotland and the Scottish Consortium of Learning Disability.

There have been challenges in shaping independent living principles into legislative proposals and putting them into the structure of the bill. For example, the key element of independent living choice is already dealt with by the provisions in the bill that enshrine choice and by the general principles in section 1(2).

However, I am confident that amendment 1 succeeds in introducing on to the face of the bill core principles of independent living: being treated with dignity and having your desire to participate in community life respected. I am confident that the amendment will help to ensure that the existing principles contained in section 1—principles that are largely concerned with the process of self-directed support—are accompanied by ones that define the end goal of the person's social care assessment and care and support plan. Self-

directed support processes need to be informed by that end goal.

The independent living principle will join the existing Social Work (Scotland) Act 1968 duty on local authorities to promote social welfare and in many respects it will reinforce and provide a modern interpretation of that end goal of social care.

As with the principles in section 1, the principles that are introduced by amendment 1 will help to guide practitioners when they implement the various duties and powers that are contained elsewhere in the bill and when there is interaction with social care assessments and support provision. I ask the committee to support the amendment.

I move amendment 1.

11:15

Dr Simpson: I welcome the amendment. As the minister alluded to, I indicated that the amendment is an important expansion of the general principles that would incorporate some of the evidence that we had from those who were concerned to ensure that the principles included clearer aspects of independent living.

Nanette Milne: I, too, welcome the amendment.

Amendment 1 agreed to.

Section 2 agreed to.

Section 3—Options for self-directed support

The Convener: Amendment 2, in the name of the minister, is grouped with amendments 3, 21, 4 to 6, 22, 7, 7A, 11, 11A, 12, 12A and 20.

Michael Matheson: As committee members will be aware, section 3 defines the options for self-directed support that will be available to an individual when they are eligible for social care. In the bill as introduced, the direct payment option was described in section 3(2) as

"a payment of the relevant amount by a local authority to a supported person".

Amendments 2 to 7, 11, 12 and 20 have been lodged in response to concerns raised by stakeholders through the bill steering group that a transparent budget is a vital component of not just the direct payment but all the options that an individual may choose. In response to those concerns, amendments 2 to 5 introduce the element of "relevant amount" into the description of options 2, 3 and 4 in section 3(1). When considered alongside current option 1—the direct payment—it will mean that all four options for self-directed support will include a reference to a transparent financial resource.

Amendment 6 makes the necessary consequential amendments to the definition of "relevant amount"; it removes the current reference to "direct payment" and replaces it with a more generic reference to support, which is meaningful for all four options.

Amendments 7, 11 and 12 impose a further duty on local authorities to inform the individual—the child, the parent, the adult or the carer who is being provided with support—of the amount of funding available under the options and the period to which that funding relates. That ensures that there is transparency about the funding available, regardless of whether it is a service that will be arranged by the local authority, a direct payment or an individual service fund that the person may direct.

Amendment 21, in the name of Richard Simpson, seeks to make clear that the budget allocated for a person's support under option 2 can be managed by a third party; in other words, the budget could be managed not only by a local authority but by a delegated third-party provider organisation, which could manage with the consent of the supported person. In effect, that would be the same as a third-party direct payment whereby a sum of money is paid to someone other than the local authority or the supported person.

We intend to make provision for that in the regulations, using the regulation-making powers in section 13. That will allow for a more flexible approach, as some third parties may be providers but others may not be described as such; in other words, they may include brokerage organisations or, indeed, individuals. Statutory guidance will also make clear that the budget can be delegated to a third party and that that can include a provider organisation. I am clear that it is unnecessary to amend the bill to add detail that will be better situated in the regulations.

I suspect that, by lodging amendments 22, 7A, 11A and 12A, Richard Simpson is attempting to address unfairness in the setting of rates between various options. However, it is not appropriate for the Government to restrict flexibility without a full understanding of the potential consequences of doing so. In guidance, we will give full consideration to commissioning, procurement and finance issues that will lead to discrepancies in the application of resources that need to be addressed better. Furthermore, amendments 2 to 7, 11, 12 and 20 will increase the transparency of the choices that are available to individuals, which should lead to a fairer and more open system.

Therefore, I urge Richard Simpson not to move any of the amendments in his name. However, if he is minded to move them, I urge the committee to reject them.

I move amendment 2 and ask the committee to support the other amendments in my name.

Dr Simpson: I welcome amendments 2 to 7, 11, 12 and 20, because they increase transparency, which is an important first step in assuring people who apply for direct support about the money that they would get under the different options. That is extremely welcome.

However, my amendments address concerns. First, amendment 21 tries to put into the bill what is stated in paragraph 23 of the policy memorandum, which says:

"The resource can remain with the local authority or it can be delegated to a provider to hold and distribute under the individual's direction."

The Coalition of Care and Support Providers in Scotland and other organisations that are involved in social care have recommended that that should be in the bill. That is important. It is in the Government's policy memorandum, so having it in the bill would not in any way restrict the process. However, it would augment and enforce the fact that the third sector providers could, with the agreement of the supported person, act in that way.

I realise that that approach is not banned at the moment and that it can be implemented by regulation, but I believe that it should be in the bill, so I will press amendment 21.

Amendment 22 deals with the difference between the options, which will be transparent if we agree to the Government's amendments, and the fact that a local authority should not automatically assume that option 1 or 2 would cost less than option 3.

The committee received some evidence that, where direct payments were made, they were already less than the payments under options 3 and 4. Amendment 22 merely says that there should be no automatic assumption that that would be the case. The importance of the word "automatic" cannot be overstressed, because there may be circumstances in which it is necessary and appropriate for the local authority to offer different options under the bill. Those options will be transparent under the Government's amendments; under amendment 22, they will not automatically be different.

Under amendment 7A, which is linked to amendments 11A and 12A, the local authority will be required to provide in writing the reasons why there is a difference between the options.

I will illustrate a case in which that is a possibility. Let us take a day centre that is currently run by the local authority and which 15 people attend. With direct payments being offered, five people might opt out of that day centre provision. That would create considerable difficulties for the local authority's ability to sustain that provision for the remaining 10. In other words, the unit cost might rise. However, it is important that, as part of the process, we drive efficiency in the system. That means that, if the unit cost has to rise, we should understand why it must rise and what the local authority has done to try to reduce the unit costs so that the majority of the funds can be transferred to those who are undertaking self-directed care.

My approach builds on the Government's amendments. It ensures that the supported person and the individual who supports the person who seeks supported care, to whom we will come later, will see the difference in cost between the options clearly and, I hope, understand the local authority's reasons for varying the cost, but there will be no automatic variation.

Amendments 21, 22 and 7A lend considerable additional clarity, and I will pursue all three.

Bob Doris: I welcome amendments 2 and 7, which I think are necessary to ensure that all four options for self-directed support are clearly communicated to the person seeking to exercise them. It would have been remiss for that not to have been put on the face of the bill, so I am keen to support those amendments.

My concern about amendments 7A and 22, in the name of Richard Simpson, is that they hint at the resource allocation that may be formulated following the care assessment, whereas the bill does not touch on that. I see what he is trying to achieve, but I would like to think that any inappropriate assessments would be picked up by the care inspectorate during its routine inspection of the local authority. For that reason, I will not support amendments 7A or 22.

