The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 24 June 2014

Session 4

Tuesday 24 June 2014

CONTENTS

HEALTH AND SPORT COMMITTEE
21st Meeting 2014, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central 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)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Lindsay Anderson (Scottish Government)
Aileen Campbell (Minister for Children and Young People)
Morris Fraser (Scottish Government)
Michael Matheson (Minister for Public Health)
Katy Richards (Scottish Government)
Professor Bill Scott (Scottish Government)
David Thomson (Scottish Government)
Diane White (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Health and Sport Committee

Tuesday 24 June 2014

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 21st meeting in 2014 of the Health and Sport Committee. As usual at this point in the meeting, I ask everyone in the room to switch off mobile phones, as they can interfere with the committee's business. I should point out that members and officials are using tablet devices instead of hard copies of their papers.

Agenda item 1 is a decision on whether to take in private item 10, which is consideration of our approach paper on the Mental Health (Scotland) Bill. Do members agree that we should take item 10 in private?

Members *indicated agreement.*

Subordinate Legislation

Registration of Social Workers and Social Service Workers in Care Services (Scotland) Amendment Regulations 2014 [Draft]

09:45

The Convener: Item 2 is subordinate legislation. We have one affirmative instrument to consider: the draft Registration of Social Workers and Social Service Workers in Care Services (Scotland) Amendment Regulations 2014.

As usual with affirmative instruments, we will have an evidence-taking session with the minister and her officials. Once we have had all our questions answered, we will have the formal debate on the motion, if necessary.

I welcome the Minister for Children and Young People, Aileen Campbell, and her officials from the Scottish Government: Diane White, senior policy officer in the office of the chief social work adviser; and Katy Richards, solicitor in the food, health and community care division.

I give the minister an opportunity to make a brief opening statement.

The Minister for Children and Young People (Aileen Campbell): Thank you for the opportunity to introduce the regulations, which were made under sections 78(2), 78(3) and 104(1) of the Public Services Reform (Scotland) Act 2010. The regulations amend the schedule to the Registration of Social Workers and Social Service Workers in Care Services (Scotland) Regulations 2013.

The 2013 regulations require social services workers within the scope of registration to register with the Scottish Social Services Council—specifically, all new workers who are commencing employment in any of the groups that are within the scope of registration must achieve registration within six months of commencing employment—and set final dates by when existing workers must achieve registration.

The draft regulations relate to the latest group of workers for whom registration with the SSSC will commence in June 2014—namely, supervisors who work in care-at-home and housing support services. The provision amends the schedule to the regulations to set the date when existing workers who work in those services must achieve registration with the SSSC.

In summary, the regulations maintain and fulfil the policy intention that registration with the SSSC is a prerequisite of employment and continuing

employment, and provide the final dates of registration for the latest group of workers.

I am happy to answer any questions that the committee may have.

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

Rhoda Grant (Highlands and Islands) (Lab): I wonder whether there is a qualification attached to the registration. Is there a minimum qualification that those people need to attain? If so, how long does it take for someone with no previous qualification to get to that level?

Aileen Campbell: The level of qualification that is required is Scottish vocational qualification level 3.

Diane, would you like to comment on timing?

Diane White (Scottish Government): The timing can vary between 12 and 18 months. It depends on how much experience the worker has, because their experience goes towards the accreditation in obtaining the qualification.

Aileen Campbell: The regulations provide for a lead-in time up to 2017, so there is a period in which workers can register. The closing date is 2017, so there is time for this group of workers to gear up to be able to register.

Rhoda Grant: Do you think that three years is adequate to allow people to qualify, given that they may not get the certification first time?

Aileen Campbell: The original bill was consulted on and we put out the draft regulations for consultation to all employers, employees and unions and representative groups such as Unison, but no comments came back. I think that the timescale is achievable for this group of employees and that there will be enough time for them to get the right qualifications. The act was passed in 2010 so, as well as having the time from now until 2017, the workforce has understood since 2010 that there will be a requirement for registration.

Richard Lyle (Central Scotland) (SNP): Good morning, minister. Is there a cost for registration? If so, will it be uprated yearly or at other points?

Aileen Campbell: The cost will depend on the level of the person's role—for example, the cost for senior managers is £30 and the cost for the group that we are talking about today is £20. There are different strands and tiers of cost, depending on the person who registers.

Richard Lyle: Is it a yearly cost?

Aileen Campbell: Yes.

The Convener: There are no other questions from members, so we now move to item 3, which is the formal debate on the affirmative Scottish statutory instrument on which we have just taken evidence. I remind the committee and others here that the members should not put questions to the minister during this formal debate session and that officials cannot speak in the debate.

Motion moved,

That the Health and Sport Committee recommends that the Registration of Social Workers and Social Service Workers in Care Services (Scotland) Amendment Regulations 2014 [draft] be approved.—[*Aileen McLeod*.]

Motion agreed to.

The Convener: I thank the minister and her officials for their attendance this morning.

Aileen McLeod: Thank you.

09:52

Meeting suspended.

09:58

On resuming—

National Health Service (Pharmaceutical Services) (Scotland) (Miscellaneous Amendments) Regulations 2014 (SSI 2014/148)

The Convener: Under item 4, we will take evidence on the National Health Service (Pharmaceutical Services) (Scotland) (Miscellaneous Amendments) Regulations 2014 (SSI 2014/148). It should be said that it is slightly unusual to take evidence on a negative instrument but because, as everyone would agree, there has been a fair bit of interest in this issue, I thought that it would be useful to invite Scottish Government officials along to answer any questions that members might have.

We have with us this morning a panel of witnesses from the Scottish Government: Professor Bill Scott, chief pharmaceutical officer and deputy director, finance, e-health and pharmaceuticals directorate; David Thomson, deputy director, primary care division; and Katy Richards—still with us from earlier—who is a solicitor in the food, health and community care division.

We will go straight to members' questions.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I hope that our witnesses are aware of the questions that I asked in last week's meeting of the Public Petitions Committee, which were designed to give notice of the areas in which I have a particular interest. I should begin by declaring my membership of the Royal College of General Practitioners and the British Medical

Association, and I remind members that I have an interest—although not a personal one any more, I am glad to say—in the area that we are discussing.

10:00

This is our second bite at this. We changed the pharmaceutical services regulations in the previous session of Parliament and thought that we had got them right then, but we clearly had not. I hope that we have got them right this time. I very much welcome the new regulations, but there are some outstanding issues.

Can the witnesses give us an indication of the potential definition of the new concept of controlled localities, which will be designated to protect remote and rural practices? That would help those who still have concerns about how geographically large or small a protected locality is likely to be. Can the witnesses give us further information on that?

Professor Bill Scott (Scottish Government): I ask David Thomson to address that.

David Thomson (Scottish Government): Thanks for the opportunity to explore the regulations with the committee. Through the regulations, we hope to address four objectives. We want to enhance the objectivity of the process; to give due weight to the effect on a dispensing practice that is affected by the application; to ensure that all those who are affected have the right to consultation; and to improve access to pharmacies for patients of dispensing practices. Those are the aims of the regulations.

The amendments introduce the concept of controlled localities, as Dr Simpson said. The aim of the controlled locality is to provide some extra process in the consultation for areas within a health board that are remote or rural in character and that are served by a GP dispensing practice. That is the policy aim behind it. Katy Richards will be able to talk you through the elements of the regulations that provide that definition.

Katy Richards (Scottish Government): I am the drafting solicitor and can help to explain the effect of the 2014 regulations.

