The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 5 March 2013

Session 4

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HEALTH AND SPORT COMMITTEE
7th Meeting 2013, 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:

Michael Matheson (Minister for Public Health)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 6

Scottish Parliament

Health and Sport Committee

Tuesday 5 March 2013

[The Convener *opened the meeting at 11:08*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning. I welcome members and the public to the seventh meeting in 2013 of the Health and Sport Committee. As ever at this point, I remind everyone present to switch off mobile phones, BlackBerrys and other wireless devices, as they can often interfere with our sound system.

The first item on the agenda is to consider whether to take in private item 9, which is consideration of the committee's approach to waiting lists. Is the committee agreed?

Members *indicated agreement.*

Subordinate Legislation

Tobacco and Primary Medical Services (Scotland) Act 2010 (Incidental Provision and Commencement No 4) Order 2013 [Draft]

11:09

The Convener: Agenda item 2 is consideration of subordinate legislation. This morning the committee will consider three affirmative instruments, and we will take evidence from the Minister for Public Health on and debate each instrument in turn before we move to the next.

Moving on to the first instrument, I welcome Michael Matheson, the Minister for Public Health, and Rosemary Lindsay, principal legal officer for food, health and community care, and Siobhan Mackay, tobacco control adviser, both from the Scottish Government. I invite the minister to make an opening statement.

The Minister for Public Health (Michael Matheson): Thank you, convener. The purpose of this draft affirmative order is to commence section 9 of the Tobacco and Primary Medical Services (Scotland) Act 2010, which bans the sale of tobacco products from vending machines. Although the legislation was approved by Parliament in 2010, as the committee will know this provision has been subject to a legal challenge from Imperial Tobacco and Sinclair Collis. I am pleased to say that the courts have dismissed both challenges and that we are now in a position to implement this provision, which will come into force on 29 April.

I am happy to respond to committee members' questions.

The Convener: Thank you, minister. Do members have any questions?

Dr Richard Simpson (Mid Scotland and Fife) (Lab): What discussions have you had about the order with vending machine operators, who of course were originally opposed to the measure, and what was their response?

Michael Matheson: We engaged with the companies who operate vending machines during the passage of the legislation. At the end of January, we notified them of the date when the order will come into force, which will be 29 April.

The Convener: If members have no other questions, I thank the minister and his officials for their evidence.

We now move to the debate on the motion under agenda item 3. I remind members that rule 12.2.2 of standing orders allows no more than 90

minutes for the debate but I am confident that we will not need all that time. I should also say that the time for asking questions is now over and that, as we have entered the debate, Scottish Government officials may not speak.

I invite the minster to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Tobacco and Primary Medical Services (Scotland) Act 2010 (Incidental Provision and Commencement No.4) Order 2013 [draft] be approved.—[*Michael Matheson.*]

The Convener: Do you wish to make any opening remarks, minister?

Michael Matheson: I simply stress that the measure is an important part of our overall tobacco control strategy to reduce smoking in Scotland, which is itself an important public health measure.

Dr Simpson: I congratulate the Scottish Government on seeing off the attempt to prevent the implementation of this important tobacco control measure. I know that I am not allowed to ask questions at this point but I would be interested in finding out whether, as I would hope, we have been awarded costs in fighting these challenges. I find it interesting that worldwide the tobacco industry challenges the implementation of every tobacco control measure—indeed, Australia and New Zealand are facing the same problem in relation to plain packaging—so I very much welcome this measure and the order that will effect such an important change.

The Convener: Do you wish to wind up, minister?

Michael Matheson: I agree with Richard Simpson on the issue of costs. We are pursuing the matter and I have indicated that, should the courts decide to award us costs, the money will go back into the tobacco control strategy and will possibly go towards an education programme.

The Convener: The question is, that motion S4M-05715, in the name of Michael Matheson, be agreed to.

Motion agreed to,

That the Health and Sport Committee recommends that the Tobacco and Primary Medical Services (Scotland) Act 2010 (Incidental Provision and Commencement No.4) Order 2013 [draft] be approved.

11:15

Meeting suspended.

11:16

On resuming—

Social Care and Social Work Improvement Scotland (Requirements for Care Services) Amendment Regulations 2013 [Draft]

The Convener: Agenda item 4 is consideration of another affirmative SSI. The minister has remained in his place, but he is now joined by Mike Liddle, team leader for reshaping care; Kirsty McGrath, branch head at the Scottish Government's protection of rights unit; and Victoria MacDonald senior, principal legal officer for the food, health and community care division of the Scottish Government. Welcome to you all.

Michael Matheson: Thank you for the chance to say a few words about these draft regulations.

The committee will be aware that, over the past few years, there has been an increase in the number of care service providers experiencing financial difficulties. Most notable among those has been the Southern Cross Group and its collapse. At the time of those difficulties, the Scottish Government worked closely with colleagues at the Convention of Scottish Local Authorities and Social Care and Social Work Improvement Scotland—the care inspectorate—to ensure that the needs of care service users were prioritised. In particular, we sought to minimise the disruption to care home residents when care homes had to shut down.

Many lessons were learned from the work that was done around the collapse of Southern Cross, and it is important that we build on that. To that end, we have continued to work with colleagues in the United Kingdom Government, COSLA, the care inspectorate and other stakeholders to put together a package of improvements in the delivery of care services, incorporating increased scrutiny, contingency planning and the development of new models of service delivery. All of that work will take time, but the draft regulations before us mark a first significant step in improving matters.

The regulations do two things. First, they remove the offence of continuing to provide a care service while the provider is in administration. Secondly, they require care service providers immediately to notify the care inspectorate of any insolvency event.

On the first of those points, when a care home provider enters administration, the administrator will generally appoint a new provider to take over provision of the service. In certain cases in the past couple of years, however, it was clear that the best solution for residents of some homes was to

allow the existing provider to continue to provide the service while in administration. That gave important reassurance and continuity of care to service users but, unfortunately, it was in breach of the rules on providing a care home service while in administration.

Following discussions with the care inspectorate, it became clear that that offence no longer served any purpose and could in fact be detrimental to care service users if it prevented the best option for service users being taken. We therefore seek to remove the offence.

It would, however, be inappropriate to remove the offence without making some provision for ensuring that the care inspectorate is fully aware of the financial position of a care service provider, hence the new requirement for care service providers to notify the care inspectorate immediately when an insolvency event has occurred or is about to occur.

We have found that the earlier the care inspectorate is made aware of the financial situation of a care service provider, the sooner it can assess the situation and respond appropriately. The response of the care inspectorate varies on a case-by-case basis but can include increasing the risk assessment of the care service, increasing the level of financial monitoring, alerting and liaising with other agencies and, if necessary, taking enforcement action to ensure adequate standards of care are maintained.

The new requirements will ensure that the care inspectorate is notified at the earliest opportunity of any financial difficulties that a care service provider may be facing and can take the appropriate steps to support the provider and, most importantly, the service users during any transition phase.

I am happy to respond to any questions that committee members may have.

The Convener: I thank the minister for that opening statement. As there are no questions from committee members, will someone give me an idea of what an insolvency event is or would look like?

Michael Matheson: It could be a business that is struggling to pay some of its debts and, as a result, is getting into a position in which it may be insolvent. At that point, the business should notify the care inspectorate that it is having financial difficulties.

The Convener: We have dealt with this issue and are very supportive of that type of action as a first step. If overdraft facilities were denied to a business or if there was some issue with the bank, at that point they would be in discussions with the care inspectorate—is that right?

Michael Matheson: The business would be expected to notify the care inspectorate that it was entering financial difficulties as a result of that type of thing.