I will vote against amendment 21 just now, but I reinforce Richard Simpson's view that third-party providers in the voluntary sector should be seen as a key player—it should not just be the local authority. However, I will wait to see what appears in the guidance on that.

The Convener: Do other members want to speak to the amendments?

Dr Simpson: Convener, on a question of process, will I get the opportunity to respond to points raised against my amendments?

The Convener: No. I call on the minister to wind up.

Michael Matheson: I understand the objective behind Richard Simpson's amendments, but I think that the Government amendments bring a greater transparency to the process, which will be extremely valuable in helping people to get greater clarity on the decisions made by local authorities.

I remain of the view that the wider issues on which Richard Simpson has raised concerns are better dealt with through the guidance that will accompany the legislation. I have stated very clearly that, in the accompanying guidance, we will give full consideration to the issues around commissioning, procurement and finance that can lead to discrepancies in the allocation of resources. Alongside that, we will make it very clear in the regulations and in the guidance that a third party can hold an individual budget on someone's behalf. I believe that guidance provides us with greater flexibility in dealing with these issues, and I have given a clear commitment to the committee that we will give consideration to these matters as part of that guidance.

Amendment 2 agreed to.

Amendment 3 moved—[Michael Matheson]—and agreed to.

Amendment 21 moved—[Dr Simpson].

The Convener: The question is, that amendment 21 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 21 disagreed to.

Amendments 4 to 6 moved—[Michael Matheson]—and agreed to.

Amendment 22 moved—[Dr Simpson].

11:30

The Convener: The question is, that amendment 22 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 22 disagreed to.

Section 3, as amended, agreed to.

Section 4—Choice of options: adults

Amendment 7 moved—[Michael Matheson].

Amendment 7A moved—[Dr Simpson].

The Convener: The question is, that amendment 7A be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 7A disagreed to.

Amendment 7 agreed to.

Section 4, as amended, agreed to.

Section 5—Choice of options under section 4: assistance

The Convener: Amendment 23, in the name of Dr Richard Simpson, is grouped with amendments 8, 24, 9, 10, 27, 35, 14, 36, 15, 16 and 39.

Dr Simpson: Amendment 23, and the linked amendments 27, 35 and 39, have been sent to us by the Law Society of Scotland. It believes that the reference to adults with physical and mental disabilities creates an ambiguous and incorrect notion that section 5 should be applied where the supported person does not have capacity

"because of mental disorder or difficulties in communicating due to physical disability".

The removal of those terms broadens the definition, and means that local authorities must provide assistance to anyone who requires it.

The consequence of that is seen in amendments 27, 35 and 39, which either repeat amendment 23's requirements or remove the need for the mental health definition from the bill because, once the initial terms of mental and physical disability are removed, there is no need for such a definition.

Amendment 24 refers to the Adults with Incapacity (Scotland) Act 2000. I am sorry that it is written in the form of a double negative—it refers to the supported person being "not incapable". It must be written that way because the act refers to adults with incapacity, not adults with capacity. That is a hangover from the legal work carried out by the Health and Community Care Committee in the first session, which I was involved in, along with the minister.

The Law Society is concerned that the wording of section 5(2) does not place any obligation on the authority to ensure that the supported person has the capability and the capacity to make a decision. The amendment will place that obligation on the authority and it will ensure a safeguard against the appointment of assistance to a supported person who lacks capacity.

The Law Society is concerned that, without amendment 24, there will be a risk that the procedure under the bill may be used for people who lack capacity. Therefore, the effect of the amendment will be to add conditions that must be satisfied to determine whether assistance should be provided to the supported person.

Consequential to that, amendment 36 deals with the question of competence and simply says that if the local authority is satisfied that the supported person is not incapable, it can go ahead with the assessment. It amends a later section, which deals with assessment.

Amendments 9, 10 and 14 to 16, in the name of the minister, are helpful amendments and I welcome them.

I move amendment 23.

Michael Matheson: It feels like only yesterday that we were dealing with the Adults with Incapacity (Scotland) Bill.

I will respond to Richard Simpson's amendments and also speak to amendments 8 to 10 and 14 to 16, which are in my name. Amendments 23 and 35 seek to remove the phrase

"because of mental disorder or difficulties in communicating due to physical disability"

from sections 5 and 15. That will widen the effect of sections 5 and 15 to allow assistance to be provided to anyone who might need it. However, that would contradict the policy intention of sections 5 and 15, which is to underpin specific types of assistance, particularly that which might be required by people who have a mental disorder or difficulty in communicating. Sections 5 and 15 are not intended to provide general assistance to all social care clients. I recommend that that focus be retained in sections 5 and 15.

Amendments 24 and 36 seek to add a detailed requisite that the local authority must be satisfied that the supported person has capacity to agree that another person should be involved in assisting them in making decisions about relevant matters and in choosing one of the options prior to identifying someone who could assist them. Although I agree with Richard Simpson's broad aim of underpinning positive social work practice, we should bear in mind that sections 5 and 15 do not provide for a formal appointment process under which individuals might make decisions on another person's behalf. However, I give Richard Simpson the commitment to use the powers that are provided elsewhere in the bill to provide clear and unambiguous statutory guidance to local authorities on the matter. I fully intend for that guidance to cover those important good practice principles.

Amendments 8 to 10 and 14 to 16 were lodged partly as a response to a concern that was raised by the Law Society, the Mental Welfare Commission, and the Office of the Public Guardian in their evidence to the committee. The committee's stage 1 report asked the Government to consider their concerns, and it is in response to the committee's request that I have lodged the amendments in the group.

Amendments 9 and 15 have exactly the same purpose and effect. Amendment 9 relates to assistance in making the choice in relation to section 3. Amendment 15 relates to assistance to complete the initial assessment of social care needs. The amendments will ensure that local authorities must have the supported person's consent to the individual who may have been identified to assist them in making or communicating their decisions. That reinforces the position that assistance from other individuals under sections 5 and 15 will only be in relation to supported people who have capacity. The supported person must agree to any assistance in making decisions being provided by another person or persons. At the point of consent, the supported person would demonstrate that he or she has capacity. I hope that that deals with the concerns that Richard Simpson has sought to address.

The assistance provisions cannot be used where there is an appointed proxy under the Adults with Incapacity (Scotland) Act 2000. The bill currently defines such a proxy as a guardian or a

welfare attorney, and amendments 8, 10, 14 and 16 have been lodged following discussions with stakeholders who queried why the list of legal proxies was restricted to welfare attorneys and did not include continuing attorneys. I agree that it is necessary to add an explicit reference to such attorneys and amendments 8, 10, 14 and 16 seek to rectify the omission by adding the term "continuing attorney" to the list of individuals whose presence would disapply the assistance provisions.

In conclusion, I urge the committee to support amendments 8 to 10 and 14 to 16 and ask Richard Simpson to withdraw amendment 23 and not to move the other amendments in the group. If he is minded to press amendment 23 and move the other amendments, I urge the committee to reject them.

Dr Simpson: I welcome amendments 8, 10, 14 and 16 and the addition of continuing attorneys to the list of proxies, which is a logical and welcome step. Moreover, amendments 9 and 15, which seek to ensure the agreement of the supported person, are pretty important, and I welcome the fact that the Government has listened to stakeholders on this matter.

