HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 29 June 1999
(*Afternoon*)

Meeting 1

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*attended

COMMITTEE CLERK:

Jennifer Smart

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Craig Harper

Scottish Parliament

Health and Community Care Committee

Tuesday 29 June 1999

(*Afternoon*)

[THE OLDEST MEMBER OF THE COMMITTEE *opened the meeting at 14.20*]

Dorothy-Grace Elder (Oldest Member of the Committee): I give a warm welcome to those attending the first meeting of the Scottish Parliament's Health and Community Care Committee. I especially welcome members of the public who are here representing vital groups. One of our major concerns is that the public should be involved not just by buzz phrases such as social inclusion, but by being present. It should be made clear to the wider public, as well as to the people who are present today, that the committees will receive deputations from the public to ensure that those who are done unto by legislators can make representations directly in Edinburgh. That will be a lot easier than going to Westminster.

Today we have representatives from the national health service in Lothian; the occupational health service; the institute for housing, which has very important links with health; Unison; the NHS Confederation; the Royal College of Nursing; the British Medical Association; the Scottish Consumer Council; and the National Pharmaceutical Association, which represents Scottish pharmacists. That is a splendid turnout for our first meeting.

This committee is charged with life and death matters—nothing is more important than the health of Scotland. It is also responsible for the welfare of the staff of the NHS and related services, including social work. We have to ensure that they get fair play.

I am convening the committee only because it has been discovered that I am the oldest member. I think people should always give their age in dog years; that is much better for people's mental welfare. I will hand over shortly to the real convener.

Interests

Dorothy-Grace Elder: We are required to make a declaration of interests that might affect our judgment or prejudice us. I will declare my interests first. I have no commercial ties with any body that is connected with health but I have been a fund-raising trustee of the Royal Hospital for Sick Children in Glasgow for 19 years. I have received no payment or expenses in connection with that role. I am a patron of the mental health body, No Panic, and a member of the Medical Journalists Association, but the idea is that the members pay it, not that it pays them.

Do any members want to declare an interest?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I am a member of the public sector union, Unison. I receive no financial gain from that role, but I want my membership to be noted.

Dr Richard Simpson (Ochil) (Lab): I will be a partner in general practice and will be employed as a psychiatrist until I can complete my notice. I am employed as a medical adviser on adoption and fostering. I chair an educational group on prostate disease that is sponsored by Merck Sharpe and Dohme. I have a directorship of an organisation called Nursing Home Management, which has nursing home beds in England. I will undertake some locum work as a medical practitioner. I write articles for various medical journals. I am a member of the British Medical Association, the Royal College of General Practitioners, the Royal College of Psychiatrists, the British Association of Psychopharmacology and the Scottish Association for Mental Health. Finally, I have an honorary professorship of psychology at Stirling University, where I am engaged in medical research.

I am sorry to have taken up so much of the committee's time.

Dorothy-Grace Elder: Gosh, you are busy. We are quite stunned by such industry.

Kay Ullrich (West of Scotland) (SNP): That is a hard act to follow. I am a simple, ordinary member of Unison. Like Margaret, I would like my membership registered, although I receive no pay for it.

Dorothy-Grace Elder: Does anyone else want to declare an interest? People will be able to declare interests at subsequent meetings if they have forgotten that they had them.

Convener

Dorothy-Grace Elder: We now move to the most important part of today's business, which is the election of the convener. As people might be aware, in the interests of fairness, it has been decided that the convenerships of the committees will be allocated to different political parties. The Parliamentary Bureau has decided that the party that is eligible to hold the membership of the Health and Community Care Committee is the Liberal Democrat party. Margaret Smith is the person nominated. Does she accept the

nomination?

Mrs Margaret Smith (Edinburgh West) (LD): I accept the nomination.

Dorothy-Grace Elder: Do the members confirm that—or affirm it, or acclaim it, or whatever the word is?

Mrs Margaret Smith was elected convener by acclamation.