The process is quite specific and we believe that it should be readily understood. A newly inserted paragraph 1A of schedule 3 to the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 sets out two requirements that an area must satisfy to be classed as a controlled locality. First, the area must be remote or rural in character and, secondly, there must be a dispensing doctor in the area. The term "remote or rural" is further explained in the "Scottish Government Urban/Rural Classification 2011-2012", and the existence of a dispensing doctor will be a matter of fact. In that regard, the requirements for a controlled locality are known in precise conditions, and dispensing GPs can look at the "Scottish Government Urban/Rural Classification 2011-2012" to assess the likelihood of their area being classified as remote or rural. In addition, paragraph 1A states that, once a particular area has been identified as being a controlled locality, the boundary of that controlled locality will be the same as the dispensing doctor's practice boundary.

Dr Simpson: Thank you for that. I hope that that information will be fed out in more detail, perhaps even in a map or in a list of the practices that would fall within the scope of the regulations, so that every doctor will not have to look it up but will be aware of it. That would be helpful in reducing the significant tension that exists among dispensing practices.

Can I ask a supplementary question, convener?

The Convener: Yes.

Dr Simpson: At the moment, the proposal is that the designation will last for three years, except in exceptional circumstances such as the building of a new housing estate or some other substantial development that might alter the character of the locality. We should remind ourselves that GPs are running businesses and, in my view, three years is not long enough for people to be able to plan the future of their businesses. A limit of three years could create uncertainty except in very remote and rural areas, where change as a result of the regulations will be much less likely.

It is that borderline that has been pushed out. We want more pharmacy services but we have affected those practices badly, as the Wilson and Barber report indicates. In paragraphs 49 to 51 of that report, the authors state that they are very concerned about destabilisation. I am still concerned about that boundary and wonder why the Government has settled on the limit of three years rather than five years or even, for some areas, a longer designation that would allow certainty in business planning and in investment in the dispensing part of a practice.

Professor Scott: I can understand that sentiment, Dr Simpson. When we put the consultation out, the response that we got back was from one year and upwards. I have to be honest; we chose three years just to get a balance. That was linked to the pharmaceutical care planning that the boards have to do. In that planning tool, they review their plans every three years.

Dr Simpson: Thank you. That is a helpful explanation, but it does not give comfort to the

ones on the boundary and their business planning. I still think that that is wrong.

As you know, convener, I did not move to annul the regulations because it is important to get this done quickly. This is a useful advance, but the situation will need to be watched carefully to see whether there will be considerable tensions on that boundary in the future.

Professor Scott: We will take into account the points that are made here as we look at the guidance that we will put out.

Dr Simpson: Thank you.

Rhoda Grant: I have a couple of questions. The first is about when a GP and a pharmacist want to co-locate but other pharmacists in the area block that. What is the role of the community if it supports the co-location? How much credence is given to its wishes to have co-location?

Professor Scott: The regulations do not prevent co-location. However, the regulations look at all applications that come in, so we have to be aware of the possible unintended consequences of that, such as the inadvertent introduction of commercialisation in the primary care services, effects on the financial interests of GPs and others, and whether large companies that have money to go in with industry to build health centres then apply for the contract. That means that other pharmacies in the high street could be affected, which could have the unintended consequence of reducing the number of pharmacies, because they still depend on prescriptions.

If a health centre that has a pharmacy closes at the weekend, patients cannot get pharmaceutical services. We have found that in a number of pharmacies within health centres. It is therefore not just the one aspect of coterminosity that applies in the regulations. This issue goes much wider.

Rhoda Grant: What notice is taken of the community's position? For example, a community might be keen to have co-location because it makes it easier for people who are, for example, travelling a distance and who might not want to have to go somewhere else to access the pharmacy. What credence is given to the community's position if it is keen to have co-location but pharmacies from outwith the area are keen to stop such development going ahead, because patients normally have to go to their GP and then travel to the pharmacy, which might be some distance away? Sometimes the other pharmacists, who are obviously trying to protect their businesses, are given more credence in the discussion than the community that will benefit.

Professor Scott: We have asked the pharmaceutical services care plan to look at the services that are provided and where they are provided, and to match those with the demographics of the surrounding area. That is one vehicle that the community can use to make its representation.

Rhoda Grant: So the community representation will be taken seriously.

Professor Scott: Yes. Those plans will not be constructed by the boards without taking into account the communities that they serve. The communities will have input into the plans.

Rhoda Grant: I have another question, which turns the thing slightly on its head. I welcome the regulations before us, as there are lots of issues that need to be dealt with. However, my view is that they do not deal with allowing patients in remote rural areas to access pharmacy services. People obviously want their GP services to be protected; they do not want a pharmacist if it is going to cost them the GP services that they know and enjoy. The regulations do not deal with the issue that people will benefit if they get access to pharmacy services. How can we get people in those rural areas to have access to pharmacy services that do not undermine their GP services?

Professor Scott: As you know, we are going to have clinical pharmacists to support the general practitioners with their patients, for reasons of helping with complex medicines and complex patients. The issues that you are addressing may relate to the minor ailments service. How do people get medicines without having to go to the general practitioner all the time? We would want to consider how we do that in future in a way that does not undermine the general practitioner, yet, at the same time, does not require the community pharmacy to put in an expense on which it is not getting a return.

Rhoda Grant: So that is work in progress.

Professor Scott: It is work in progress.

Rhoda Grant: There is also the issue of people with complex conditions who would benefit from sitting down and speaking to a pharmacist, rather than having the GP getting advice and the patient then getting that advice from the GP—who might themselves benefit from sitting down with a pharmacist, going through the patient's medication and perhaps tweaking the regime to suit the patient's lifestyle. That is particularly important with long-term conditions and palliative care.

Professor Scott: I agree. We received a project proposal from the Western Isles just yesterday. We are considering it, as it will help us to shape the model that will serve patients in rural communities.

Nanette Milne (North East Scotland) (Con): I do not have a declarable interest in this subject

although, some years back, my sister-in-law ran a dispensing practice in the north of Scotland.

I am aware that GPs invest a significant amount in equipment, in readapting premises and in employing staff. If a community pharmacy were to take over in an area, is there any plan to compensate GPs in any way for the outlay that they might have made? What about the staff whom they are employing specifically to do pharmacy work? Would they be transferred to the incoming pharmacy? Has any arrangement been made about that?

Professor Scott: I will ask David Thomson to answer that.

David Thomson: GPs, who are independent contractors, continually make decisions about their own investments. In contrast with pharmacy contractors, who are responsible for the provision of all infrastructure and staff who are required to deliver pharmaceutical services, dispensing doctor contractors, in addition to the dispensing remuneration that they receive, also have the costs of the premises that they require to provide dispensing services covered by the health board. They are already getting a potential advantage there.

On the question whether any redundancy costs would fall to the original employing practice, should staff be made redundant, the contractor would normally seek to redeploy those staff if possible. We are aware that, in practice, some staff have, as you have said, transferred to the new pharmacy, where the costs would obviously be borne by the new pharmacist.

When a dispensing practice loses its dispensing rights, health boards normally allow a period of grace for that practice to continue to dispense, giving it access to income to help with winding-down costs, including stock recycling and some staff redundancy costs.

In our view, it is important that the board and the practice are in discussion at an early opportunity to discuss the impact on the individual GP contractor's business and to consider jointly how to continue the delivery of GP services in the area.

Nanette Milne: Would any transfer of staff be under the Transfer of Undertakings (Protection of Employment) Regulations 1981?

David Thomson: I am not a lawyer, so I would not want to answer that. I am not sure whether Katy Richards is qualified to answer that either. I think that, in some circumstances, TUPE would apply, but I could not say that definitively for each situation.

10:15

Nanette Milne: It would seem reasonable that they should have the same terms and conditions as they have been used to.

The Convener: Do the witnesses have any further response?

Katy Richards: As David Thomson said, it is not my area, but what I know about TUPE is that it tends to be fact specific, so it is not possible to make a general statement about whether something would or would not transfer without knowing specific information about cases.