That said, although it might at first sight be clear that a supported person who does not have capacity should not be invited to decide whether they need assistance, that is in fact not clear in the bill and should be made clear. Putting it into statutory guidance would be a welcome move and, if amendment 24 is not agreed to, we will look at the suggestion to see whether it would be acceptable to those who support the amendment. At the moment, however, I will press amendment 23, because I think that we need to make this issue clear in the bill by deleting the references to "mental disorder" and "physical disability" and thereby broadening the definition. The local authority should, in initiating an assessment, reach a view as to whether the supported person requires additional assistance to make informed decisions. As that is not the same as whether they have capacity—after all, the person in question might have communication difficulties or might because of other vulnerabilities want to involve another person—I believe it entirely appropriate to broaden the term as suggested by the Law Society.

I will therefore press amendment 23 and move the other amendments.

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

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 23 disagreed to.

Amendment 8 moved—[Michael Matheson]—and agreed to.

Amendment 24 moved—[Dr Simpson].

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

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 24 disagreed to.

11:45

The Convener: Amendment 25, in the name of Richard Simpson, is grouped with amendments 26, 37 and 38.

Dr Simpson: Amendment 25 is another amendment that we received from the Law Society of Scotland, which is concerned that the bill does not provide the necessary safeguards or place an obligation on local authorities to protect against undue influence being exerted over an assisted person. The amendment would require that the authority take reasonable steps to ensure that any person who is appointed to assist someone is suitable, in accordance with the new subsection proposed by amendment 26.

We have had cases in which relatives have acted in a manner that was substantially overrestrictive on individuals who have capacity. I am not talking about people who may, through

learning disability, have incapacity, as they would be treated and protected differently. The amendment provides a protection whereby the local authority must ensure that the individual does not exert undue influence, overly restrict the person or use the funds in an inappropriate way.

Amendment 26 is a consequential amendment that sets out how a suitable person would be identified. It requires the local authority to have regard to the variety of conditions that are set out in the amendment and to be satisfied that they have been met.

Amendments 37 and 38 simply repeat the contents of amendments 25 and 26.

I move amendment 25.

Michael Matheson: Section 5(4) requires the authority to

"take reasonable steps ... to identify persons having an interest in the care of the supported person".

Richard Simpson's amendments 25 and 37 would change the wording to a person

"who the authority considers ... suitable"

and his amendments 26 and 38 provide various tests against which the person's suitability should be measured.

Although I agree with the broad aim that Richard Simpson has in mind—namely, to underpin positive social work practice—we should bear it in mind that sections 5 and 15 do not provide a formal appointment process where individuals may make decisions on another person's behalf. However, it would be appropriate—and again I give Richard Simpson a commitment on this—to use powers that are provided elsewhere in the bill to provide clear and unambiguous statutory guidance to local authorities on the matter. I fully intend the guidance to cover these important good practice principles.

I therefore urge Richard Simpson to withdraw amendment 25 and not to move the other amendments in the group. If he is not minded to do so, I urge the committee to reject amendments 25, 26, 37 and 38.

Dr Simpson: Guidance is guidance. We have had cases in Scotland in which relatives have had undue influence over vulnerable people. I believe that it is imperative that we have the provisions that I propose in the bill in order to ensure that the local authorities ensure that the situation does not arise. I am fearful that we might have future scandals if that is not the case. I therefore strongly urge the committee to support the amendments in my name. I press amendment 25.

The Convener: The question is, that amendment 25 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 25 disagreed to.

Amendment 9 moved—[Michael Matheson]—and agreed to.

Amendment 26 not moved.

Amendment 10 moved—[Michael Matheson]—and agreed to.

Amendment 27 moved—[Dr Simpson].

The Convener: The question is, that amendment 27 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 27 disagreed to.

Section 5, as amended, agreed to.

Section 6—Choice of options: adult carers

Amendment 11 moved—[Michael Matheson].

Amendment 11A not moved.

Amendment 11 agreed to.

Section 6, as amended, agreed to.

Section 7—Choice of options: children and family members

Amendment 12 moved—[Michael Matheson].

Amendment 12A not moved.

Amendment 12 agreed to.

The Convener: Amendment 28, in the name of Mark McDonald, is grouped with amendment 29.

Mark McDonald: I will keep this pretty short and sweet. Amendments 28 and 29 follow on from a conversation that I had with Barnardo's and relate to the United Nations Convention on the Rights of the Child, specifically article 12, which assumes that all children have the right to be heard, with no age limit applied and no definition of the age of maturity. I believe that the small textual change that amendment 28 would make would reinforce that principle within the bill. I have lodged amendment 29 as amendment 28 will have the knock-on consequence of rendering section 7(6) superfluous.

I move amendment 28.

Michael Matheson: I support Mark McDonald's amendment 28 on a child's involvement in decisions about self-directed support options when they directly affect a child. The Scottish ministers believe that it is right that all children should have the opportunity to express their views on how they lead their lives. The provisions should encourage professionals to give weight to the views of younger children where there is a considered need for an appropriate course of action. I believe that that is very much in keeping with the bill's principles and that all people should be involved in decisions about their support. I therefore urge the committee to support amendments 28 and 29.

Amendment 28 agreed to.

Amendment 29 moved—[Mark McDonald]—and agreed to.

Section 7, as amended, agreed to.

Section 8—Provision of information about self-directed support

The Convener: Amendment 30, in the name of Alison McInnes, is grouped with amendment 31.

Alison McInnes (North East Scotland) (LD): Good morning, convener. I hope that amendments 30 and 31 are uncontentious. My intention is to make it clear that the provision of information should be tailored to the individual's needs. If there is truly to be choice, it will not be enough simply to hand out a leaflet that explains what people's options are. The bill's intentions are good, but I hope that the amendments will strengthen it by ensuring that local authorities take a person-centred approach to the provisions.

With regard to amendment 31, there is no doubt that, in many cases, people will benefit from having more control over their care or the care that is provided to their children. Although I hope that amendment 31 would assist everyone, I am thinking in particular of parents who are caring for a child with complex needs in a family. As we all know, those parents are involved in care 24/7, and they are often exhausted by the demands of care. Self-directed support might well provide a more responsive care package for them, but the requirements to set up recording mechanisms and budgets and to secure the services themselves would be a burden too far for some of those parents. Amendment 31 would ensure that local authorities provided the proper support to people to allow them to have a choice. I am grateful to Aberlour for working with me on drafting the amendment.

I move amendment 30.

Michael Matheson: The bill aims to ensure that people have informed choices about self-directed support and understand not only what the four options are, but which of those options will best meet their needs.

Amendment 30, in the name of Alison McInnes, would make it explicit in the text of the bill that the explanation of the options for self-directed support must relate to each person's circumstances. Section 8(2)(a) already requires the local authority to explain the nature and the effect of each option. The nature and effect, and what each option means in practice, will vary from person to person. I consider that the point is already covered and that that level of detail is appropriate to the statutory guidance that will accompany the bill.