The Convener: How would we ensure that that happened?

Michael Matheson: There is now a requirement for that. There is a responsibility on care providers to ensure that they comply with the regulations. It is important that they notify the care inspectorate of financial difficulties as early as possible. It is difficult for the care inspectorate to be aware of the situation unless it has been notified. This is the first time that such a requirement has been placed on providers.

The Convener: What happens if they do not meet that requirement?

Michael Matheson: If they do not meet the requirements in the regulations, there is always the risk that the issue will be notified later to the care inspectorate, at which point the action that it will have to take will be different. I would suggest that it is in the interests of a service provider to notify the care inspectorate as early as possible, but it is down to the service provider to do so.

The Convener: Insolvency, managerial breakdown and financial crisis can have serious consequences for the residents of a care home. If a service provider is not meeting the regulations relating to the people in its care, what imperative is there for it, for its own sake, to let people know that there are problems?

Michael Matheson: There is a range of ways in which the care inspectorate can get intelligence on such issues. For example care managers in a local authority who are working with a care home provider might notice that there have been changes in the standard of care. Although they might not be aware that that is because the provider is getting into financial difficulties, they could report the matter to the care inspectorate. A requirement has been placed on providers. Ultimately, the care inspectorate could cancel their registration if they are not complying with the requirements that are placed on them under the regulations. However, it is down to providers to notify the care inspectorate of any issues.

Bob Doris (Glasgow) (SNP): The regulations provide reassurance about continuity of service for cared-for people in a residential setting should a company go into administration or face financial difficulties. In the past, the committee has heard that a lot of service users have thought that they would have to find another provider immediately, which created huge uncertainty.

I have a couple of questions on wider issues. If a company did not inform the care inspectorate as it was statutorily obliged to do, would that constitute a criminal offence for which the owners or the board of the company could be prosecuted?

The terminology "insolvency event" is pretty well explained in the regulations and is quite clear, so I will not ask a question on that. I want to go back a stage. We would be keen to know if there is an imminent threat of an insolvency event. However, my understanding is that even if a company knows that it is on the brink, there is nothing to compel it to inform the care inspectorate that it is potentially facing insolvency. My understanding is that the requirements come in only once it enters the insolvency process. We looked at this issue in detail before, I think, and found that there were significant difficulties in doing this, but is there any way in which the Parliament or the Government can compel care home owners to inform the care inspectorate of their financial health and wellbeing at a pre-insolvency event stage? If so, would you look to legislate on that in the future? If not, would you seek to have such powers?

Michael Matheson: Your first point was about notification. That would be a breach of the regulations, which are to do with a provider's registration as a care service provider. If the company failed to comply with the regulations, it would be for the care inspectorate to start the process of looking at its registration and whether it would have to take enforcement action. Members will appreciate, I am sure, that it is difficult for the care inspectorate to have day-to-day oversight of a care service provider's financial situation. The new step is to require providers to give notification should they find themselves in an insolvency event.

The wider issue around the financial stability of care service providers is part of the discussion that has been taken forward with COSLA and other stakeholders as part of the national care homes contract. We have been considering whether more work can be done around the diligence process for care agencies and providers on the financial factors around their businesses. We are continuing work with COSLA to see whether measures can be put in place to consider further these types of issues when local authorities are looking to place contracts with care service providers. That is an area of work that we are still taking forward. How that materialises—whether in regulations or as part of the national contract—has yet to be decided. If there are measures that we can take that will help to make the system more robust, there is a willingness on the part of the Government to take them, but we have to find the mechanism for achieving that.

Bob Doris: I am completely reassured by what you said about the discussions with COSLA. The committee has seen the difficulties in working out how to measure and monitor the financial robustness of any business involved in the care sector.

You said that it would be a breach of the registration requirements if a provider did not inform the care inspectorate of an insolvency event. This might not be within the powers of this Parliament, but I would have thought that there should be a duty beyond the registration process for a company to inform the care inspectorate—or whoever within the Parliament and Government—if they were experiencing an insolvency event. I would like to think that that could go beyond the scope of registration, meaning that their registration was withdrawn, and that other consequences could befall individuals in breach of the requirement. Has the Scottish Government considered that?

11:30

Michael Matheson: We are still considering the different models of care provision and it will prove difficult, I imagine, to define when a business has financial difficulties. We can clearly identify an insolvency event, but different businesses will view their financial situations differently, so part of the challenge in trying to ensure that care service providers notify the care inspectorate at the earliest opportunity is to define in regulations when service providers have to notify the inspectorate.

That can be addressed partly through the routine, continuing work that the care inspectorate carries out with individual care providers. It discusses their financial situation with them, and if there is an indication that problems exist, it will decide whether further scrutiny is needed and whether it needs to place enforcement requirements on the providers.

Part of the challenge is how we define when a care service provider has financial difficulties and the point at which it has to notify the care inspectorate of that.

Gil Paterson (Clydebank and Milngavie) (SNP): I have a question along the same lines. Perhaps there are a couple of questions rolled into what I am about to say.

Private companies have a duty of care in relation to health and safety and all sorts of other things but not in relation to insolvency. In business, companies hold that information really close to their chest. It might be about a short-term cash-flow situation that they will get over, so they try not to put it out into the wider public domain. Do the regulations incorporate such a duty of care for care home providers? It seems like that to me.

Normally, we get to hear about insolvency or cash-flow problems because suppliers or employees of the company concerned blow the whistle and say that they are not getting paid. That has happened frequently in football teams. I am sure that the care inspectorate would not have the powers to go into a private company and audit its books. I do not think that that happens in any other instance. Therefore, the duty of care kicks in and somebody needs to notify the inspectorate.

If a complaint came in from an outside body, a supplier or an employee that a care provider was not fulfilling its financial obligations, would the care inspectorate go in and ask for information about the financial situation?

Michael Matheson: Gil Paterson raises an important point. Often, if commercial businesses have financial difficulties, they keep the information close to their chest because of the implications that it can have for their business, particularly in relation to competitors.

If a company that supplied a care provider with a particular service notified the care inspectorate that its bills were not being paid, the inspectorate could ask for financial information from that care provider if there was a suspicion that it was having financial difficulties. The care inspectorate could also increase its risk assessment of that care provider as a result.

The care inspectorate would take a largely intelligence-based approach to the evidence that it received from the company that was not being paid and the further financial information with which the service provider provided it. Such intelligence could be used as one piece of information to indicate that there were problems. The care inspectorate would then consider what action might be appropriate and proportionate, such as whether it would need to increase its risk assessment of the care provider and request information from it to determine whether problems existed.

Gil Paterson: I know how it works. Companies in this field have competitors—there are always competitors.

If such a situation arose, would the care inspectorate quietly assess what was happening and whether the business was experiencing a short-term problem? Would it go in quietly or would it go in with all guns blazing? Would the public get to know about the situation smart-ish, or would it be handled sensitively?

Michael Matheson: I would like to think that the care inspectorate would proceed quietly until it had built up a body of evidence on any issues that existed. If, once it had undertaken an assessment, it felt that other parties—for example, the local authority or other service users—needed to be involved in considering a response to the financial difficulties that the company had, it would look at engaging with them to consider what action could be taken.

The first step in the process would be to gather as much evidence as possible and to assess what response was necessary and who else might require to be involved in any response. That could be the local authority or other service users. Issues such as whether the process should be extended to the notification of residents and families of residents would have to be dealt with on an individual basis, depending on the circumstances, with the care inspectorate responding to issues as it saw appropriate at the time.

Gil Paterson: Thanks for that, minister.

Dr Simpson: I should declare an interest in that I have had a relative in a care home that was one of a group of three that was in administration.