Dr Simpson: My understanding is that there is no protection. Unlike any other business, GPs do not have the right—nor should they have the right—to sell the good will, so they are not able to receive recompense for their investment. I understand the point about premises, but the GPs are still left with premises that they may be renting or that they may have built or purchased, unless they can use them for other purposes or renegotiate a rental agreement or recompense from the board to compensate them for the bit of space that is now no longer required.

Frankly, there is a failure in the regulations to address the whole area of the retraction of a service from general practitioners. For example, the GP in Drymen had invested a not insignificant amount for a small practice—£3,500 or £4,000—in software to improve patient safety. That is now of no value to her whatsoever. She cannot sell it to anybody else; it has no value. When the pharmacists take over the dispensing, they are not paying anything to us as taxpayers or to the health service for the effective good will that they are acquiring.

We have a commercial situation in which, if the new pharmacy's financial sustainability is borderline, that is now one of the items looked at in the new regulations, and I am glad to see that. However, if the pharmacy is in a town and is highly sustainable, it can be acquired without any purchase of good will from the health service. I feel that we have lost an opportunity to say that, in some cases, we will want there to be a pharmacy, because it will be in the practice's interest and it will charge nothing, whereas in other areas, we would like to charge something.

The Convener: That was a supplementary question.

Dr Simpson: I appreciate that, convener.

The Convener: We need to allow the witnesses to respond, and other committee members have questions.

Professor Scott: At the pharmacy in Millport, there were four members of staff working in the

GP practice, two of whom were re-absorbed into the practice and two of whom were transferred over to the pharmacy. That may not be a TUPE agreement, but it was a way of trying to sort things out. Good will does not exist for NHS services. Good will is about commercial services. As we discussed some weeks ago when we considered prescription for excellence, the amount of business that is coming through the front door of community pharmacies is now decreasing because of other competitors. Pharmacies receive no help with their rental, electronic systems or staff, so we are not publicly giving them money for that, and there is no good will in general practice, as Dr Simpson said.

Bob Doris (Glasgow) (SNP): Can I just check something? It may have been a turn of phrase that Dr Simpson used. He has made a lot of good points, but he spoke about a failure in the regulations and I would like to clarify whether the regulations strengthen the position of dispensing GPs in remote or rural areas.

Professor Scott: I can answer that. The Cabinet Secretary for Health and Wellbeing has listened with concern to what has been said in the Parliament and what has been coming through from communities and from people who have written in. He was most insistent that it should be a priority for us to address how we strengthen dispensing doctor practices. That is the purpose of the regulations.

Bob Doris: That is helpful. I just wanted to be clear that there is not a failure in the regulations. Dr Simpson and others perhaps think that there may be an opportunity to go further, either now or later, if the regulations are reviewed at a later date. The fact that the regulations strengthen the position of dispensing GPs was getting a little bit lost there.

Professor Scott, you used the word balance. I agree. The word commercialism has been used quite a lot as well. GP practices are commercial concerns, as are community pharmacies. I agree that there should be additional protection in certain circumstances but you are also in effect providing a commercial monopoly to one business against another. Is that one of the reasons why you went for a review period of three years? It is quite a big thing to give, for all the right reasons, a commercial monopoly to one commercial interest and exclude other commercial interests. Was that a concern when you went for three years?

Professor Scott: That is one of the concerns. You may get a new housing estate or some new use of land that could alter the balance; we have to keep looking at that.

As we have said before, we are very conscious that the national health service is a public service. Regardless of any commercial activity, our requirement is to provide an environment for co-operation within the NHS. One of the aspects that we considered was trying to strengthen co-operation between the clinical pharmacists and the GP surgery, just as we are doing in the wider pharmacy and GP community.

Bob Doris: You mentioned clinical pharmacists. In theory, is there anything to stop community pharmacists from forming such a relationship with GP practices in remote and rural areas? Are they excluded from doing that?

Professor Scott: We can use pharmacists who are employed in any capacity. The one thing that we must do, though, is to ensure that we are not providing a perverse incentive. We have to ensure that a pharmacist's activity is about the patient and not any commercial approach that their employer would want.

Bob Doris: It is about who is best placed to provide the service in that area.

Professor Scott: Yes.

Bob Doris: Financial sustainability is a key criterion. I am not talking about GPs per se. My colleague Gil Paterson has business experience that I do not have, but I suspect that if you ask a dispensing GP in a remote or rural area whether their dispensary is vital to their sustainability, every single one will say yes, because if they do not have a monopoly on that, they will lose money. However, losing money does not necessarily make a GP practice unsustainable; it just means that it has less money. How do you get the balance between commercial self-interest and what is sustainable? How is that teased out?

Professor Scott: I will bring in David Thomson.

David Thomson: It is important to note that dispensing income for GPs is never intended to cross-subsidise the delivery of core services. That is in our statement of financial entitlement and those directions are the financial basis for the regulations. We do know that that is not what plays out on the ground. It is important that we recognise that, even if the rules state something slightly different.

You asked about balancing the commercial interests of both parties. That is why we have drawn the regulations in such a tight way, with a very specific set of criteria to define a controlled locality: it will be remote or rural, and it will have a dispensing GP practice. We recognise that there will be tensions. As has played out previously and will play out under the new regulations, there will always be an argument about whose commercial interests are best served.

Katy Richards: I will clarify the effect of a controlled locality. Words such as "monopoly"

have been used and I want to ensure that people's understanding is correct. A controlled locality designation does not necessarily mean that a pharmacy application will not be granted. The existing test of necessity or desirability still applies but, in addition, the pharmacy practices committee of the NHS board looks at whether granting the application could prejudice the existing provision of primary medical and pharmaceutical services in the controlled locality. If the PPC decides that an application would create no prejudice, it can grant the application. The aim is to strike the balance.

Bob Doris: That explanation is much more nuanced and has helped me to understand the position; I lacked understanding before.

It helped that Mr Thomson put it on the record that there is no cross-subsidy. The issue is more about how we retain in certain localities GPs who might for whatever reason otherwise decide to relocate; it is not about making the delivery of primary healthcare affordable, because there is no cross-subsidy from the dispensing part of the business—it was helpful to know that.

I am a city MSP, so I do not know the nuances and dynamics in remote or rural areas, but I think that a community pharmacy can involve not just a pharmacist but someone selling a loaf of bread and a pint of milk. Such an outlet could address other social concerns. A dispensing pharmacist in a community could have a regenerative dynamic, outwith a GP's dispensing role. Is that considered as part of the overall package when a community pharmacist seeks to go on an area's pharmaceutical list? Are such issues looked at in the round?

Professor Scott: The main concern for the NHS is the national health services that would be provided.

Bob Doris: I am just trying to understand the bigger picture. I have no further questions.

Richard Lyle: I welcome Professor Scott's comments about safeguarding and strengthening the situation. Like others, I have received a couple of emails. One was sent to me by a doctor, whom I will not name. They suggested that the regulations say nothing about how commercial pharmacies will be sanctioned if they do not fulfil the promises that they make to a health board. How will they be sanctioned?

Professor Scott: We have systems in the NHS whereby, if a contractor does not provide the required service, they can be taken to a disciplinary committee. Further to that, if a patient or the board is not satisfied, the pharmacist can be referred to the General Pharmaceutical Council—the regulator—which could have severe consequences.

Richard Lyle: The regulations do not need to specify that—other legislation or procedures can be invoked against pharmacies that do not fulfil their duties.

Professor Scott: Yes.

Gil Paterson (Clydebank and Milngavie) (SNP): TUPE has been mentioned and I have a couple of questions on it, which I will round up. I take it that someone who is employed by a dispensing GP is employed solely by the GP and that the health service does not participate in that. Is that right?

Professor Scott: That is correct, unless a board employs a member of staff to work in a dispensing practice. That does not apply in this case.