Access to practical information and assistance is a significant element in shaping a successful support package. Amendment 31, in the name of Alison McInnes, would place a specific example of a person who can provide a particular type of assistance in the text of the bill. Section 8(2)(c) already requires the local authority to provide a supported person with information about other organisations that can provide information and assistance, and in particular information about managing support. That is a broad provision, and I consider that such information about managing support would include advice about structuring and commissioning a support package.

In addition, section 8(2)(b) requires the local authority to give the supported person information about how to manage their support. Again, that is a broad provision that will cover all aspects of advice about managing support, including those that are specifically listed in amendment 31. Those provisions will be underpinned by statutory guidance that will provide further detail about the level of support and advice that a person should expect to receive.

Amendments 30 and 31 are therefore not necessary, and their sentiments are best covered in the statutory guidance that will accompany the bill. I do not support amendments 30 and 31, and I ask Alison McInnes not to press amendment 30 and not to move amendment 31.

The Convener: I ask Alison McInnes to wind up and press or withdraw amendment 30.

Alison McInnes: I hear what the minister says, but to allow for truly informed choice I would like those assurances to be in the bill. That will ensure that local authorities have no wriggle room in interpreting how they implement the regulations. I press amendment 30.

The Convener: The question is, that amendment 30 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 30 disagreed to.

Amendment 31 moved—[Alison McInnes].

The Convener: The question is, that amendment 31 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 31 disagreed to.

Section 8 agreed to.

After section 8

12:00

The Convener: Amendment 32 is in a group on its own.

Drew Smith: The purpose of amendment 32 is to include provisions for independent advocacy and, specifically, to enshrine in the bill a right of access to independent advocacy.

I should first be clear about what independent advocacy is and is not. During the stage 1 debate on the bill, the minister said that impartial information and advice are crucial. In direct response to that, the Scottish Independent Advocacy Alliance said in its briefing of 17 October:

"While the Bill contains duties on councils to signpost people to sources of impartial advice, this would by its nature not include advocacy. Independent advocacy should never be impartial; the point of independent advocacy is that it is there to stand firmly on the side of the individual, listening to them and supporting them to make their own decisions and choices. While an advocacy organisation will support an individual to gather all relevant information advocacy will not offer advice on choices."

The reasons why that is important in the context of the bill were well explained by Pam Duncan in evidence to the committee, when she said that

"the provisions in the bill should be as strong as those in the Mental Health (Care and Treatment) (Scotland) Act 2003 that give a right to independent advocacy. That is our view not just because the default position is choice, and, therefore, people must have support in order to make that choice, but because of the intricate situations that disabled people and other care service users experience. It is important that we make the bill strong on those aspects."—[*Official Report, Health and Sport Committee*, 22 May 2012; c 2329.]

That is not likely to be required by everyone making use of the provisions for self-directed support outlined in the bill. I would go further and say that it would not be necessary, desirable or—to refer to the evidence that we heard—proportionate for everyone. To be clear, the purpose of amendment 32 is not to create compulsory advocacy; rather, it is simply to ensure that there is a guarantee of an opportunity if it is required by those outlined in subsection (1) of amendment 32.

I am sure that no one around the table, including the minister, disputes that advocacy has a crucial role to play in the increasing take-up of self-directed support. The question is only whether we acknowledge that a right to it is more likely to ensure that all those who need it can get it, regardless of whether advocacy services are well supported in all areas of Scotland in future. Some local authorities that have developed self-directed support have already placed a strong emphasis on advocacy, particularly when it comes to needs

assessments, but we know from evidence that others have not.

I hope that members will support amendment 32. If the Scottish Government is not minded to do so, I hope that the minister will indicate whether he would be willing to have further discussion about alternative wording that might satisfy any concerns that the Government has and address the concerns that I and, I think, many others raised at stage 1.

I move amendment 32.

Mark McDonald: I understand the intention behind amendment 32. The difficulty that I highlight is that it appears to set in train a process that may at the end be unnecessary in so far as it requires the local authority to secure the availability of independent advocacy services before determining whether advocacy services are already operating on the individual's behalf or whether the individual wishes to make use of independent advocacy services. Subsection 2(b) of the amendment is about taking appropriate steps to ensure that the individual has the opportunity to make use of the services. It may be that they do not wish to use that opportunity or that that opportunity is not necessary, but the local authority will still have had to go through the process of securing the potential independent advocacy service. There is a little bit of cart before horse in the wording of the amendment. On that basis, I do not think that I can support it.

Bob Doris: I listened with interest to Drew Smith's comments. I have some sympathy with what Mark McDonald said in terms of the wording of the amendment, but I also have strong sympathy with the distinction that Drew Smith draws between advocacy, and advice and information, and I think that some of his points were well made. I am not minded to support the amendment, but I am keen to hear what the minister says. I remain open minded as to how we deal with the issue.

Gil Paterson: Some good points have been made by all who have spoken. My concern touches on what Mark McDonald said. We have only a finite amount of money and I am worried about putting in place bureaucracy for something that we do not need. People can access a service at the present time. Implicit in this amendment seems to be a requirement to provide the service even though the majority of people will not go and get it.

At the moment, there is capacity in the system to look after those who need help. I do not think that it makes any sense to build in additional bureaucracy.

Nanette Milne: Many of the stakeholders from whom we have heard during the passage of the bill have made the case for the need for a right to independent advocacy, if required, and for that to be in the bill. People such as Pam Duncan made extremely good cases in that regard. In general, there is a good case for what is suggested. I am therefore inclined to support the amendment. I await the minister's comments with interest.

Dr Simpson: I, too, await the minister's comments with interest. Independent advocacy is a critical part of the whole structure. In answer to Gil Paterson's point, the local authority should procure the service on the basis of individual cases and there should not be a generalised setting up of an independent advocacy service. That is perfectly possible. As Drew Smith said, only the cases of those who wish to avail themselves of the service would involve a cost to the local authority. It is imperative that no one should be prevented from undertaking what is proposed in the bill—which the Government is also keen on—because they do not have independent advocacy in order to ensure that their assessment and the package that they are offered are appropriate for them.

Michael Matheson: I am clear that independent advocacy services have a vital role to play in the delivery of the bill and that independent advocacy plays a vital role in helping those who need support to express their views, but I am not convinced that a general right to advocacy should be provided in the bill.

As I said at stage 1, people should have access to a range of support services, but not everyone will want or require an independent advocate in every instance. That view was shared by this committee in its stage 1 report.

It would be inappropriate for the bill to privilege one type of support when many people will choose to access support from other sources, such as carers organisations and user-led support organisations.

It is worth highlighting that a large group of people will have a right to advocacy as part of their social care assessment under the Mental Health (Care and Treatment) (Scotland) Act 2003, which provides a right to advocacy for every person—adult and child—with a mental disorder, as defined under section 238 of the act, which includes people with learning disabilities and mental ill health.

It should reassure the committee to know that the statutory and best-practice guidance that will accompany the bill will advise social work professionals to consider whether advocacy is required each time that they have a discussion with or assess an individual.

I would be happy to have further discussions with Drew Smith on the matter prior to stage 3.

However, I ask Drew Smith to withdraw amendment 32. If the amendment is pressed to a vote, I ask the committee to reject it.