I very much welcome the proposed change, because I think that it is inappropriate for it to be an offence to continue such a business under the administrator—that is what happened quite satisfactorily in the case of my relative's care home.

However, I am slightly concerned that we will place only a duty on the provider to notify the care inspectorate of an insolvency event. Why did you decide not to make it an offence to fail to notify the care inspectorate? It seems to me that notification is the important issue, so it might have been more appropriate to make failure to notify an offence. Could you outline the thinking behind the Government's position? Perhaps one of your officials could do so, as it is a slightly complex issue.

Michael Matheson: The approach that is being taken, in consultation with the care inspectorate, is to tie the issue to the registration requirements that a care service provider must meet. The change that is being made will mean that a company must give such notification as part of their registration as a care service provider. In the care inspectorate's view, that was the most pragmatic way in which to deal with the issue. In my view, it appears to be a proportionate way of doing things.

The focus must be on ensuring that we maintain the quality of care for service users. We see tying notification to registration as a way of helping to reinforce that.

Dr Simpson: In the future, the committee might want to hear from you about how well that system is working, because I have some residual concerns. Bob Doris's questioning was along a similar line. We need to ensure that such

companies provide notification. If a company is going out of business anyway, what is in it for it to provide notification? It will lose its care registration anyway. The administrator will take over the business. Why should a company bother notifying the care inspectorate in the first place, when there is no comeback? I have slight concerns about that.

Michael Matheson: Part of the challenge relates to determining at which point further down the chain we could require information to be provided to the care inspectorate if a company was experiencing financial difficulty. For different businesses, the threshold will be different. Different companies will experience financial difficulties in different circumstances. That is probably quite difficult to define, but I think that the earlier notification takes place, the better.

One way in which we can help to make improvements in this area relates to the way in which local authorities, through the national contract, undertake the diligence process that they go through when they are looking to use a particular service. I think that there is room for further progress to be made in that area. It is clear from the feedback that we have had from COSLA that that is an area in which it wants further progress to be made. That could help us to address some of the concerns—which I think are legitimate—that members raise.

Dr Simpson: Thank you.

The Convener: It is reassuring to hear the minister say that there are some concerns.

We all need to bear it in mind that, if a care home is not up to standard, the nuclear option is to close it down, which will impact on the continuity of care for the residents. I am struggling to understand how the measure will not lead to the same conclusion. If a care home hits a temporary financial crisis, decides not to report it, becomes insolvent and loses its accreditation—Richard Simpson described that—or if it is found out later that a home did not report an insolvency event that it had and it loses its accreditation because of that, the measure will, in effect, bring about the closure of those homes.

I do not see how the measure will change behaviour. We all support the changing of behaviour and the early flagging up of financial problems in order to get discussions going with the residents, but I am not convinced that what is proposed will do that.

Michael Matheson: I am not suggesting that the regulations are a panacea to deal with all the issues around the financial challenges that care service providers face. What we are discussing are just two of the initial steps that we are taking to try to address issues that have been highlighted in the learning from the Southern Cross experience. We are still undertaking work with the UK Government to look at other models of service provision and we are taking forward work with COSLA and the sector. This is not the end of the process. If anything, it is the beginning. We are discussing a couple of examples of immediate steps that we can take.

As things stand, there is no requirement on care service providers to notify the care inspectorate if they have an insolvency event. I had an issue a number of years ago when a care service provider in my constituency literally brought down the shutters on a Friday afternoon and the local authority had to step in and try to help many of those whom the provider cared for. There was no requirement on the provider to notify anybody about the situation.

The requirement that we are discussing places an obligation on providers as part of their registration to ensure that the care inspectorate is notified. It is important that, as soon as it is notified, it assesses what action is appropriate. Alongside that, if there is an issue about managing the care setting at that time using the existing staff, the regulations provide an opportunity for that to happen without anyone committing an offence. That will allow continuity of care for service users.

This is very much a first step. It is not the final answer to the wider issue of the financial challenges in the care sector.

Dr Simpson: My question follows on from Gil Paterson's question. If someone makes a complaint about the care in a home, it will be registered with the care inspectorate and I understand that it will go up on the website, even if it is then investigated and found to be incorrect, or regardless of whether it is upheld, partially upheld or not upheld. I do not think that that is inappropriate, because things should be open and transparent, although I know that some care homes are concerned about that because people can make complaints that are not appropriate.

It is one thing to do that in relation to the quality of care, but it is another thing to do it in relation to financial quality. A creditor might complain because their bill has not been paid, but it may be that the bill is in dispute. If that goes up on the website, it might trigger other creditors to say, "Hang on a minute. We need to rush in here." It might force an insolvency that would not otherwise have happened. Gil Paterson hinted at the fact that it might create a degree of uncertainty and expose the person's business in a way that we would not really want.

Will creditor complaints be treated differently from other complaints, or not?

Michael Matheson: I tried to explain to the committee, in response to Gil Paterson's question, that I would expect the care inspectorate to use the piece of intelligence to check with the care service provider whether there were financial issues, to request financial information, and to deal with it sensitively. It is a good point: there could be unintended consequences if you go in with "all guns blazing", as Gil Paterson said, and make everyone aware of the issue. If a particular creditor has not been paid, it is for the care inspectorate to identify the reasons for that, be it a disputed bill or that the person just does not have the money to pay. If it is the latter, we need financial information to consider what further assessment we have to make of the risks for the business.

11:45

It is difficult to lay down a single black-and-white policy for all those issues, because they will materialise in different ways and will have to be dealt with individually and case by case. The approach must be intelligence-based and ensure that, where there is an issue, action that the care inspectorate should take is identified as a result of the information that is provided.

I hope that that provides reassurance that the process is not about creditors using it as a way of embarrassing the company to get a disputed bill paid, but that it is used by the care inspectorate to find out where a business has a genuine problem, rather than there just being a dispute between a creditor and the purchaser.

The Convener: Thank you for that answer. I am sure that you are aware that our questioning is based on the committee's work. It is useful to record that the committee recognises that this is an issue and that early information about the financial status of such homes—indeed, information at the time of their accreditation—is very important for continuity of care. We are at one on that, and it is interesting.

My final point is to suggest that, as a result of this discussion and the committee's work, we might create an opportunity for you to come back and discuss the issue more widely, rather than just within the confines of the SSI. That might put you in a better position to discuss all that is happening and the Government's intended progress. I hope that you will agree to that happening at a future date.

Michael Matheson: Of course. I am sure that I or the cabinet secretary would be more than willing to do that.

The Convener: Thanks for that.

As we have no other questions, we move to agenda item 5, which is a debate on the affirmative instrument on which we have just taken evidence from the minister. I invite the minister to make any opening remarks and move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Amendment Regulations 2013 [draft] be approved.—[*Michael Matheson*.]

The Convener: I invite other members to take part in the debate.

Bob Doris: I will make a few observations that link into what the convener said. The regulations are positive. It seems odd that if, say, a high-street company that sells jeans goes into administration, the administrator can still open the doors and sell jeans, whereas technically, under the current rules, a care home would have to close its shutters, cease trading and cease supporting the most vulnerable people in society. It is vital that we implement the regulations and I certainly will support the motion.

The wider conversation has been around the inquiry into the regulation of care for older people that the committee carried out not that long ago. That was one of the most rewarding Parliamentary inquiries that I have been involved in, because the Government responded to concerns raised before we had even completed our inquiry. That shows how this Parliament's committees can work with the Government to improve the system of regulation for older people. It is important to put that on record.