Gil Paterson: So the health service has no input into the number of people who are employed in a location, who those people are and what they do. Is that right?

Professor Scott: David Thomson can back me up on this, but I think that dispensing practices are commercial businesses, so it is for them, and not the NHS, to determine who they employ and how those staff are used.

10:30

Gil Paterson: In other words, they are actually working in the private sector, not the public sector, and they are therefore covered by employment law. Just like the business that I own, they need to adhere to employment law. That means that the employer—whether it is me or a doctor—is responsible for any redundancy if the business closes for whatever reason. That is presumably the case.

Katy Richards: I am sorry, but I do not feel qualified to answer that question.

Gil Paterson: It would be extremely worth while to have an answer.

The Convener: It may be. The issue has been raised, but we are now getting into employment law. There would need to be an arrangement. The message that we are getting is that the national health service would not be expected to incur any additional costs as a result of any change in delivery of the service. Of course, if TUPE applied, the national health service would need to take on the liability for the tens of years of employment and, as a consequence, it would become liable for any future redundancy. The issue is pretty complex. I suppose that TUPE could apply, if the move was presented as some sort of takeover. However, the message that we have had is that the national health service in Scotland will not incur any additional costs as a result of the

arrangements on the ground, and nor should it. Is that the position?

Professor Scott: The transfer of any staff from one private sector body to another would be for the private sector. We regard community pharmacy, in that respect, as a private employer.

The Convener: Okay. We have one more question, which is from Richard Simpson.

Dr Simpson: It is on the new consultation process. Whereas previously the applicant was required to consult the community, the consultation process will now be agreed between the board and the applicant. Concerns have been expressed to me about the fact that there does not appear to be a role for the GP practice that will be affected, or for the community. One problem is that GPs have encouraged their communities to—need I go on? The witnesses will know exactly what I am talking about. That is fair enough, but I am concerned.

I am not saying, as Bob Doris suggested, that the regulations are a failure. I very much welcome the regulations, but they do not address the issue of how the community can be involved in ascertaining that the process that is proposed in the consultation is one that it subscribes to. I can foresee a situation in which the board and the applicant agree, the consultation goes out and the community—whether or not it is encouraged by anybody else—says, "I'm sorry, but we don't think this process is reasonable, fair or correct." How will you get communities involved in agreeing that? Should the board be required, through guidance, to consult the community council, which eventually will put up the named person? Will you explain that a little more?

I am sorry, convener, but that is not my last question.

Professor Scott: As you know, health boards have a general duty to ensure that any consultations that they undertake are consistent with the Scottish health council guidelines. As we produce our guidelines, we shall look to address some of those concerns. I take the point that we have to ensure that we differentiate propaganda from fact.

Dr Simpson: My last question arises from Katy Richards's comment that being a protected practice or designated locality—or whatever the term is; I have forgotten it—does not give any protection, because an application can be made for any area in Scotland.

That is a slight concern, because although there would be a three-year designated locality, an application could be made and there would then be an assessment as to what effect it might have on the practice. As far as I can see in the regulations—I might be wrong, because they are quite detailed—there is no requirement on the board to have any discussions with or investigations of the practice to determine what the potential effect might be before the process starts. In a designated locality, if an application comes in, is there a requirement on the board to go and talk to the practice and say, "We've received this application. You're in a protected locality. What effect will it have on you if we proceed with the application?" Can Katy Richards explain that to me?

I ask that question, because my other concern is about a basic fallacy that is not being addressed, which David Thomson has alluded to. We know very well that there is cross-subsidy—he has said that on the record. Although the intention is that there should not be, the business of general practice has a wholeness to it—it takes a holistic view—which includes dispensing in its costs and any money that it gets in from it. I have a serious concern that we have not got this right. I hope that we have, Mr Doris, but I still have that concern. Could that issue be addressed? There has not been a review of the effectiveness of our previous regulations on practices, which I have asked for.

The Convener: We have had a very good question-and-answer session here, Richard. I want the witnesses to respond to your question. Gil, do you want to ask something?

Gil Paterson: No, it is okay. I will forego my second question.

The Convener: Could we have a response from Katy Richards and others to the question that Richard Simpson put?

Katy Richards: As I said before, the idea of the controlled locality is to increase the protection that is given to a dispensing GP. It introduces a further layer of scrutiny for boards in relation to existing primary medical services, which did not apply under the old regulations, so that is a new thing.

You asked how a PPC might assess the effect on a practice. That is about the new joint consultation process. New regulation 5A, which introduces that new concept, sets out specific questions that the community is asked to provide views on, one of which is the potential for pharmaceutical services provided by the applicant to impact on existing NHS services. It would be for a dispensing GP and any members of the community who had relevant views to write in. After the consultation has finished, a consultation analysis report will be created, which will summarise the responses. The PPC has to look at that report when it determines an application.

David Thomson: We recognise that dispensing income might have become part of the business planning model for a number of practices. When a

practice is having to withdraw or reduce a patient service as a result of the loss of dispensing income, and the continuation of that service is considered to be necessary for the community, we expect that the health board and the practice will be in discussion to put in a properly funded contractual arrangement for that. We recognise the situation.

The Convener: I thank the witnesses for their attendance this morning at this longer-than-expected session, with extended questions and answers.

Petition

Co-location of General Medical Practices and Community Pharmacies (PE1492)

10:39

The Convener: We come to item 5. PE1492 was referred to us last week by the Public Petitions Committee. Of course this relates to the evidence that we have just taken and to the SSI that we will consider formally later in the meeting.

As members will know, the committee paper suggests that we can either close the petition or allow it to remain open and return to the issue later in the parliamentary session. I invite comments from committee members on the paper before us.

Bob Doris: We have just had a question-and-answer session that very much relates to the issues raised in the petition. I suspect that the committee will look—we obviously discuss our work plan in private in normal circumstances—at prescription for excellence again in the future. It is very much about the new relationship and dynamic between dispensing GPs, clinical pharmacists and community pharmacists and how we can better meet the needs of patients and constituents who are not getting the pharmaceutical care that we would like them to get.

Rather than close the petition or do a specific piece of work on it, I suggest that the next time that we scrutinise prescription for excellence we think about how we can incorporate some of the petition's themes in our evidence session.

The Convener: Is there an alternative view? As there is not, do we agree that we will allow the petition to remain open and that it will be a focus in our future discussions on prescription for excellence?

Members *indicated agreement.*

Subordinate Legislation

National Health Service (Pharmaceutical Services) (Scotland) (Miscellaneous Amendments) Regulations 2014 (SSI 2014/148)

10:41

The Convener: Agenda item 6 is more subordinate legislation and we will consider two Scottish statutory instruments that are subject to the negative procedure. The first instrument is SSI 2014/148. There has been no motion to annul the regulations and the Delegated Powers and Law Reform Committee has made no comments on them. As members have no comments on the regulations, does the committee agree to make no recommendations on them to the Parliament?

Members *indicated agreement.*

National Health Service Superannuation Scheme (Scotland) (Miscellaneous Amendments) Regulations 2014 (SSI 2014/154)

The Convener: The second instrument is SSI 2014/154. There has been no motion to annul. The Delegated Powers and Law Reform Committee has drawn the instrument to the attention of the Parliament—the details are outlined in the committee papers. Does the committee agree to make no recommendations on the regulations?

Members *indicated agreement.*

The Convener: I suggest that we suspend the meeting briefly while we set up for the minister, who will give evidence under agenda item 7.

10:43

Meeting suspended.

10:45

On resuming—

National Confidential Forum (Prescribed Care and Health Services) (Scotland) Order 2014 [Draft]

The Convener: Under agenda item 7, we have one affirmative instrument before us. As usual with affirmative instruments, we will take evidence from the minister and his officials and, once all our questions have been answered, we will have the formal debate on the motion.