The Convener: I ask Drew Smith to wind up and say whether he will press or withdraw amendment 32.

Drew Smith: I spoke at some length when moving amendment 32, so I hope that I will now be a bit quicker.

To respond to Mark McDonald's and Gil Paterson's points, it is quite clear that what we are doing is providing an opportunity, not a system whereby everyone would have to have an advocacy service or an advocate appointed in order for them to demonstrate that they did not need one. That would not be a sensible way to proceed and that is not what amendment 32 proposes.

I am grateful for others' comments. We took quite significant evidence on this issue at stage 1 and there has been considerable debate about it. I think that we are all clear, minister, that not everyone requires advocacy, but advocacy is different from some of the other kinds of support that you mentioned. To my mind, the bill is all about choice. I said at stage 1 that in order for us to achieve what the bill intends, the choices that people make must be meaningful. For that to be the case, people's voices need to be heard, which is a separate issue from that of the other support that individuals might seek.

An independent advocate has the crucial role of ensuring that people's voices are heard. By not including in the bill a right to independent advocacy, we run the risk of creating a situation whereby a person in any local authority in Scotland who required an independent advocate in order to exercise meaningfully the choice that the Parliament seeks to give them would be unable to access that advocate because we had failed to provide the right to do so.

In light of the minister's comments that he is willing to have some further discussion about the issue before stage 3, however, I am happy to withdraw amendment 32.

Amendment 32, by agreement, withdrawn.

Sections 9 and 10 agreed to.

Section 11—Further choice of options on material change of circumstances

The Convener: Amendment 33, in the name of Alison McInnes, is in a group on its own.

Alison McInnes: I hope that amendment 33 is self-explanatory. It is not made clear in the bill that opting for self-directed support is a reversible choice. For it to be a proper choice, people must be able to say "I've tried this, but it's not working for me." So, it should not be about only a change of circumstances, but about what is best for the person. I am concerned that, as it stands, the reference in section 11(1)(c) to "material change" could be interpreted very narrowly. Amendment 33 would provide greater clarity.

I move amendment 33.

Gil Paterson: One aspect of the need for the bill is that assessments in some parts of the system have not been good. However, it is implicit in what the Government is doing through the bill that assessments will be done regularly, and that should be picked up. The suggestion that the bill will in some way fix in place a person's choice is patently wrong, because people will be able to make their choice within a rolling programme. I cannot therefore support amendment 33. I agree with what Alison McInnes said about the issue, but I think that it is implicit in what the bill is trying to do that choices will be readily available and that councils will engage with individuals, monitor what happens to them and make any required changes, which will be based on what the individual thinks is good for them.

Dr Simpson: Section 11(2) states:

"The authority must offer the person another opportunity to choose one of the options".

Section 11 is about further choice and material change of circumstances. I am therefore not sure that Alison McInnes's amendment 33 would add further appropriate layers. However, before I come to a conclusion on the matter, I want to hear what the minister has to say on it.

Michael Matheson: The bill already provides significant opportunity for a person to change options if necessary. Section 11 will require local authorities to offer individuals the opportunity to change their choice of options when they become aware of a material change in circumstances.

When a person decides that the selected option is not appropriate to their circumstances, they will have to make the local authority aware of the change. In that situation, the bill already provides for the opportunity for change. Section 11(3) provides that the authority and the person may agree that the opportunity to choose another option can be taken up, even if there has not been a material change of circumstances.

I do not believe that it would be appropriate to oblige the authority to offer another choice for reasons that were determined solely by the supported person. When there is not a material change of circumstances, the correct balance is that the authority and the supported person agree to a review.

Nevertheless, we need to be clear that when a person's support does not meet the outcomes that were agreed in their support plan, the support must be reviewed and other options must be considered. The statutory guidance that will accompany the bill will make that clear.

Therefore, I invite Alison McInnes to withdraw amendment 33.

12:15

Alison McInnes: I appreciate Gil Paterson's comments. He said that people's ability to change their choice

"is implicit in ... the bill".

It is, indeed. What I am trying to do is to make it absolutely explicit.

The minister mentioned that a "material change" would be the trigger for reconsideration of a case. I am trying to have it defined that one such material change would be the individual's saying that their chosen option just does not work for them, even though they had thought that it would. The local authority might well say that their circumstances have not really changed, so I suppose that I am proposing a belt-and-braces approach.

I will press amendment 33.

The Convener: The question is, that amendment 33 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Torrance, David (Kirkcaldy) (SNP)

Abstentions

Milne, Nanette (North East Scotland) (Con)

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

Amendment 33 disagreed to.

Alison McInnes: Might I excuse myself and return to the Justice Committee?

The Convener: That is fine—you are spared.

Section 11 agreed to.

Section 12—Power to modify section 3

The Convener: Amendment 13, in the name of the minister, is grouped with amendments 17, 18 and 19.

Michael Matheson: The amendments in the group arise from discussions with and consideration of the recommendations by the Subordinate Legislation Committee. Before I explain their purpose and effect, I again express my thanks to that committee for the role that it has played in scrutinising the subordinate legislation powers in the bill.

Amendment 17 will make consultation a formal precondition before draft regulations that are made under section 12 or section 21 can be laid before Parliament. That requirement will be in addition to use of affirmative procedure, which already applies to such regulations that are to be made under the bill. I hasten to add that the Scottish Government would have every intention of consulting before modifying any of the options or disapplying the local authority duty. However, I agree with the Subordinate Legislation Committee that, in this case, it is expedient to make that a statutory obligation.

Amendment 13 applies to the power to modify options that is contained in section 12. It seeks to add sections 13(2)(b) and 21(1A) to the list of provisions that may be amended under section 12. It is a necessary technical amendment, as both those provisions may require consequential amendment if the power in section 12 is used.

Last, I turn to amendments 18 and 19, which relate to section 21 of the bill, which provides a power to disapply the duty to offer self-directed support options in specific circumstances. The purpose behind the proposed power is primarily associated with options 1 and 2, where there are likely to be specific circumstances in which choice over provision would simply not be appropriate. The intention is to remove choice in such circumstances, not to remove support. Amendments 18 and 19, therefore, clarify that if the section 21 power is used, the regulation "must"—rather than "may"—include provision to deem a person to have chosen option 3.

I move amendment 13.

Dr Simpson: If ministers are going to have the power to modify by regulation primary legislation, which appears to me to be the case under section 12(a), under which modification of section 3 might occur simply on the wish of the minister, it is vital that we have extensive consultation. I remain nervous about the section because I do not believe that we should be able to amend primary legislation in this way. Options 1 to 4 cover the bases of self-directed care and I cannot conceive of a situation in which those options might need to

be modified. However, I am comfortable enough to support the Government's amendments at this point in time, but I want to take further advice before stage 3 to determine whether section 12, as it is currently written, is appropriate.

Michael Matheson: Our amendments reflect the Subordinate Legislation Committee's recommendation that we ensure that there will be full public consultation prior to any changes. Changes might be required in the future so that we can adapt to innovation in social work practice. During the past 15 to 20 years, social care provision has changed dramatically, so it is appropriate to have in the legislation provision, with the appropriate checks and balances, that will allow it to be modified to reflect innovation.