It is also important during this small debate to put it on the record that, because of our inquiry, we recognise the significant difficulties in identifying a company that could be at financial risk and the point at which it would be appropriate for the care inspectorate or others to analyse that. I am delighted that work is on-going with COSLA to see whether we can flesh out a way to overcome those difficulties.

I also put it on the record that if there is a case in which a care provider can just pull the shutters down, lock the door, and not inform the care inspectorate, perhaps we have to look at determining what fate should befall the owner of that company, outwith preventing them from registering as a care home provider in the future.

Perhaps the committee needs to return to that. However, it is important to say that those instances are few and far between and that virtually all the care providers, irrespective of who owns the care homes, are putting their residents first and working closely with local authorities and other partners to provide the best possible service. In raising the concerns that I have, I would not

want to overstate the case. It is about ensuring that the system is as comprehensive as it can be, and I certainly support the regulations.

Gil Paterson: I do not come from a health background, but I will try to put myself in the position of a business, as the institutions are, broadly, businesses. There are bad or good reasons for people going bust. That is often not their fault—I am not talking about Southern Cross in that regard. If someone has a big debtor who does not pay them and their cash flow goes AWOL through no fault of their own, that could threaten their business. That is why I asked about going in quietly.

I have found banks to be very helpful with my business through this bad time. I hear everybody's doom and gloom about banks, but that is not my experience: they have been good for my company. If a person has a short-term problem, they can approach a bank or other creditors and say, "Somebody has taken me to the cleaners here. I've lost a pot of money. Can you give me a bit more time?" That is what typically happens in every other business, and I see the same thing happening in the sector that we are discussing.

There is one thing that I do not agree with. I think that company law prevents anyone from going into a company to examine its books and I do not think that we could make that stand up, if we tried to do that. That could be challenged, and my view is that we would lose that challenge. A company has the right to run its business and it needs to keep many things from its competitors. It would be strange if we took one sector out of every other sector and said, "This is how you're going to be treated." I do not think that that could happen.

However, I very much support what is proposed. Businesses would have continuity, and the end result will be people in care being looked after at a very traumatic time so that another buyer for the business could be found. I do not like private buyers and sellers in this market; rather, I would love it all to be in the public sector. That is my position but, nevertheless, that is the world that we are in.

A business needs continuity and there needs to be continuity for the individuals who are being cared for, so I very much welcome what is proposed, and I like the idea of pressure on businesses regarding a duty of care. I do not think that a lot of people know how important that is and how most responsible businesses react to it. I see including in the framework a duty of care in relation to finances as quite a powerful weapon. That does not happen anywhere else. If we can make that stack up, we will have a potent weapon.

The Convener: As no other member wishes to take part in the debate, the minister may respond with closing remarks.

Michael Matheson: Very helpful comments have been made. Both contributions illustrate the complexities of the issue.

We must continue to look at how we can improve the way in which we operate with private care service providers on financial difficulties that may arise from problems that they have as businesses. It is fair to say that the Regulation of Care (Scotland) Act 2001 created the offence of a company in administration continuing to provide care because it was considered that such a company would not meet the fit and proper person test. It is only recently that practical experience has shown that that could be an inhibitor to maintaining individuals' care, rather than always getting something in the best interests of the service user. The new regulations allow us to ensure that we learn from that experience and put in place measures that make the system robust and focus on maintaining the quality of care that service users receive.

The Convener: The question is, that motion S4M-05716, in the name of Michael Matheson, be agreed to.

Motion agreed to,

That the Health and Sport Committee recommends that the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Amendment Regulations 2013 [draft] be approved.

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2013 [Draft]

The Convener: Item 6 on our agenda is evidence on a third and final affirmative SSI. I invite the minister to make an opening statement.

Michael Matheson: Thank you, convener. I will be brief. The draft affirmative order reflects the Scottish Government's commitment to increase free personal and nursing care payments in line with inflation. If approved, the order will continue to benefit vulnerable older people. Last year, we increased the personal nursing care payment for residents in care homes in line with inflation. The regulations will further increase, in line with inflation, the weekly payment for personal care by £3 to £166 per week and will increase the additional nursing care payment by £1 to £75 per week. In line with our partnership agreement with local Government, councils will meet the costs of the inflationary increase totalling around £1.8 million in 2013-14. An additional £1.5 million annually was added to the funding for local authorities in October 2012 to cover those additional costs in the current spending review

period up to 2014-15. The free personal care and nursing care policy continues to command strong support, and I hope that the draft order will receive the committee's support.

The Convener: Thank you for that, minister. Are there any questions from members?

Members: No.

The Convener: Agenda item 7 is a debate on the affirmative instrument on which we have just taken evidence from the minister. I invite him to make any opening remarks and move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2013 [draft] be approved.—[*Michael Matheson*.]

The Convener: As the minster does not wish to make any further remarks and no member wishes to debate the motion, I will put the question. The question is, that motion S4M-05713, in the name of Michael Matheson, be agreed to.

Motion agreed to.

11:58

Meeting suspended.

11:59

On resuming—

Teenage Pregnancy Inquiry

The Convener: Item 8 is our final evidence-taking session in our inquiry into teenage pregnancy. I welcome back the Minister for Public Health, who has remained in his seat throughout the suspension. He is joined by Felicity Sung, sexual health and HIV national co-ordinator at the Scottish Government.

I invite the minister to make an opening statement.

Michael Matheson: The rates of teenage pregnancy have been reducing consistently over the past four years, with rates for under-18s being at their lowest level since 1994. That is a significant achievement and should not be underestimated. It reflects the hard work of our stakeholders in addressing teenage pregnancy through the use of evidence-informed and effective interventions. However, we cannot be complacent. I want Scotland to continue to follow that trend while also achieving larger reductions in our rates of teenage pregnancy, acknowledging the impact that early parenthood can have on the parent and the child.

The committee has already heard about the complex issues that lie behind teenage pregnancy. We know that the prevention of teenage conceptions cannot be achieved by health interventions alone, and we need to better acknowledge the role that deprivation, inequality and lack of aspiration and opportunity can have. I want all stakeholders to take account of the most up-to-date evidence on what works so that we can support our young people to delay parenthood until they are in a position to provide a stable home for parent and baby.

The impact of local authorities should not be underestimated, particularly with regard to their role in preventing teenage pregnancy and supporting young people to stay connected with education, so that they have aspirations and opportunities for the future.

For those young people who become parents at a young age, high-quality support services, such as those that are provided by family nurse partnerships, are vital. Young mothers have been telling me about their experience of motherhood—the difficulties and the positives—and how, in some cases, their role as a parent has impacted on their lives for the better. It is important that we listen to young people and understand how we can best support them to delay parenthood but also appreciate that, if they choose parenthood,

we must help them to become the best parents they can be.

I would be happy to respond to any issues that are raised by the committee.

Dr Simpson: Our system in Scotland involves the local authorities' single outcome agreements. As you said, the role of the local authorities in delivering a continuing downward pressure on unwanted teenage pregnancies is important.

In your review of the health boards, have you learned what sort of discussions have taken place between them and the local authorities on the single outcome agreements? Is reducing teenage pregnancy now a specific item? Scotland still has a teenage pregnancy rate that is above the average, and it has a significantly higher rate of teenage pregnancy than, say, Holland. We still have a long way to go. We cannot afford to be complacent. Is there questioning of what is happening at a local level?

I ask that question in part because of my experience in going to Oldham. Even though clear guidance had been issued nationally in England and there were toolkits to work with, teenage pregnancy in Oldham was not declining in the way that was wanted—it was still way above the average. The ministerial team called in the local authority to see what was happening and to examine what further support could be offered in areas in which it was not achieving the desired results. The result of that was a renewed focus by all the chief executives, the director of education and so on. That led to a substantial reduction, because there was a highly co-ordinated response.