I welcome the Minister for Public Health, Michael Matheson, and his officials: Ailsa Garland, principal legal officer for food, health and community care, and Sue Moody of the survivorScotland team in the care, support and rights division, both from the Scottish Government. I give the minister an opportunity to make an opening statement.

The Minister for Public Health (Michael Matheson): Thank you, convener, for the chance to say a few words about the order.

The order sets out what a care or health service means for the purpose of eligibility to take part in the national confidential forum. Members may recall that, at stage 2 of the bill that became the Victims and Witnesses (Scotland) Act 2014, I made a commitment to the committee that we would aim to offer the opportunity to take part in the forum to as many people as possible who were in institutional care as children in Scotland.

The order meets that commitment, and we have sought to prescribe as broad a range of care and health services as possible. We have also tried to reflect the different types of care and health services that have existed in the past 80 years. We want to ensure that everyone who is alive today who was in institutional care as a child at any time can take part in the forum.

The order makes no distinction between private and public providers of institutional care, nor does it distinguish between arrangements made by the state and private arrangements made by families. In that respect it is, again, designed to enable as many people as possible who were in institutional care as children to participate regardless of their circumstances.

The order potentially includes services that were not designed exclusively or mainly for children. We know that children have in the past been placed in adult facilities, including prisons and poor law institutions. In article 2, the order prescribes

"health services provided in—

(a) a hospital;

(b) an independent clinic;

(c) a sanatorium."

A range of care services are prescribed in article 3, which members can find on page 2 of the order.

The prescribed services in the order should be read alongside the conditions that are set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 with regard to eligibility to participate in the forum. For example, one of the conditions is that the care or health service in question included residential accommodation for children.

I reiterate that the intention is to include a wide range of services to make the forum as accessible as possible, and I am happy to answer any points that the committee wishes to raise.

The Convener: Thank you, minister. I open the session for questions from committee members. Are there any questions for the minister?

Rhoda Grant: On the minister's comment about residential care, what happens to those who were not in residential care? Do they still have rights to access the forum?

Michael Matheson: Members may recall that we discussed such issues, including kinship care, at stages 1 and 2 of the Victims and Witnesses (Scotland) Bill. The Centre for Excellence for Looked After Children in Scotland undertook some work in that area, but there was a very low response to its consultation on whether care provision outwith an institutional setting should be included in the national confidential forum.

Given the findings, it was decided that it would not be appropriate for the national confidential forum to include those from what would be considered non-residential settings, so the forum is focused on institutional settings. There is scope for anybody who was in a non-residential setting to raise concerns with the appropriate authorities. However, the forum has been focused on institutional settings right from the outset, when the time to be heard pilot was established.

Rhoda Grant: Okay. I am just thinking of schools and the like.

Michael Matheson: As long as there is a residential element, it is included in the care definition set out in the order.

Rhoda Grant: Okay, but that does not include an ordinary school.

Michael Matheson: Not if it does not have a residential setting.

Bob Doris: The briefing note indicates that about 450 stakeholders took part in what was quite a substantial consultation exercise but that there were only 12 "substantive replies". Why were there so few?

Michael Matheson: Are you referring to the CELCIS consultation work?

Bob Doris: Yes. The policy note states:

"Over 450 stakeholders, including survivors, support organisations, Child Health Commissioners, service providers and purchasers, academic experts and regulatory bodies"

were consulted but only "12 respondents" gave "substantive replies". The policy note does not say specifically that the work was done by CELCIS, but that may be the case.

Michael Matheson: The respondents' replies indicate that there is general support for what is set out in the order. I am not sure whether the figures that you quoted are from the CELCIS consultation, but I know that it had a very low return. However, a significant portion of those who responded were in support of kinship care and foster care being included in the national confidential forum.

Bob Doris: That is helpful. Thank you.

The Convener: As there are no other questions, we now move to agenda item 8, which is the formal debate on the affirmative SSI on which we have just taken evidence. I refer to my earlier warning on a previous order about the difference between having questions and having a debate on the order, so I do not need to repeat that. I invite the minister to move motion S4M-10414.

Motion moved,

That the Health and Sport Committee recommends that the National Confidential Forum (Prescribed Care and Health Services) (Scotland) Order 2014 [draft] be approved.—[*Michael Matheson*.]

Motion agreed to.

The Convener: I thank the minister and his officials for their attendance.

I will suspend the meeting briefly before we take agenda item 9, on the Food (Scotland) Bill, for which the minister is staying.

10:53

Meeting suspended.

10:55

On resuming—

Food (Scotland) Bill: Stage 1

The Convener: Agenda item 9 is our final evidence session on the Food (Scotland) Bill. I again welcome the Minister for Public Health, Michael Matheson, and his officials: Morris Fraser, the bill team leader; and Lindsay Anderson, a Scottish Government solicitor. Welcome to you all.

Minister, am I correct in thinking that you will not make an opening statement and that we can move straight to questions?

Michael Matheson: Yes, I am happy to move straight to questions if you wish to.

The Convener: Good. Who would like to ask the first question?

Are there no questions for the minister?

Michael Matheson: Will I go back to my statement?

The Convener: We nearly had to ask you to do that, but Nanette Milne has a question.

Nanette Milne: The financial memorandum to the bill says:

"The financial grant provided to FSS will exceed that currently provided to the FSA in Scotland by approximately £5 million".

That increase in funding is to compensate for the extra roles that food standards Scotland will have. I presume that it takes on board the activities that will be taken away from the Food Standards Agency south of the border. Am I right in thinking that?

The financial memorandum goes on to say:

"The intention is to have this increase offset through a financial transfer from the FSA UK-wide budget to the Scottish Government to represent the activities which will now be delivered in Scotland rather than on a UK-wide basis."

That confirms that I was right in my assumption.

The financial memorandum also states:

"The level of that financial transfer is the subject of on-going negotiations."

Can you provide any information on how those negotiations are going? I have been told that they are proving a little difficult, although that is anecdotal. Has a time limit been set? What is the current situation?

Michael Matheson: The Scottish Government gives funding directly to the FSA in Scotland, but funding also goes into the United Kingdom central pot for performing functions for the Scottish ministers. Some of the negotiations that are taking place are about the repatriation of some of that money.

The negotiations are at a very advanced stage. I am confident that we will reach a point of agreement and a final outcome. Essentially, we are talking about moneys that have gone from the Scottish Government to fund aspects of the FSA at a UK level and the performing of certain functions for us, covering three office bases. I am confident that we will reach agreement.

Nanette Milne: I have heard that the negotiations have not been straightforward. Can you comment on that?

Michael Matheson: They have been straightforward in that they have taken place within the machinery of Government. I do not think that there have been any particular difficulties with them, other than the fact that the two sides have taken different positions, as we would always expect in such negotiations. I am confident that we will reach an agreement that reflects what we are satisfied is an appropriate amount to be returned to the Scottish budget.

The Convener: Whatever the financial arrangements, we have heard in evidence—as you probably know—that the other important factor is not to disturb too much the existing networks, the exchange of information and the research that is currently carried out. The importance of that has been highlighted to us in evidence. How are you getting on with the task of ensuring that we do not cause too much disruption and that we can still use all the important networks, which we have been told should be maintained?

Michael Matheson: We are making good progress with that. We have had a very good working relationship with the FSA at a UK level from the outset, ever since we made the decision to establish the FSS and to maintain a good partnership with the FSA. There are aspects of the current arrangements that it is keen to maintain, because there are areas of research and expertise in Scotland that it wants to continue to be able to make use of, and we are keen to work with it.

Opportunities will be opened up for us at a European level that would normally be filtered through the London office and which the FSS will be able to tap into directly. There are potentially new opportunities for us in areas such as research.