Amendment 13 agreed to.

Section 12, as amended, agreed to.

Section 13—Power to make further provision about direct payments

The Convener: Amendment 34, in the name of Jackie Baillie, is grouped with amendments 43 and 17A.

Jackie Baillie (Dumbarton) (Lab): Thank you, convener. I was going to wish you good morning, but we seem to have slipped into the afternoon.

I gather that amendment 34 has excited a degree of interest, and rightly so. Indeed, the committee spent some time considering the issue, which is about whether it is appropriate to register or regulate personal assistants. It is important to say at the outset that I accept that many disability organisations and disabled people do not want regulation. They prefer people not be viewed as being vulnerable or as needing protection. I understand all that. They would prefer that people be given the tools that will allow them to make the right choices. Again, I agree with that.

I also recognise that a disabled person might want the right to employ a personal assistant because that is the way for them to remain in control of much more flexible support. I accept that there is a view that the focus should be on training the disabled person to become a good employer and to recruit safely, rather than their having to rely on legislation.

Although I recognise and support those views, it is Parliament's job to weigh up potential risks. I have received correspondence from parents that has caused me to stop and reflect a little more on the question, as I am asking the committee and the minister to do. Those parents were worried about the safety of their child. He is a vulnerable adult who lives independent of his parents, but he has complex needs. Naturally, his parents do not want him to be taken advantage of in any way or under any circumstances—I am sure that we all agree with that—but they feel that the reassurance of registration and regulation would be important for their peace of mind and their son's wellbeing.

We need to recognise that there have been instances of abuse that have not been confined to residential homes and which have shocked us. People have absolutely abused their positions of trust, and the question for all of us is how we can guard against that. I do not believe that only the process of registering or regulating personal assistants will be a panacea, but it will require us to give much more serious thought to how we can achieve a balance between the needs of disabled people who rightly want their independence and want to decide how to employ their personal assistants, with the needs of more vulnerable people. It is incumbent on us to strike that balance.

I am struck by the fact that, when those who are responsible for regulation and registration appeared before the committee, there was a divided view on how best to proceed. That underlines the genuine quandary that the committee and the Government face. The Coalition of Care and Support Providers in Scotland argued for a basic level of accreditation and for people being the subject of protection of vulnerable groups checks. The Scottish Social Services Council argued for registration, minimum induction training and distinguishing complex care and care for particularly vulnerable service users so that that category could be regulated without unfairly limiting personal choice for everybody else.

I recognise that the minister and the committee do not want the overprofessionalistion of personal assistants. I share that view, but the committee considered that more could be done to reduce risk and thought that there is merit in the recommendations from the Scottish Social Services Council. Amendment 34 would not put that in the bill and does not suggest that that needs to be done now. To put things quite simply, it would give a power to ministers to make regulations at some point in the future. That does not mean that they have to do so, but that they could if they considered that to be necessary. On balance, that is an effective safety net for the future.

Amendment 43 is related to amendment 34. It seeks that the regulations be subject to affirmative procedure rather than to negative procedure. That reflects the importance of the issue and the need to engage in more discussion and scrutiny should such regulations come before Parliament. I recognise that the Subordinate Legislation Committee believes that use of the negative procedure in section 13, which deals with

secondary legislation, is appropriate. However, we would be adding something quite substantial, which is why I have gone for affirmative procedure.

Amendment 17A is, of course, a technical amendment that reflects the minister's consideration of the Subordinate Legislation Committee's recommendation.

I move amendment 34.

Drew Smith: I will be brief.

I associate myself with what Jackie Baillie has said about the desire of many people who will be affected by the bill for independent living, and recognise the sensitivities that the amendment raises. However, rather than our thinking that we have resolved the matter at stage 2, Jackie Baillie is probably right to highlight the fact that the effect of what is proposed would be to provide ministers with the power and the option to think about registration and regulation in the future, should that be deemed necessary. I do not think that the issue was resolved in the evidence that we heard; quite significant questions remain.

I hope that a future registration, regulation or other scheme would support people who are employed as personal assistants. In thinking through registration issues, we often open the door to training and other opportunities. We may not want to professionalise the workforce, but we have a responsibility in any labour situation to consider both sides and to ensure that people are properly supported, whether they are the procurer or provider of the service.

12:30

Nanette Milne: As Jackie Baillie has suggested, we tread a fine line here in seeking to regulate in respect of people who really do not want a fully qualified registered assistant. Nevertheless, Parliament needs to protect vulnerable people and, where we can and as far as possible, we want to prevent their being put in vulnerable positions and being abused. As a result, I agree with amendment 34—in particular, given that the measure will be set out in regulations and subject to affirmative procedure.

Bob Doris: The committee has been finely balanced on the matter, and I do not think that I have reached the point of agreeing that the power that is set out in amendment 34 should be extended. I am slightly nervous that, with this kind of power, there might be an expectation from certain groups about its use and we are not yet clear about how it might be taken forward.

Members have also talked about professionalising the at-home workforce and personal assistants. We should be careful about how we use the word "professionalisation"; after all, some of those people are deeply professional and caring individuals. However, I want to associate myself with the comments that have been made about supporting care staff. I do not think that that needs to happen through regulation, but we certainly need to look at how we might provide more support in such situations.

Gil Paterson: I do not think that the points that I want to make have been covered yet.

I am anxious about the issue. On one hand, we are seeking to provide more opportunities for family members. A whole lot of things are going through my mind about that; indeed, I have already mentioned the issue.

Vulnerable people come in many guises. I do not want to play to the television, but I need only highlight the Jimmy Savile case. Who would ever have imagined that such things were happening in front of our eyes to 14-year-old children on television? As heavily involved as I am in these matters, I simply do not think that you can regulate for them or put anything in place that covers all the issues.

I am also worried that in regulating for everyone we might in some way stigmatise the unregulated personal assistants who are already doing a good job. I am caught between two stools: I want to protect not only vulnerable people but ordinary family members who might already be doing the work of personal assistants very well and in a very professional way. I worry about putting in place something that might professionalise part of what we are seeking to provide. I want to hear what the minister has to say.

Michael Matheson: Amendment 34 seeks to introduce a regulation-making power to enable ministers to establish a scheme to regulate the quality of support that is provided by personal assistants who are employed through direct payments. One of the key strengths of the self-directed support mechanism is the flexibility that it affords individuals, and a key factor of that flexibility is the workforce's response to it.

It is also worth keeping it in mind that it is not compulsory for anyone to choose a direct payment and that there are three other options they can choose. At stage 1, witnesses from groups representing disabled people, including the independent living in Scotland project and the Scottish Personal Assistant Employers Network, explained in personal terms the vital importance of people being able to choose their own employees and taking responsibility for their training. Indeed, the committee will recall how Pam Duncan from the independent living in Scotland project explained that what is important to her is not that her PA has been on a food hygiene course but

that they know how to blow-dry and straighten her hair.

I am not convinced of the need for a regulation-making power that would, if it was used, limit flexibility, especially given that there are already proportionate safeguards in place to protect people who employ or receive support from a personal assistant.

The protecting vulnerable groups scheme strikes a balance between proportionate protection and robust regulation. A personal employer who chooses to employ a PA who is a member of the PVG scheme is entitled to see that person's scheme membership statement to confirm that they are not barred from doing regulated work with adults or children.