What has the Government been doing to try to drive the rate down, particularly in areas in which the rate has remained high or above the average?

Michael Matheson: We must take a number of different approaches, because there is no magic bullet in dealing with teenage pregnancies. A multi-agency response is required, with local authorities, the health service and, when necessary, third sector organisations working in partnership.

The sexual health and blood borne virus framework recommends that local authorities include progress on reducing teenage pregnancies in their single outcome agreements. Some local authorities are acting on that.

The progress that we could have made has, at times, been limited by an overfocus on treating teenage pregnancies as a health issue that can be dealt with through our health service. I have no doubt that the committee has noted in its visits that local authorities have an important part to play in keeping young people engaged in education and so on. The base that you visited in Glasgow is a good example of that. It helps to keep young mothers engaged with education and to improve their aspirations and opportunities for the future.

I am interested in the challenge that we face in ensuring how our health boards and local authorities engage and work much more co-operatively in dealing with the different issues for which they are responsible. There are some areas where there has been good partnership working between the health service and local authorities, but there are other areas where that has not been so successful. Part of the challenge is how to achieve that good partnership working. Key to that is recognising that teenage pregnancy policy is not a matter that sits with the health service alone and that a multi-agency response is needed. I am looking to develop that further, particularly the partnership between the health service and local authorities, and to focus on areas where there are high levels of teenage pregnancies.

Dr Simpson: One problem is that we are not particularly good at spreading good practice. The committee has seen a lot of good practice on our visits. In addition, the family nurse partnership is being rolled out, and that will at least help those families who are eligible to get on the programme. We have Healthcare Improvement Scotland for the health service, but how do we ensure the effective transmission and rolling out of good practice that is being undertaken by the local authority either on its own or jointly with the health service?

Michael Matheson: When I see good practice in a health board area, it is a constant challenge to get other health boards to learn from, utilise and build on that experience, rather than reinventing the wheel and doing something differently on their own patch. There have been a number of attempts over the years to hold good-practice events through which organisations share experience that others can learn from, take back and use within their own local authority or health board area.

Obviously, the committee will present its own recommendation following its inquiry. However, I would be interested in hearing the committee's views on whether teenage pregnancies should be dealt with outwith the sexual health and blood borne virus framework. Should there be a stand-alone strategy that is jointly managed by the local health service and the local authority? That could give greater focus in drawing the areas together and in the consideration of how resources are used and shared more effectively. That may be a way in which we can go about drawing together some of the good practice between health services and local authorities, so that they work closer together and share that experience more effectively.

Perhaps a lesson from Oldham—about which I have limited knowledge—is that a strategy that brings the two services together and has shared outcomes might achieve much greater direction at a local level. I would be interested in hearing the committee's view on whether that idea would merit consideration, given the committee's experience and the evidence that it has heard.

Dr Simpson: I will allow others to comment on that.

My final point is that underlying it all is having adequate data. What impressed me in Oldham is that the data was published for council ward and school. The schools that were comparable in terms of deprivation were matched up, so there was a friendly element of competition. Some schools thought that they were doing very well, but when they saw their data published, they were pretty horrified, frankly, and the issue became a priority. Are you satisfied that we have data down to the level that would allow the local implementation groups to have the effects that we want?

Michael Matheson: The data at national level is published by the Information Services Division. The challenge is how far we can go down to a localised level with that data without causing difficulties in some communities where only a small amount of information is held on a particular ward, for example, so people can be identified. However, NHS Fife has been able to get data down to individual areas using postcodes and has identified four schools in a particular area. It has been able to use that data to target specific resources into particular areas.

It is therefore possible to get down to that level, given the available data. However, the challenge is to get our boards and local authorities to use such data in a consistent way and to learn from the experience in Fife. Some of the Fife data is only a year or so old, as are some of the actions done on the back of that in particular schools. We are still learning from that experience, and we are due to meet NHS Fife next month to explore some of that. We need to see whether we can get other boards and local authorities to work at that local level and target their response to particular schools in a much more tailored way that would allow them to respond to local issues.

The Convener: Does the data measure only teenage pregnancies? Should we measure other elements, such as teenage terminations? Should we aim to reduce the incidence of those as well?

Michael Matheson: The data can be 18 months old, but the data collection point is when a termination takes place or the baby is delivered. The data is submitted to and checked by ISD, then it is published. There is a time lag, but my understanding is that data on terminations is collected.

The Convener: I think that all committee members recognise that progress has been made, as is shown by the figures that the minister gave in his opening statement. However, the disappointing feature is that progress has not been made consistently across Scotland or, indeed, across some communities and that there is wide variation in that regard. Significant resource has been provided across Scotland, but although some headteachers are interested in the issue and opt in, others show no interest in it. Some local authorities show an interest in the issue, while others do not. We have been presented with evidence that illustrates the role of nurses and the family nurse partnership. We heard earlier in the meeting about nurses for looked-after children. There are also the roles of midwives and health visitors. I asked some of those people when they came before the committee whether there was a cluttered landscape of roles.

Has the Scottish Government any idea about what sort of investment is available out there? There seems to be significant resource, but I am not sure whether it is being used to the best effect in a co-ordinated way, which goes back to Richard Simpson's question. There seems to be significant resource out there, from youth workers and sexual health workers to other people on the ground. Do we know how much we are spending on the issue?

12:15

Michael Matheson: It is difficult to say that we are spending this or that amount purely on preventing teenage pregnancies. The fact is that there is a very strong correlation between socioeconomic disadvantage and the level of teenage pregnancies, and a whole range of resources is going into areas of deprivation to tackle some of society's inequalities. Many of those resources come from local authorities, and the third sector and the health service will also be involved. Instead of their being focused on this issue alone, resources in a range of areas can impact on reducing teenage pregnancies.

I can tell the committee that part of the £29 million a year that we spend on the sexual health and blood borne virus framework is for teenage sexual health education programmes and a variety of other service provision. However, because of the breadth of the issue and its strong link with socioeconomic disadvantage, many of the resources that are used to tackle inequality impact on teenage pregnancy levels. It is incredibly difficult to say exactly how much resource is going into that specific area at any given time.

The Convener: How difficult would it be to identify in a particular area the number of people working on this who receive part of their funding from local government, the health service, charities, the third sector and so on? You mentioned deprivation; we know that what you have said is the case but, as I pointed out last week, the situation in Greenock and Port Glasgow, where deprivation is evident—and where, in fact, there are at least three postcode areas in which the level of deprivation is equivalent to that in Glasgow—can be contrasted with that in Dundee, which has similar levels of deprivation but double the level of teenage pregnancies among under-16s. Obviously, there is a link with deprivation, but it is not the only cause. Have more resources been available in Inverclyde and have they had proportionately more of an effect on this issue than in Dundee? How do we measure the resources that are available in a given area and the amount that is committed by local authorities and health boards? I would not have thought that that would be difficult.

Michael Matheson: Because of the very specific services that are provided, it is probably easier to identify the health spend in some of these areas. For example, there might be a drop-in sexual health service in Inverclyde where young people can get advice on sexually transmitted infections and contraception. On the other hand, if a local authority-run community centre has a youth club for young people up to the age of 16—indeed, some of you might have visited the Citadel Youth Centre in Leith in Edinburgh—such a service helps to keep them engaged and to get involved with and play a role in their local community. It can also give them an opportunity to think about other things than perhaps becoming a parent at a young age. However, it is difficult to isolate that and say that this or that amount is specifically going into reducing the amount of teenage pregnancies. That might happen as a result, but the funding has not been identified for that purpose.