We are also developing a memorandum of understanding with the FSA on accessing and sharing expertise and information among the agencies. In general, there has been a very cordial and good relationship right from the outset in looking to maintain and support access to relevant bodies of expertise in Scotland, the FSA and the rest of the UK.

11:00

The Convener: On the opportunities, will we be competing with the UK agency for European research funding? Does that happen now?

Michael Matheson: That would be taken forward on a corporate basis by the FSA at a UK level. Obviously, there are areas of expertise in Scotland. For example, Scotland is seen as a leading authority in the world on shellfisheries. Quite a bit of that research was passed to the Scottish office to conduct on the FSA's behalf.

From an operational point of view, there will also be an opportunity for the FSS to consider where it wishes to carry out other specific research and how it wishes to fund it, whether by using its own resources or by tapping into other international resources that are available to it, particularly at a European Union level. That opportunity will exist in a way that does not currently exist for the FSA office in Aberdeen because of the corporate nature of the FSA and the way in which it operates across the UK.

The Convener: I wonder whether it would disturb the relationships if it was competing for European funds with the UK body.

Michael Matheson: I do not think that it would be a case of competing. It is about utilising expertise and areas in which the UK agency feels that it has expertise. Money is allocated on the basis of where expertise is and the quality of the research. I would not see it as being competition. The FSS will be allowed to look at areas in which it wants to build up its expertise and to apply for any funding that it thinks might be appropriate for that, as it sees fit. The approach is based on expertise and the quality of the research that will be undertaken.

The Convener: We have heard constantly about joint submissions and that there is no single point of expertise in respect of how to pursue funding and which issues would be suitable for research. The main thrust was to keep the network pretty tight and that it was more about joint submissions. I do not think that we received any evidence that there would be an opportunity for people to go away on their own researching. We did not seem to receive that evidence.

Michael Matheson: There would be absolutely no reason why the FSS and the FSA could not make a joint submission for the purpose of pursuing research.

The Convener: This is the first time that we have heard in evidence about the opportunities that may exist for our research institutions to work on their own. That was not in any of the written submissions; indeed, the evidence was the opposite of that.

Michael Matheson: I cannot comment on that. There would be no reason why, for example, a university in Scotland that wanted to do a piece of research with the FSS in a particular field would not be in a position to look at taking that forward with it.

The Convener: The universities can do that now.

Michael Matheson: They can, but the type of work that they can do is more limited because of the corporate nature of the FSA and how it carries out its research.

Rhoda Grant: I have a supplementary question on finances. We have received evidence that, as things stand, the financial memorandum is okay. However, there is scope in the bill to increase the duties of food standards Scotland—there was talk about nutrition, diet and the like. Will further resources become available if the scope of the agency is increased?

Michael Matheson: We have designed the bill in such a way that, if it were decided at some point that the FSS should have additional responsibilities, the legislative framework would allow that to happen. We are creating the footprint. However, there would have to be a reason for committing any additional responsibilities to the FSS in future. We would have to consider the evidence base and justification for doing that, as well as the cost implications, so due process would be followed before any additional duties were undertaken. Because we are not extending the role significantly, there is no need for any additional resource at present, but if that changed in future we would have to look at the financial implications of that.

Rhoda Grant: We took evidence on the make-up of the board. There seemed to be general consensus around the fact that a board of three would be far too small. Have you had thoughts about the size and make-up of the board and about whether it should include industry representatives or whether, as many people have suggested, board members should be independent of industry? Should there be a place on the board for trade union representatives?

Michael Matheson: The board will have a minimum of four and a maximum of eight members, which broadly reflects the board make-up for other non-ministerial-led organisations of that size, such as the Office of the Scottish Charity Regulator and the Scottish Housing Regulator. Bigger organisations such as the Scottish Environment Protection Agency and Scottish Enterprise have a higher number, with a minimum of five and a maximum of 10 members. If the number of FSS board members dropped down to four, that would be too low. We would want to

manage the numbers to maintain a higher level, as close to eight members as possible.

The FSS is a consumer protection organisation, so it is important that the board has a clear commitment to that responsibility and to the organisation's objectives, and the board membership should reflect that. Rather than choosing someone from one sector or another, the choice of members should be based on people's ability to contribute to achieving those objectives and on their expertise and knowledge, to assist the FSS in achieving its outcomes.

On trade union membership, the process for public appointments to a board of that nature is through the Commission for Ethical Standards in Public Life in Scotland's public appointments process. I expect the FSS to have good industrial relations, as the FSA has, and to have in place a structure to allow union representatives to engage fully in the organisation's processes.

Rhoda Grant: Would a ring-fenced trade union place on the board not enhance trade union relations, and is that not commonplace on other boards?

Michael Matheson: No, it is not commonplace on other boards. The board has been constructed in the same way as that for any other public body. For example, health boards have employee directors who are trade union representatives with responsibility for engaging in the process. I would expect that the processes that the FSS board and chief executive put in place outwith the board structure will maintain and support good industrial relations and will ensure that trade unions have a strong voice and a role to play in helping to shape and manage the organisation. Once the board is in place, it can look at how best to achieve that.

Rhoda Grant: Will you legislate to ensure that that happens?

Michael Matheson: It is not in the bill. We have constructed the organisation in the same way as other public appointment boards are constructed, and appointments will be made on the basis of an open public appointment process.

Nanette Milne: The bill says that food standards Scotland will have

"no fewer than 3 nor more than 7"

members, but you mentioned the figure four. Will that be written into the legislation?

Michael Matheson: Lindsay Anderson can clarify that.

Lindsay Anderson (Scottish Government): That figure includes the person who is appointed as the chair. It will be three plus one, or seven plus one.

Richard Lyle: Rhoda Grant asked the question that I was going to ask, but I will explore it a bit further. I take the point about trade unions but if we really want the FSS board to have people from the sector that you talked about, such as environmental health officers or someone from industry, I take it that we will advertise and do interviews after the bill is passed. Who will select the board? Will it be officers or the cabinet secretary, or even you, minister?

Michael Matheson: The process will be the same as that which is set down by the Commission for Ethical Standards in Public Life in Scotland. An open and transparent process will be conducted, involving public advertisement, an interview panel and then recommendations to ministers about who should be appointed to the board. That is what happens with the board of the FSA. The FSA's appointments are a shared responsibility. All four ministers who are responsible for the FSA in the UK have to agree to appointments to the board, and the FSS will use the same process. It will be an open and transparent process that fully complies with the Commission for Ethical Standards in Public Life in Scotland, and appointments will be made on recommendation from the interview panel.

Richard Lyle: I do not doubt that. However, during the past couple of evidence sessions, there has been a lot of interest in who will be on the board. At the end of the day, various firms do not want to see someone from another firm on the board. We have well-respected people who have been consulted on food issues in the past, such as Professor Pennington. Will the board members be people of a high standard who are there to ensure that the standards of Scottish food and drink, which are the best in the world, are kept up? We want to ensure that whoever we choose and interview, the best people are on the board. Is that your intention?

Michael Matheson: It is certainly the intention. Obviously, it is down to individuals whether they choose to apply to be a member of the board. As I said at the outset, the FSS will be a consumer protection organisation and the board members should reflect that type of approach by having the knowledge and expertise that will assist in achieving the FSS's objectives, which will have to be submitted to Parliament.

I want the best possible people to be on the board. It comes down to who applies and to the interview panel, which will make recommendations to ministers with the objective of getting individuals who can achieve the objectives of the FSS as a consumer protection organisation.

Bob Doris: A line of questioning was pursued that got some quite constructive answers from the industry. A representative from Tesco talked about

the testing that those in the sector, particularly large supermarkets, would do. Following the horsemeat scandal, a number of large providers, including Tesco, are voluntarily putting much more of their testing regime into the public domain for everyone to see.