Social workers have significant adult protection duties, including a responsibility to ensure that the personal employer understands the importance of PVG scheme membership, the rules on seeking and sharing information and the risks of employing an unsuitable individual.

Social workers also have a critical role in ensuring that employers of a PA fulfil their responsibilities in training their PAs in the skills that are necessary to meet the needs of the supported person. In complying with their duty of care, social workers must use their professional judgment when they sign off a direct payment package that involves a PA. If they do not think that the PA can provide the services that are necessary to meet the assessed needs of the supported person in a safe way, they must not agree to that support package.

As I mentioned in my response to the Health and Sport Committee's stage 1 report, Scottish Government officials are working closely with their partners, including the SSSC, to improve the training and awareness of PAs through the SDS workforce action plan. The Scottish Personal Assistant Employers Network and a number of other local organisations are already supporting employers in recruitment and training.

The Scottish Government is supporting the self-directed support in Scotland initiative, in partnership with the Association of Directors of Social Work, to map the range and variation in information and support that is provided on self-directed support throughout Scotland. The information from that exercise will inform further activity to ensure that there is comprehensive national advice on PA employment, including information about SSSC codes of practice.

In striking a balance between the need for proportionate safeguards and the right of individuals to make decisions, I do not think that it is necessary or desirable to include a regulation-making power in the bill that is to establish a scheme for registration of PAs. Amendments 43 and 17A would make all regulations under section 13 subject to affirmative procedure and to a statutory duty to consult. There is perhaps some merit in applying those requirements to regulations to establish a regulation scheme. However, I have said that I do not support amendment 34. Even if that amendment is successful, amendments 43 and 17A go too far in that they apply to the whole of section 13, even where it is used to make other regulations about direct payments.

The Subordinate Legislation Committee was satisfied with the procedures and the consultation powers for the existing provisions in the bill. I therefore do not support the amendments in group 10, so I invite Jackie Baillie to withdraw amendment 34 and not to move amendments 43 and 17A.

Jackie Baillie: I intend to press amendment 34 and to move amendments 43 and 17A, and I will address the points that have been made. I say specifically to Bob Doris that legislation by the current Government and previous Governments is littered with powers that have not been used, so I do not think that the amendments would create an inappropriate expectation. The amendments are more about safeguarding those who are most vulnerable.

I say to the minister that I recognise and support the need for flexibility. We are trying not to have a scheme that covers absolutely everybody, but to have one that is proportionate. In his comments, the minister almost appeared to suggest that social workers themselves would assume a lot of those responsibilities. I do not think that that is reasonable, given their other duties, and in practical terms it is unlikely that that would be consistently applied.

In terms of subordinate legislation, I agree absolutely that section 13 is entirely appropriate for the current provisions in the bill. What I will be adding, if amendment 34 is agreed to, is a substantive new power for the minister to make regulations. I think that in those circumstances, even he would agree that affirmative procedure would be suitable.

This is all about striking a balance; I have tried at least to provide a proportionate response to some of the likely risks. Disabled people's view that they should be able to make their own choices about personal assistants is absolutely legitimate but, equally, it is our responsibility to safeguard those who may be particularly vulnerable. I rest on the fact that the advice to the committee was from the Scottish Social Services Council—the Government's own agency—and I urge the committee to listen very carefully to it.

The Convener: The question is, that amendment 34 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

McNeil, Duncan (Greenock and Inverclyde) (Lab)
Milne, Nanette (North East Scotland) (Con)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Torrance, David (Kirkcaldy) (SNP)

The Convener: The result of the division is: For 4, Against 5, Abstentions 0.

Amendment 34 disagreed to.

Section 13 agreed to.

Section 14 agreed to.

Section 15—Assessments under section 12A of 1968 Act: assistance

Amendment 35 not moved.

Amendment 14 moved—[Michael Matheson]—and agreed to.

Amendments 36 and 37 not moved.

Amendment 15 moved—[Michael Matheson]—and agreed to.

Amendment 38 not moved.

Amendment 16 moved—[Michael Matheson]—and agreed to.

Amendment 39 not moved.

Section 15, as amended, agreed to.

The Convener: I am conscious of the time so I am going to press on.

Dr Simpson: You are going to press on?

The Convener: I think that Bob Doris thinks that we should press on.

Bob Doris: We had previously said that 1 o'clock would be a good time to draw a line under things. The question is whether we can dispose of the next section by that time.

The Convener: I do not want to constrain the debate in any way, but committee members have been here for four hours hearing evidence from the cabinet secretary and participating in this process. We have time for this business next week, as well. Members may want to press on, but I cannot guarantee that we will finish at 1 o'clock.

Bob Doris: I think that we should hold off until next week, in that case.

Michael Matheson: I may have helpful comments for the two members who are moving the next set of amendments, which should help to move things on.

Jackie Baillie: Ooh.

The Convener: We are tempted. However, it is important for the committee to know that I cannot guarantee that we will not still be here at 1 o'clock. Some of us may have been here for five hours by that point. Shall we press on?

Bob Doris: Yes, let us press on. We are tantalised by what the minister has said.

Section 16—Power to charge for services provided under section 2

12:45

The Convener: Amendment 40, in the name of Jackie Baillie, is in a group on its own.

Jackie Baillie: Having packed up my stuff, I will rapidly unpack it in anticipation that the minister is going to say something interesting. I am very pleased to move amendment 40, and I hope that the committee—and, indeed, the minister—might be minded to accept it.

Section 16 introduces the prospect of charging carers for the services that they receive. I think that we should have regard to the unanimous view expressed to MSPs in the submission from all the carers umbrella groups in Scotland, which said:

> "The proposed Bill will give local authorities the power to charge carers for the services they are assessed as needing. We strongly oppose this. As key partners in care, and the largest contributors of care, it would be wholly unjust to charge carers for the cost of support which helps them to carry out their caring role."

It might be helpful to recall that the Community Care and Health (Scotland) Act 2002—which I am sure the minister was involved with—established the principle that carers are in fact care providers and therefore require resources, in much the same way as health and social care workers do, to enable them to fulfil their caring role. In some instances, that might mean training or respite, but usually it is an incredibly small amount of money to give the carers the tools to do the job or some light relief to sustain them in their caring. There is a distinction, therefore, between the support provided to carers and the support provided to those who are cared for.

Charging carers is very much contradictory to the principle enshrined in the 2002 legislation, but it is also contradictory to the approach taken by this Parliament. The committee's stage 1 report recognised the vital contribution of carers. The

Scottish Government regularly cites how much carers save the state by making the contribution that they make. It is clear that we value carers, but we need to do more than simply say that. If we support carers, we help them to continue caring. That benefits us all, because it benefits the person cared for and it can help to prevent a crisis by enabling the carer to carry on doing what they are doing.

On that point, and in anticipation of the minister's comments, I move amendment 40.

Michael Matheson: I note the arguments that Jackie Baillie has put forward in moving amendment 40.

Section 16 is largely a technical provision to provide consistency in the legislative powers on charging. Some argue that carers are providers in their own right and so charges should never be applied to any support that they might receive. I can recognise that there is merit in that view.