In short, although we can identify the health spend in some of these areas, it is more difficult to do so from a local authority point of view. After all, there can be a range of services for young people including those provided by youth workers and local authority education workers who work with those at risk of dropping out of school and help them to stay in education. All those people contribute to reducing the risk of young people getting into early parenthood but, as I have said, it can be difficult to put a budget on that and label it as part of the overall strategy to reduce teenage pregnancies. I am not saying that what you suggest cannot be done; all I am saying is that, because some of these services have other purposes, it would be difficult to say that this or that portion of their funding is for reducing teenage pregnancies.

The Convener: But headteachers will say, "I'm here to educate children, not prevent teenage pregnancies." Headteachers and local authorities can opt in or out of the strategy. Where is the focus that we require in order that people deliver on the targets that are laid out by the strategies?

Michael Matheson: There is a requirement for local authorities, through curriculum for excellence, to cover relationships, parenthood and sexual health. Local authorities are responsible for taking that forward in their schools. Even prior to curriculum for excellence, there was a level of provision in our schools, which was delivered by teachers.

An additional part of our work on respect and responsibility in 2008 was to look at how we can provide advice services outwith schools that could be utilised by school-age pupils. For example, drop-in centres could be used by people to get advice and information from nurses. School nurses are able to provide advice and information and signpost pupils to services and sexual health clinics. A number of health boards have taken that forward in partnership with local authorities. There has been the development of drop-in facilities outwith schools but close by so that they can be used by young people, and there is the provision in the education curriculum on relationships, parenthood and sexual health issues.

We all have a part to play. It can be challenging to ensure that that is happening consistently throughout the country, in every local authority and health board area. Part of the challenge going forward is to see whether we can build on the progress that has been made to ensure that it is happening in a much more co-ordinated and joined-up way.

The Convener: That is what I was trying to get at. There are projects that we visited in Dundee and Glasgow that are not available to some people even in Dundee or Glasgow, and such services are certainly not available throughout the country. School nurses and drop-in centres are not available in all areas. Many of these services are not available throughout Scotland and it brings us back to the question whether we believe that young people have the right to such services.

Michael Matheson: Different approaches have been taken in different local authority and health board areas to deal with the issue. We issued guidance in 2008 on the development of drop-in facilities that are accessible for young people to get information in a youth-friendly way.

Part of the challenge will be to ensure that, when a young person needs advice and information, it is provided in the way that is most

appropriate to them. Most school nurses are not in the school all the time, so it is about ensuring that young people have access to advice from a school nurse even if the school nurse is not in the school. It is about education provision, physical service provision and related support services. It has always been a challenge to get consistency, but progress has been made. Some of the young people I have met have been able to make use of those services. We are getting evidence about the experience of service delivery over the past year in Fife. What young people have said about the services has shown improved uptake and access.

One of the challenges is perhaps whether we are good enough at listening to young people's views on how such services might best be delivered. I think that there is much more scope for us to look at what their views are on service delivery—whether that be the drop-in services or the education that they receive in school—to see whether we can use that to inform how local authorities and health boards take forward some of this work.

The Convener: Will that require a shift in budgets between health boards and local authorities? We know that the health budget is being protected, but we know that local authorities are facing difficult times. The budgets of local authorities are not being protected but, at the same time, we are asking them to do more. I think that Glasgow City Council described its setting up of a young mothers unit as a brave decision, which was not necessarily cheap. Where will the money come from to get equality of access and support across Scotland?

Michael Matheson: Are you asking about funding for preventing teenage pregnancies?

The Convener: I am asking about the funding for preventing teenage pregnancies and supporting young mothers. How will that be provided across the board?

Michael Matheson: A key component of helping to prevent teenage pregnancies is, as with many other issues in tackling health inequalities, retaining young people in education for as long as possible. We need to give them aspirations and ensure that there are opportunities for them to move on after school to employment or to further or higher education. In my view, a core part of a local authority's role is to keep young people as engaged with education for as long as is reasonably possible as well as to support them in making informed choices if they choose to leave education at a particular stage.

With regard to the base for teenage mums in Glasgow that the committee visited, the local authority there has taken that approach to try to retain those young people in education. Part of the local authority's function is to support such 15-year-old mothers to stay on at school so that they can remain within education. Obviously, the national roll-out of the family nurse partnerships is another approach that can support young teenagers who are parents for the first time. That can help with a whole range of things, but it can also improve their educational outcomes and employment opportunities.

The issue is not whether we need to give more money to local authorities or to health boards. What we need to get better at is working together more effectively and in a co-ordinated way. That gives an opportunity for local authorities and health boards to pool their resources much more effectively both to reduce the number of young people who become parents in the first place and, where young people choose to do that, to support those young people to become the best parents they can be.

The Convener: I agree with the need to pool resources, but that goes back to my original question about what resources are available. What is being spent by the health service and what is being spent by the education service of local authorities? If we had more information about the people, resources and budgets that we have, we might be able to provide a wider service that would offer—to use the buzzword—a preventative strategy.

Bob Doris: I will make a brief observation before I come to my question. The convener mentioned that the focus of headteachers is on educating people, but I have met many headteachers who take very seriously their wider role of developing young people in their school. That role is not just about getting young people through exam results, and I think that curriculum for excellence will promote that further. It is worth making that point about the approach that I see in schools in Glasgow.

I want to ask about the varying success rates of different local authorities in Scotland. Governments are always accused of having either too many or not enough targets—they never get it just right; people always have an opinion that there should be more or fewer—but does the Government have a target for narrowing the difference between the best-performing and worst-performing local authorities in terms of addressing teenage pregnancy rates? If not, might that suggestion be considered in future?

12:30

Michael Matheson: When we consulted on the sexual health and blood-borne viruses strategy, stakeholders appeared to want an outcome-focused strategy, rather than specific targets in

one particular field that had to be achieved. The five outcomes that are set out in the strategy reflect that view. One of the outcomes is about reducing the number of teenage pregnancies and reducing terminations, so there are different components. Some of the work that we undertake with local authorities and health boards is about monitoring the progress that they are making in taking that forward.

There is merit in considering whether there is a need to have specific targets that are weighted in such a way as to give both health boards and local authorities much more of a focus on the areas where there are particular challenges. I would be interested in the committee's views on that. If we were to set a target to reduce teenage pregnancies by 5 per cent nationally, which would be tremendously ambitious, my view is that that should be calibrated in a way that focuses on areas where there are higher levels of teenage pregnancy, such as Dundee or parts of Fife. Such a target would have to be shared between local authorities and health boards, given the intrinsically linked nature of their roles in dealing with the issue.

As I said earlier, perhaps one of the things that we could consider is whether we should take the teenage pregnancy issue out of the sexual health and blood-borne viruses strategy and have it as a stand-alone strategy that is shared between health boards and local authorities. As part of that, there might be merit in having specific targets that can be shared between local authorities and health boards but which would be calibrated in such a way that the focus would be on areas where there is a higher prevalence of teenage pregnancies. That might be a way of providing focus. However, the ultimate objective must be to improve overall outcomes, as set by the overall sexual health and blood-borne viruses strategy.

Bob Doris: You make a strong suggestion. I have written in my notes that we should perhaps have a single accountable individual, irrespective of whether they are a local authority or health service individual, who captures everything that is happening within the local authority or health board area.

At our meeting last week we heard from Alison Hadley, who took forward the English strategy for reducing teenage pregnancies. She said that it was not necessarily about taking a nationally prescriptive plan from the centre into each local authority area, although that was important, and that it was more about the focus—the local authorities knew that the centre was watching to see what was happening and that questions would be asked if there was no progress.