How consistent is that across all such players within the industry? Is the Government minded to have a voluntary code around that? At present, there is no statutory obligation in the bill to compel that. Where does the balance sit in working in partnership with industry and the sector not just to see the results of tests, but to provide support to ensure that an informed, risk-based approach to testing is being taken? It would be good to have more information on the voluntary basis of that, the potential for a voluntary code and the need for any statutory moves in that regard.

11:15

Michael Matheson: It might be helpful if I give a wee bit of background to the horsemeat fraud issue, as I was involved in dealing with that. Although it was a food labelling issue, not a public health issue, I was involved because of my responsibility regarding the FSA in Scotland.

One of the challenges was that, although retailers were conducting testing, the results of that testing were not routinely shared with the FSA at that time. During the horsemeat scandal, it was put to the retail industry that it would be helpful if the results of that testing were shared with the FSA so that it would have a clearer understanding of the findings. That was agreed on a voluntary basis and, when appropriate, that information was placed in the public domain.

Some retailers have a system whereby they give some indication of the outcomes from some of the testing that they conduct. It will be for the FSS to advise us on the policy and whether there should be a mandatory scheme. If the FSS advises ministers that we should move the system to a statutory footing, we will have to consult on that and consider how to take that forward. The FSS's role will be the same as the FSA's role at the moment, which is to advise ministers on what we should do in the area—whether the scheme should be voluntary or mandatory and what it should look like. We will respond to that advice and look to proceed with a consultation process.

Bob Doris raises an important point about the relationship between the industry and food safety bodies such as the FSA and the FSS. There is a decision to be made about whether that type of information is useful in driving forward consumer protection or whether there is a more appropriate way in which that can be achieved, and it will be for the FSS to advise the Government on how it should proceed. Its job is to advise and inform us openly, and if it says that the system should be put on a statutory footing we will consult on how we can take that forward.

Bob Doris: Thank you. That is helpful. I would like to pursue another line of questioning, unless colleagues have other questions on the subject.

The Convener: We have raised the matter of food inspection with some of our panels. We had an evidence session with fish processors when we visited Aberdeen, and they explained to us that the level of inspection for the various supermarkets is very high, whereas local authorities inspect maybe once a year. There is a lot of inspection, though, and we asked about the inspection and regulation that already goes on. The counter-view was about the importance of having independent testing and inspection, whether that is co-located in Scotland or whatever, rather than it being the responsibility of individual small councils. Do you want to comment on that, given that lots of local authorities have withdrawn their inspection and regulation services?

Michael Matheson: You raise a good point, convener. At present, the FSA, as the competent authority, works with local authorities and provides them with guidance and structure for some aspects of the testing that they should be engaging in, but there is independence at a local level in how they put that into practice.

Moving forward, testing would be an operational matter for FSS. There is an opportunity to explore how some of the testing regime is taken forward, whether there is scope for a greater element of testing at a national level and what aspects should be left to local responsibility. There is an opportunity to look at the relationship between the local level and FSS, once it is established, and at whether there should be an element of centralised testing, rather than leaving it to local discretion. The FSS would have to discuss and explore that with its counterparts in local authorities. That is an issue that merits further consideration, and I imagine that the new FSS would want to consider it.

The Convener: Bob Doris and others have discussed with previous witnesses food hygiene and safety, food quality, the labelling regime and what happens when food is mislabelled. We got a strong message from Archie Anderson at one of our recent evidence sessions that we should not be wasting good food. We discussed the consequences of finding that something is mislabelled—it is pork, not beef, but there is nothing wrong with it—and how we dispose of it. Do you want to speak to any of those issues, which have been tested in our evidence sessions?

Michael Matheson: The food and drink industry is of tremendous value to the Scottish economy. It is in our interest to have in place a robust and clear regulatory regime for food safety and food quality, given that, in general, Scottish produce is seen as being of a high quality.

The reason that the horsemeat incident was not a public health issue is that it was about labelling. It was not the case that consuming horsemeat would do harm to someone's health; the issue was that the label did not say that the products contained horsemeat. On that basis, it was fraud, because the product contained something that was not on the label.

Through the bill we are taking forward some of the recommendations that were made by Professor Jim Scudamore and his team, who reviewed the horsemeat incident. They made recommendations in relation to taking robust, appropriate and swift action if there is mislabelling. The regulatory powers that enforcement officers will have will allow them to deal with those types of things more robustly. There is a need to make sure that the public can have confidence that the labels on products actually say what the products contain. We have to balance a reasonable testing regime and the necessary enforcement powers to make sure that action can be taken quickly and robustly if there is an issue around the mislabelling of products.

The Convener: We heard last week that European regulations are already in the system—the food information for consumers regulations. You do not intend to go beyond those regulations, do you? I see Mr Fraser nodding.

Michael Matheson: The bill goes a bit further than what is contained in the regulations. The enforcement point of the European regulations is not yet clear, so there is an issue around that timeframe. We are taking things a bit further with regard to responsibility: even if someone is not selling the product, they will have a responsibility to report it if they believe that there might be an element of mislabelling. That was recommended on the back of the horsemeat scandal as a way of trying to drive forward improvement and clearer responsibility for reporting when someone suspects that there might be mislabelling. You might not be the producer but if you are a distributor and you believe that there is an issue around mislabelling, you have a legal responsibility to report that.

The Convener: So if something looks too good to be true, you have a responsibility to report it.

Michael Matheson: Exactly.

The Convener: Would that go beyond the regulations?

Michael Matheson: That goes a bit wider than what is set out in the European regulations.

The Convener: Are there any other elements where that is the case?

Michael Matheson: It is principally just that element. There is still a lack of clarity around the timeframe.

Morris Fraser (Scottish Government): The timeframe is likely to be roughly the same as ours. There is not very much difference.

The committee may have heard evidence that there might be a perception of duplication, but there clearly is not. Our bill brings forward the duty for someone to report to the central authorities that they think that something is going on; that is an intelligence-gathering tool to try to clamp down on something. The food information regulation relates to situations in which someone who knows something ought to tell their supplier and those to whom the food is being supplied, not the authorities. There is no duplication.

The Convener: The issue was raised in relation to the experience of some manufacturers. They produce pallets of prepared food such as fish, which go to destinations such as Norwich and all over the UK, and they were anxious that any changes in labelling requirements should not harm their business. You have given us the assurance that there will be no duplication.

Morris Fraser: There is perhaps one other thing to give assurance on. The authorised officers do not only have powers to detain, seize and offer the courts an opportunity to destroy; simple relabelling and recomposition can also be carried out. The food need not be wasted just because a label is found to be wrong. The authorised authorities have the power to ask people to take certain action, which might be just to relabel, so that the food will not be wasted.

Bob Doris: There have already been answers to most of the questions that I was going to explore, and they absolutely nailed the things that needed to be asked about. However, I seek a little clarity in relation to cases of deliberate labelling fraud. Would there be an option to do more than just seize the food in such a case? I previously referred to something being wrongly destroyed—I was comparing a situation to having hooky goods, say, which may or may not be destroyed. Could an order be made to pass the food on to food banks or charities, for example?

I do not want to sound too heavy handed with regard to some elements of the industry—I am sure that those concerned are in a minority—but if someone is getting 500g of something for 50p rather than £4.99, that is blatant fraudulent activity. I do not mind if those concerned are not allowed to

relabel that food; I would be quite content for that food to go somewhere else, as long as the move is commensurate with the scale of the fraud. Is there the power to redirect safe but fraudulent food elsewhere?

Michael Matheson: The enforcement officer has broadly two options. One is that they can enforce a fixed penalty. They can prevent the person from moving the food anywhere until they have done further investigations into the matter. The authorities might come back and say that the product must be relabelled to make it correct, because what is contained in the packet does not constitute what is on the label.