However, charging is a complex area—as I am sure Jackie Baillie is aware—and we need to be careful of any unintended consequence of the proposed amendment. We need to give detailed thought to the interaction between services being provided to the cared-for person and services provided to the carer. I would be happy to meet Jackie Baillie in the time permitted prior to stage 3 in order that we can discuss the possible consequences that I have outlined and consider whether further steps could be taken in this area.

In conclusion, I ask Jackie Baillie to withdraw amendment 40 and to meet with us prior to stage 3 so that we can discuss the issue further.

Jackie Baillie: While I do not accept that the amendment would have any unintended consequences, in the spirit of co-operation I am happy to withdraw the amendment and I look forward to my discussions with the minister.

Amendment 40, by agreement, withdrawn.

The Convener: That was, I hope, worth waiting for.

Section 16 agreed to.

Section 17—Promotion of options for self-directed support

The Convener: We move to amendment 41.

Nanette Milne: Amendment 41 is a probing amendment that is based on representations from the many organisations that make up Health and Social Care Alliance Scotland. The alliance feels that it is important that information on accessing self-directed support is offered to people who may be entitled to it at the very earliest opportunity, so that they can make informed decisions about their future support needs. For hospital in-patients, that should be when they are discharged home from secondary healthcare services.

The alliance feels that if local authorities communicated with health services in their area at that time, to identify people who may require information about SDS after a spell in hospital, that would lay the groundwork for effective collaboration between health and social services in seeking positive health and social care outcomes for long-term conditions and for people with disabilities.

Clearly, such co-operation will be essential if the integration of health and social care is to be effective. I would be interested to hear the minister's views on amendment 41 vis-à-vis the forthcoming legislation on the integration of health and social care before deciding whether to press or withdraw the amendment.

I move amendment 41.

Dr Simpson: My one concern is that, while it is appropriate to instigate a broad discussion, most services are now moving towards having an acute rehabilitative phase before an assessment of long-term needs is made, so I am not sure that the amendment is phrased in quite the way that I would want it to be.

Michael Matheson: The promotion of the availability of self-directed support under section 17 is broad and aims to ensure that local authorities actively publicise information so that people who may need support and people who work in local authorities are aware of the relevance of self-directed support to eligible people.

Amendment 41 proposes that local authorities must take reasonable steps to promote the availability of self-directed support options to—among others—people who are being discharged from hospital. I agree that, where a person who is discharged from hospital is eligible for support under the 1968 act, they should have the opportunity to choose one of the self-directed support options, and the bill already provides for that. Eligible people, including those who are discharged from hospital, must be given the options that are available under the bill. As I have stated in relation to other amendments, the statutory guidance will make that clear.

I do not think that amendment 41 would widen the provision that currently exists in the bill, and it would not be helpful to dilute the general nature of section 17 by picking out one type of group that is in need of support.

If amendment 41 is pressed to a vote, I ask that the committee rejects it.

Nanette Milne: Having heard the minister's views, I will press amendment 41.

The Convener: The question is, that amendment 41 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Milne, Nanette (North East Scotland) (Con)

Against

Doris, Bob (Glasgow) (SNP)
McDonald, Mark (North East Scotland) (SNP)
McLeod, Aileen (South Scotland) (SNP)
McNeil, Duncan (Greenock and Inverclyde) (Lab)
Paterson, Gil (Clydebank and Milngavie) (SNP)
Simpson, Dr Richard (Mid Scotland and Fife) (Lab)
Smith, Drew (Glasgow) (Lab)
Torrance, David (Kirkcaldy) (SNP)

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

Amendment 41 disagreed to.

The Convener: Amendment 42, in the name of Nanette Milne, is in a group on its own.

Nanette Milne: Amendment 42 is supported by the Health and Social Care Alliance Scotland and the Coalition of Care and Support Providers in Scotland. For individuals to have a real choice of social care services, there must be a range of high-quality personalised support services available to choose from. If nothing is done positively to promote and sustain the availability of a range of providers, it is likely that, in time, there will remain only a small number of providers, which are likely to be the large organisations that have sufficient economies of scale to survive.

Effectively, that would result in no real choice for service users. Amendment 42 seeks to put a duty on local authorities to take reasonable steps from time to time to ensure the continuing availability of a suitable range of providers. That would help to realise the bill's ambitions by giving greater choice and control to users within a diverse marketplace of service providers.

I move amendment 42.

Dr Simpson: I have considerable sympathy with what Nanette Milne proposes in the amendment. If there is no choice, the options clearly cannot be real.

The only bit of the amendment with which I have some concern is that it places the local authority in the position of having to sustain the services. That is going a step too far. Therefore, although I will be interested to hear what the minister has to say, I am minded to abstain on the amendment and reconsider it before stage 3.

Michael Matheson: Amendment 42 places a duty on local authorities to consider whether any steps could reasonably be taken to promote and sustain a diverse market for social care.

I appreciate the vital importance of ensuring that people have a range of services from which to choose. The bill is about meeting people's expectations that they will have choice and control over social care support that they receive. That choice and control are undermined if a person can choose between only a few providers in their area.

For the bill to have a meaningful impact, people must have choice within the market of service providers. However, I do not support Nanette Milne's amendment. I have concerns about local authorities taking steps to sustain a diverse market. We would have to give full consideration to the possible consequences of that—in particular, how it would interact with existing procurement legislation.

However, I support the principle behind the remainder of Nanette Milne's amendment. The way that local authorities procure and commission services affects everyone who receives social care services. Local commissioning strategies should be outcome focused and long term. They should set out how current provision needs to change to meet future needs.

The statutory guidance that will follow the bill will address in detail the role of local authorities in commissioning services and will help to ensure that the need to offer choice to people within the marketplace is embedded in local commissioning strategies.

In light of that, I would be happy to work with Nanette Milne with a view to drafting a workable amendment for stage 3 that would encourage local authorities to facilitate diversity. Therefore, I invite her to withdraw amendment 42.

Nanette Milne: In view of what the minister said, I am happy to withdraw the amendment. Clearly, he accepts the principle.

Amendment 42, by agreement, withdrawn.

Section 17 agreed to.

Sections 18 and 19 agreed to.

Section 20—Regulations: general

Amendment 43 not moved.

Amendment 17 moved—[Michael Matheson].

Amendment 17A not moved.

Amendment 17 agreed to.

Section 20, as amended, agreed to.

Section 21—Power to modify application of Act

Amendments 18 and 19 moved—[Michael Matheson]—and agreed to.

Section 21, as amended, agreed to.

Section 22—Interpretation

Amendment 20 moved—[Michael Matheson]—and agreed to.

Section 22, as amended, agreed to.

Sections 23 to 27 agreed to.

Long title agreed to.

The Convener: *That ends stage 2 consideration of the bill. I thank members for their participation and patience, which enabled such good progress.*

Members should note that the bill will be reprinted as amended and will be available from tomorrow morning. Parliament has not yet determined when stage 3 will take place, but members can now lodge stage 3 amendments with the legislation team at any time. Members will be informed of the deadline for lodging amendments once it has been determined.

I thank the minister, his team and all the others who participated.

Meeting closed at 13:00.

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