I know that targets can be quite artificial, but the advantage is not in saying that everybody must always meet their target but—where someone has fallen short of their target—in asking whether they have moved some way towards it and how they can be supported to go further in future. That is more of an outcome-based way of using targets.

Would you consider making a single individual responsible for pulling all these threads together across the health service or local authority area and whichever other partners would seek to be involved in such an initiative?

Michael Matheson: I am happy to look at ideas that can assist us in meeting the challenges around teenage pregnancies. I am sure that other members of the committee will be aware that it can often be challenging to get health boards and local authorities to come to an agreement that a particular person is responsible for taking something forward, but if there is a way in which we can try to get them on the same page to deal with these issues more consistently, that would be helpful. I would welcome the committee's views on how that could best be achieved and what action can be taken at a national level.

Any strategy that we set at a national level is completely dependent on how it is implemented locally on the ground. We must be careful that we do not set a national strategy with weak implementation at a local level. We must look at what we can do to ensure that there is effective implementation at the local level, and we must do that in a way that reflects the local needs in a particular area. That does not mean the same implementation across the country, as that might not be appropriate. For example, local implementation in Fife is likely to be different from local implementation in the Borders. We must allow that flexibility and set targets to be shared between health boards and local authorities for how they go about doing that. I am open to considering different ideas that can assist us in moving further on from the progress that has been made in recent years.

Bob Doris: I would like to see national monitoring of local strategies so that there is not a top-down approach. It is important that health boards and local authorities know that the issue is receiving some attention. Although it is clearly receiving some attention from the Government, targets focus the mind.

A lot of the questions that have been asked so far have been on the process, but I would like to speak about services on the ground. I agree that keeping expectant young women and, once they have had their children, young mothers in education is beneficial. Whether it is Smithycroft secondary school in Glasgow—which you have looked at—or Wester Hailes education centre, where before the meeting started committee members met some of the young mothers who are

taking part in that initiative, such work is important. The issue has been raised with some committee members that, although the services are becoming increasingly advanced in meeting the needs of young mothers within education, a lot of young mothers have dropped out of education and need to be identified by the system again.

The family nurse partnerships will get certain information to allow teenage mothers to enter the system. However, I have been told that—not within the family nurse partnerships, but more generally—there is not necessarily any discussion with young mothers who have left education about whether they would consider re-entering education. Whether or not such discussions took place in a community school environment such as Smithycroft secondary school or Wester Hailes education centre, they would be beneficial. Schools are not necessarily informed when young women in their care fall pregnant because there are issues of confidentiality. There must be data sharing between health and education to ensure that expectant young women and teenage mothers have the opportunity to consider all the educational opportunities that exist. In some cases, they are not being informed of them, although the information that I have is that teenage mothers who have left education are given the opportunity to opt back into it. Have you looked at that? Would the Government consider working more effectively on that than it currently is?

Michael Matheson: There is an issue about the effectiveness of the system in dealing with a young person who has dropped out of school education to become a parent but who may be able to get back into it. In Glasgow, health professionals who specialise in working with young mothers are involved where that is possible. The issue is around how we can ensure that they have the opportunity to get back into education. That goes back to the need for a multi-agency response and a co-ordinated approach, which could assist mothers who are in that situation. We have health professionals in family nurse partnerships looking for good opportunities for the young mums who are engaged with them. Young mums who are not engaged with those partnerships may have a health visitor supporting them, but they may not be engaged with a college and seeking educational opportunities. There is an opportunity for us to improve that situation.

The discussions that I had with young mums in the citadel, in Glasgow and in other places emphasised the need to listen to them when we try to identify solutions and the best approaches to take. For some mums, going back to school is not necessarily the best approach to going back into education, for a variety of reasons. There is an opportunity to consider how we get better at that, but in a way that does not prescribe a particular route that a young person should go down if they have dropped out of school education.

Bob Doris: We consider the downward trend of teenage pregnancies from year to year, although there is a long-term aspect to the issue, too. What tracking is done? Much of the evidence has been anecdotal. I am about to move on to family nurse partnerships, on which we have evidence-based information, but some of the evidence from Smithycroft, for example, is anecdotal, because things are at an early stage. It has been found that, when young mothers are given appropriate support, they are less likely to have a second child or, if they have a second child, the spacing between pregnancies is likely to be greater and their children may be less likely to become young parents themselves.

Looking at things in the round, it is not just about tracking changes over a one, two or even five-year period but about the kids who are born to committed young mothers now and providing those young mothers with ample support, undertaking long-term planning and thinking 15 years ahead, when I suspect that most of us around the committee table will be gone. Is the Government engaged in that kind of long-term planning?

Michael Matheson: You can speak for yourself about how long you will be around for. [*Laughter*.]

There are short-term responses to support young parents, as well as short-term responses to support young people in choosing not to become parents at an early stage in their life. However, there is a longer-term agenda. The family nurse partnerships have an important part to play, although they are not alone in that. They have a strong evidence base from more than 30 years. You can see from the outcomes of some of the pilots in Lothian and Tayside and from experience elsewhere that the use of models such as family nurse partnerships leads to various improvements: they increase the amount of time between the first child and the second child, and reduce the incidence of smoking among pregnant mothers.

I have some statistics. If there is engagement through the family nurse partnership, by the time the first child is four, the interval between that child and the second child is 20 per cent longer. There is also an 83 per cent increase in labour force participation by those who have been through family nurse partnerships, and a 46 per cent increase in fathers' presence in the household.

There is an evidence base there that can improve not only the outcome for the mother while she is pregnant but—[*Interruption*.] I am sorry—I thought I heard Siri's voice in the background.

Family nurse partnerships help to improve the outcome for both the mother and the child. There is evidence that, if a family nurse partnership supports a young mum in their parenting role and in preparing the child for education, which is part of the partnership's role, that can have a long-term benefit for both the parent and the child. That long-term future health benefit relates to the approach that we need to take to deal with some of the long-standing health inequalities that we face.

We can take immediate measures around giving practical advice and information while putting in place measures to help deal with some of the long-term issues that can arise from teenage parenthood. Family nurse partnerships represent one of the responses for dealing with those issues, and they have a good evidence base on the outcomes that they can help to achieve.

12:45

Nanette Milne (North East Scotland) (Con): I want to ask about community pharmacists, but first I will touch on sex and relationships education. We spoke to four young mums this morning; I do not know whether they were from four different schools, but they certainly had different school backgrounds. They were unanimous in saying that they are still not really getting relationships education. There is plenty about the biological side of sex, but not much about relationships. You commented on that aspect of curriculum for excellence—I do not know whether you are confident that it will improve.

Secondly, community pharmacists are very keen to play a role in providing short-term supplies of non-emergency contraception to people who come into pharmacies. Would you consider extending their role so that they can provide such contraception after they have provided the emergency contraception for which they were initially asked?

The pharmacists are also keen to prescribe ulipristal as the emergency contraception of choice because it is longer acting. Has any work been done on the costs and benefits of providing a longer-acting contraceptive?

Michael Matheson: In my discussions with young people, I have heard mixed reports about the nature of the relationships and sex education that is provided in schools. We must reflect on that. I am interested in the approach that has been taken in Fife, where a number of schools have engaged closely with young people to identify what they think might be the best approach to dealing with some of those issues.

The idea of moving to single-sex classes to discuss particular topics was highlighted, and that approach has been trialled to see whether it is more effective in allowing young people to discuss issues openly, which they might not feel able to do if both sexes are in the class.

We must consider whether our approach to relationships and sexual health education in schools should involve an audit of young people's views, which might be effective. We should perhaps ask young people how effective that education is, and what they think could be done to improve it to enable them to gain greater benefits.