The other option is for the matter to be referred to the procurator fiscal. It would be taken before the sheriff court, which would determine what should happen to the food. Rather than us saying that the food should go to a food bank, it would be a matter for the courts to determine that, depending on the nature of the case.

The approach will depend on the nature of the food fraud and the type of product. For example, there is a very limited timeframe for perishable goods. As you know, food banks do not really use perishable goods to a great extent, for obvious reasons.

The Convener: Bob, you can move on to enforcement, if you want.

Bob Doris: That is exactly where I was going to go, convener.

I asked about this issue in one of our first evidence sessions on the bill. I apologise for concentrating on retailers, but they are the public face. We do not always see the food chain behind them. Let us take the case of a small independent retailer, with one or perhaps two shops. Whether what the retailer has done is deliberate fraud or otherwise—let us suppose that it is deliberate—there is a fines scale to cover it. Let us then pick Tesco. I have complimented Tesco on what it is now doing, so I pick it randomly—I am sorry for singling it out. We are talking about one similar infringement in one Tesco Metro, of which there are many right across Scotland. The footprint of Tesco across the whole of Scotland is far more substantial than that of the small independent retailer. Is the fines scale—or could it be in future—flexible enough to recognise the extent of the tradeable business across Scotland in cases of an infringement by a corporation?

Michael Matheson: An important point will be who has committed the fraud. If a product is found in a shop that is independent or part of a retail chain, an investigation will have to be carried out into who committed the fraud and where the responsibility lies. Obviously, appropriate measures will then be taken.

The Lord Advocate has told the committee that he is prepared to make available to the committee, prior to stage 2, information on the advice that he will give on the type of fine structure that should be put in place, which should reflect what the courts will do. Importantly, it depends on the scale of the fraud, who is responsible and the nature of it. That will be reflected in any fine or action in relation to criminal activity.

11:30

Bob Doris: I do not feel too bad for picking out that large retailer, as I complimented it earlier on work that it is now doing.

Last week, a retailers representative—apologies, but their name escapes me—talked about labelling and food fraud. That gentleman painted a picture of small independent producers presenting at farmers markets with things that are not labelled correctly, although perhaps not deliberately. My understanding is that the bill is not about setting up a "Yes Minister" bureaucracy on the finer points of labelling and is more about tackling overt or deliberate attempts to defraud the consumer.

Can you give reassurances that, in relation to labelling and food fraud, the bill is not trying to capture someone who has five ingredients on a label when there are actually six, where the sixth one has been omitted not because the person is trying to mislead but because of a minor technical or bureaucratic oversight? That is not what the bill has in its sights, is it? It is about the more blatant and obvious large-scale labelling fraud.

Michael Matheson: It is a question of proportionality. Where fraud has clearly been attempted or where there is a significant omission, appropriate measures will be taken and enforcement officers will inspect. Enforcement officers will have discretion to determine whether something is significant enough that they need to take some form of robust enforcement action. It is about achieving that balance. The way in which that is dealt with in practical terms will be an operational matter for FSS.

The aim is not to try to pick up small retailers who might have omitted one small point. However, if that one small point is a significant small point, that will clearly be reflected in the response from enforcement officers. The one point might be that the label says that the product has pork in it when it has beef. That may just be one point, but it is significant. Enforcement officers would use discretion in considering cases. For individuals in farmers markets, where there is a small technical infringement, I would expect enforcement officers to work on a proportionate basis.

Bob Doris: I should put it on the record that, when enforcement officers and local authorities gave evidence to us, they took the view that much of their role is about supporting compliance rather than enforcement. I have no further questions, but it is important to put it on the record that that was teased out. The minister's evidence backs up that approach.

Richard Lyle: I take it that FSS will be based in Aberdeen. I understand that the current head of the FSA in Scotland is moving to Australia. Will we be advertising for new staff? How many staff will be employed? I take it that staff will be based throughout the country. Can you give us a short résumé of what is intended?

Michael Matheson: FSS will be based in Aberdeen, at the current FSA headquarters. The FSA has staff who are based in locations across the country, such as the meat hygiene inspectors, and they will continue on that basis.

Charles Milne, the director of the FSA in Scotland, is leaving us to go and work in Australia. There will be an interim arrangement, which the FSA at UK level will wish to put in place. A process will be put in place for the appointment of a chief executive of FSS, although the important part is first to get the board structure in place, so that the process can be taken forward.

Richard Lyle: So there will be no reduction in staff and there may be—

Michael Matheson: There may be an increase in staff.

Richard Lyle: That is the very point I was going to make. There is the possibility of an increase in staff to retain the high quality of food for which Scotland has a reputation.

Michael Matheson: Yes. All of the staff will transfer to the FSS, in line with the Cabinet Office agreement, which protects their pensions and all their other entitlements. The transfer will not result in any detriment to the terms and conditions of the staff, and there is no need or plan to reduce staff numbers in the creation of the FSS. If anything, I would anticipate that there is likely to be a need for an increase in some staff. It depends on what happens once the FSS has set out its operational plans and how it intends to take its work forward.

The Convener: I do not see any other questions from members. However, it would be remiss of the Health and Sport Committee not to say something about the ambition that food standards Scotland will have a greater influence on problems in Scotland such as diet and obesity. At the same time, we should bear in mind all of the bedding-in issues, such as duplication, and the concerns of retailers and suppliers. Does the minister want to put on record the ambition that the new body will have a greater influence on the diet and health of the Scottish population? Can we achieve that, while addressing the concerns of the retailers and manufacturers?

Michael Matheson: Since the recommendation was made to establish an independent food safety body in Scotland, I have been very clear that we should maintain the integrity of the work that the current body undertakes without compromising it in any way. That is why we have taken a relatively cautious approach. A lot of organisations out there have been saying that the new body should do X, Y and Z in addition to its current role. All of that has some merit, but the danger in creating the new body is that, if we add to the functions that it has to undertake, we may compromise some of its core responsibilities, particularly relating to consumer protection.

The approach that I have chosen is to protect the integrity of the consumer protection work that the FSS will undertake, while considering where we could add to its role. At present, the FSA feels that it has a greater role to play on the issues of diet and tackling obesity. What we are doing in the legislation is facilitating that opportunity. The FSS will not necessarily take the lead on that but the legislation will allow it to work in a co-ordinated way with the NHS and other organisations with a role to play in the obesity and dietary challenges that we face in Scotland. We will enable the FSS to take that role forward, which is one that the FSA feels is important.

As I mentioned, we have tried to draft the legislation in a way that creates a footprint to give the FSS responsibility for some of the other issues that have been raised, if there is a good case to do so. We can consider adding those functions to the FSS in the years to come. I do not have any preconceived idea that those functions have to be X, Y and Z. We want to create a body that can adapt and develop in future as necessary. I do not want to add lots of functions to the new body that could compromise it while it is trying to establish itself and to perform its important function of ensuring consumer protection and—particularly given the importance of the food industry to Scotland—maintaining public confidence in it. However, the legislation gives us the framework to add further functions as we go forward, as and when that is appropriate and subject to agreement.

The Convener: There are no further questions. I thank the minister and his officials for being with us this morning and for the evidence provided.

11:39

Meeting continued in private until 11:52.

Members who would like a printed copy of the *Official Report* to be forwarded to them should give notice to SPICe.

Available in e-format only. Printed Scottish Parliament documentation is published in Edinburgh by APS Group Scotland.

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

For details of documents available to
order in hard copy format, please contact:
APS Scottish Parliament Publications on 0131 629 9941.

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@scottish.parliament.uk

e-format first available
ISBN 978-1-78457-732-2

Revised e-format available
ISBN 978-1-78457-747-6

Printed in Scotland by APS Group Scotland