Dorothy-Grace Elder: I wish Margaret much success.

The Convener (Mrs Margaret Smith): I thank members for affirming me as convener. I am in a strange situation as I am the only Liberal Democrat on the committee and therefore I am the convener whether members like me or not. I hope that members will find that I act in the best interests of the committee at all times and I am a fair and reasonable convener. That is my intention.

I thank Dorothy for conducting the first part of the meeting. I have discovered another reason why women should lie about their age: to get out of doing things like that.

I echo Dorothy's point about the number of members of the public and interested groups that are in attendance and I am sure that all members of the committee agree. It is an excellent sign that people will be interested in the work of the committee. During the next few years, we will probably talk to all the members of the public who are present to get their input into the difficult and serious work of the committee. I see some well-kent faces, but also some which are not known to me and are probably not known to other members of the committee. I hope we can rectify that in the next few years and that, working together, we will be able to improve health and community care in Scotland.

Remit

The Convener: This is an important committee, which deals with life and death issues. Health is consistently the number one issue for people in Scotland. In the months and years to come, we will debate and make decisions on some important issues, including not only questions of finance and questions about what topics we want to cover—we will discuss that shortly—but the position of staff in our health and community care services.

I hope to build as much of a consensus as we can in the committee. In health, there is an opportunity for a large degree of consensus to be built. Speaking on the hustings with Kay and others, we always manage to find something in common, and I hope we have not changed our positions too much to be able to do so again. Obviously, we will disagree on occasion, but foremost in our minds will be the betterment of health care.

The committee has a number of important powers and functions, of which committee members will be aware. We are to consider and report on issues relating to the health policy and the national health service in Scotland and such other matters as fall within the responsibility of the Minister for Health and Community Care. I think that we can inquire into anything within that remit that we care to deal with.

We can consider proposals for legislation; initiate bills; consider the need for the reform of the law; consider the financial proposals and financial administration of the Scottish Administration in areas that relate to us; consider European Communities legislation and international conventions or agreements; and consider petitions that are referred to us by the Public Petitions Committee. That substantial list should keep us well occupied and off the streets for the next few years.

14:30

We will be assisted in our work by a number of officials, and some of them are with us today. The main clerk to the committee is Jennifer Smart. No doubt, committee members will become well acquainted with Jennifer and her team because she will keep us on the straight and narrow and make sure that we do not do anything that we should not. If we have any queries about how that will work in practice, for example on what we can and cannot do and on what we would like to do to make this committee as valuable as possible, Jennifer will help us.

I have had an initial chat with Susan Deacon and the junior minister, Iain Gray, and both of them are keen to have an open involvement with this committee. At some point in the future we may have to ask them to come before us to answer questions in a more serious vein, but they are keen to come before us at an early stage to outline for us what they see as the way ahead for health in Scotland, and to listen to our views on that matter.

In the absence of a health bill we have a wide remit. I would like to lead us into a discussion of the topics that members want the committee to address. I am also keen to get a flavour of the way in which members want this committee to function, because the committees will be the backbone of this Parliament and are central if we are serious about trying to do things in a more open and accountable way. I am keen to see an open and flexible committee that involves the general public and people throughout Scotland who have expertise in health and community care matters. I

am interested to hear how members see those matters progressing.

I will open up this discussion to each member in turn. If members could state their name before making their contribution it would help the people who activate the microphones.

Duncan, could you start by giving us an idea of the topics that you would like us to cover, not only those subjects that we should do something about but those subjects on which we should be briefed, as well as a flavour of how you see the committee working.

Mr Duncan Hamilton (Highlands and Islands) (SNP): I wish to raise two matters: our substantial range of issues and the way in which the committee will work. I have a number of questions on the remit of the committee, but I am not sure if you want to address them now, or hear them and return to them at a later stage.

The Convener: We will hear them now, and if we can answer them, we will. If not, we will come back to them.