Such an audit might produce some interesting suggestions for possible changes in our approach. I do not know whether the evidence that the committee has heard is producing a consistent picture from young people in that regard. I am open to considering that idea, if the committee feels that it would be helpful, based on the evidence that it has received.

I have not yet come to a fixed position on community pharmacies and the provision of contraception over the counter, but it is important that any young person who is thinking about taking oral contraception also considers the risk factors that are associated with sexual activity. Issues concerning sexually transmitted infections must be considered, and a discussion must take place in that regard.

It is a case not of saying that pharmacies do not have a role, but of recognising the wider agenda that applies to a young person who is going on to oral contraceptives. Sometimes it is best if a patient and a general practitioner or a doctor in a sexual health clinic discuss that agenda.

We would have to be careful about changing how that type of service is delivered, given the other possible consequences of young people being sexually active. We need to address all the issues rather than just a specific aspect.

Nanette Milne: Some community pharmacists feel that people who might not readily go to their GP for that sort of discussion would come to them instead. They feel that they have an active role to play. I can see their point, but with the provisos that you have stated.

Michael Matheson: As I am sure members will be aware, part of the challenge for pharmacists having such discussions in their shops is the issue of confidentiality. I am not saying that the difficulties are insurmountable, but we must be cautious about our approach given that such issues must be considered.

Nanette Milne: What about longer-acting emergency contraception?

Michael Matheson: You are referring to the 120-hour contraception rather than the 72-hour one, and my understanding is that the former is presently available only on prescription. That is

partly as a result of regulations around that form of medication. I think that the medication has possible side effects and that its use is monitored, which is partly why its availability is restricted to prescription only.

Dr Simpson: I think that that situation is changing or about to change and that the black triangle, which is the warning sign, has been taken off the medication. There is an indication that the advantages of the particular compound involved over the original one, which was simply an adaptation of oral contraception, will be significant. I hope that the minister will look at that carefully to ensure that health boards, local authorities and, indeed, pharmacists can use the newer product if it is deemed to be more effective, which we think it is.

Michael Matheson: In principle, pharmacists can already provide that type of service. The issues around the medication involved are to do with regulatory restrictions, which is why it had to be prescribed. If the position changes, there will be an opportunity to reconsider the matter because, in principle, pharmacists can already provide emergency hormonal contraception.

Mark McDonald (North East Scotland) (SNP): There have been two sides to the inquiry, one of which has focused on how we address the teenage pregnancy issue and prevent young women from becoming pregnant. The other side is that in the real world there will always be teenage pregnancies, so the question is how we ensure that when a young woman becomes pregnant she gets the right support to allow her to make the best choice for herself regarding whether to continue the pregnancy. Should she choose to continue the pregnancy, the question is how we support her appropriately to ensure that she gets the best advice during the pregnancy and that the right support is made available to her once the child is born.

Some of our evidence has shown that the reaction to someone being a teenage parent and the stigma that is attached to that hold back some support. The initial reaction to a young woman becoming pregnant is often very negative. Given interactions that she might have in that regard, the young woman can find it difficult to access support services; she might be reluctant to do so, because she thinks that she will be judged.

Alongside the strategy to reduce levels of teenage pregnancy, is work being done to ensure that, when support services are required, they are tailored so that they are accessible to young women? How do we change attitudes to young women who choose to continue their pregnancy?

Michael Matheson: Work is taking place in some health board areas on how they can ensure that their services are much more accessible. Some of the guidance on respect and responsibility that we issued in 2008 was aimed at encouraging health boards to deliver services that are more young person friendly. Boards were encouraged to make services as accessible as possible, for example by locating them closer to schools where possible, and to provide them in a non-judgmental way, particularly for young people who are engaging in sexual activity or are pregnant. Work has been done to encourage young person-friendly services and to support the work that our school nurses do. School nurses are able to signpost young people to the right services and support for advice and information as and when necessary.

The stigma that is often associated with being a young parent is an issue that young mums constantly raise with me. Part of the challenge is to ensure that we have the right services for young parents. The family nurse partnership is a very good example of that. By the end of this year, around a third of young people who can make use of the service should be covered by the service; national roll-out will be completed in 2015. There is a lot of work taking place on that at the moment, and the service has just started in Glasgow. The partnership is a very good example of the type of service that supports young people in a non-judgmental way and improves outcomes for young parents—both during pregnancy and after—and their children in moving forward in their lives.

Unfortunately part of the stigma can, at times, come through the negative media presentation of the issue. That can often create a public perception that is not necessarily true. Part of the sexual health and blood-borne virus strategy has an outcome focus on changing that perception in the media. For example, our let's talk about sex campaign, which is launching again this month, is about breaking down some of the barriers in talking about sexual issues. That can address some of the stigma that has developed in public perceptions and ensure that we have the right services to support people during their pregnancy and when they become young mums.

Mark McDonald: It is interesting that we finish on young mums. A lot of the focus, rightly in some ways, has been on the role of the female and the role of the mum.

However, in a lot of cases—not all, but a lot—there is also a young dad and a young man who has become a father. Some of the feedback that we have received is that the services are not necessarily tailored to give the best support to young men, both in the initial messaging and in the support for them when they become a parent.

There are often barriers in young men's way; for example, the family of the young female may be

reluctant to have the young male involved. That relates to the issue of stigma. When we were in Dundee at the young mums unit, for example—a very good resource at Menzieshill high school—I asked whether the father of the child, if he is also in education, has the same option as the mother to relocate to the school in order to have contact with his child. At present that is not the case. Does more work need to be done to ensure that young men and young dads are also being factored into existing services?

Michael Matheson: There are two parts to this. There is still more work to be done on young men understanding and recognising their responsibilities around the use of contraception. At times, a lot of the focus is on young women. More work can be done to ensure that young men recognise their responsibilities in that area.

13:00

More can also be done on working with young fathers and engaging them. There will always be challenges. For example, the support base in Glasgow takes in young mums from different parts of Glasgow. Some of them have to travel a fair distance to make use of that service—that challenge is there for young fathers as well.

We have an opportunity to consider how to improve the engagement of young fathers. Earlier, I mentioned the family nurse partnership outcomes, which are good examples of how young fathers can be helped to engage much more effectively with their parenting roles and their responsibilities. We need to look at how we can build upon that with regard to education, too—to look at what we can do to support young fathers in retaining and maintaining their education.

Aileen McLeod (South Scotland) (SNP): I have a question on our relationship with alcohol. A small percentage of teenage pregnancies are not just unplanned; alcohol, too, is involved. How do we ensure that young people have a healthier relationship with alcohol and how do we get our young people to understand the health effects that alcohol can have on the pregnancy itself?

Michael Matheson: To return to one of my first comments, the whole issue of dealing with teenage pregnancies is similar to dealing with many of the other factors that drive health inequalities in our society, such as socio-economic inequality, alcohol, poverty, and drugs misuse, all of which can contribute to such issues. That is why we need to look at the issue of teenage pregnancies within that broader policy field, taking into account the role that such factors can play.

There is no doubt that alcohol is a contributory factor in some cases. Part of the work that we are doing with the alcohol framework involves ensuring that young people have a clearer understanding of the harm that alcohol can cause them and the consequences that can come from that. We need to keep taking forward that important educational element.

The Convener: As there are no further questions, I thank the minister and his officials. We appreciate your evidence and the time that we have had with you. Thank you.

Michael Matheson: Thank you.

The Convener: We have one final item on NHS waiting lists, which we agreed earlier to take in private.

13:03

Meeting continued in private until 13:15.

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