Mr Hamilton: Obviously, one of our big issues is finance. Part of the committee's remit is

"To consider the financial proposals and financial administration of the Scottish Administration which relate or affect any competent matter."

For us, that matter is health.

Does the remit relate simply to the budget, or can the committee look at issues such as the private finance initiative and the levering of private capital, even though there are Finance and Audit Committees? Those are important issues.

The Convener: I understand that we can examine all of those things.

One thing that I did not say in my opening remarks is that although we can propose substantive issues that we want to deal with, one of the issues that people in Scotland want us to tackle is drugs. That issue will cut across committees and we must find methods which not only make this committee work well, but ensure that it works well with other committees.

On the matter of PFI, I said in the chamber that anyone who says they have no concern about how we are funding capital projects in Scotland in health and other areas is being economical with the truth. It is incumbent on us—and on other committees, particularly Finance and Audit, but also the Education, Culture and Sport Committee—to ensure that we are fulfilling our remit, which is to try to ensure that we have the best health care possible and that we deliver it at the best value possible to the people of Scotland. PFI is within the remit of this committee and others, and we will have to work with them to investigate it.

Mr Hamilton: Does the remit apply retrospectively? If so, it would seem to be a logical extension for the committee to look at the value that is being delivered at the moment.

On the issue of cross-committee co-operation—which, as you say, is crucial in light of what we are trying to do in the chamber and in committees—what mechanism is envisaged for ensuring that such co-operation happens? It is all very well to talk about it, but can this committee request the attendance of ministers from other departments in the same way that it can request the attendance of a health minister or official?

The Convener: I am told that the committee can do that.

Dr Simpson: I am not too sure about that. I am not saying that we should not discuss the important issue of PFI, but I think that the Audit Committee had the prime responsibility to take a retrospective view. This committee's concern should be whether PFI can, or will, deliver good health care. In other words, the committee should take a strategic view on operational matters related to health policy. We will not be the lead committee on matters of finance: that will fall to the Audit Committee under the chairmanship of Andrew Welsh.

Mr Hamilton: Obviously there is a spillover between the financial aspects and the impact on staff.

The Convener: We will have to investigate the retrospective issue, but I told the ministers that PFI was one issue that the committee might want to discuss today. I did not get the impression that they thought the committee would not examine PFI—quite the opposite. We can get clarification on that for the committee.

Hugh Henry (Paisley South) (Lab): We need clarification not only on the retrospective aspects, but on our future inquiries into whether PFI is applicable. It would be damaging if all committees start to investigate all aspects of everything. In other words, if we cease to have committees with very specific responsibilities, we will end up with committees doing nothing, rather than doing something well.

While it is right that we examine whether PFI can advance health care in Scotland, I would hesitate before we start to duplicate the work of, for example, the Finance Committee. It would not be right for the Education, Sport and Culture Committee, the Health and Community Care Committee, and the Transport and Environment Committee to begin a major investigation of PFI. They should examine PFI only as it impacts on their subject areas. The principles of PFI should

be investigated elsewhere, and we must be clear about that; otherwise, we will have five or six committees doing the same thing.

The Convener: I agree. I do not envisage that the Health and Community Care Committee will be the lead committee in looking at PFI: the most important committees will be the Finance and Audit Committees. However, there are issues for us concerning how we deliver the best health care and how we deliver the best conditions for the staff in the health service. Although the committee will be interested in PFI, I would like to see us moving forward with the positive agenda of trying to find some areas in which we have broad consensus. We need to deliver something positive early on, which people can say is an in-depth inquiry undertaken by the health committee, and which makes progress on the topics and issues that matter within health care, rather than tackling the broad umbrella subject of PFI.

Margaret Jamieson: I would like clarification on the Minister for Finance's statement on Thursday, and on the Treasury's announcement of Alan Milburn's measures regarding PFI and the transfer of pensions. Will the measures apply in Scotland? If so, a lot of the concerns of low-paid workers will be removed, particularly those of health service workers, who were the ones at risk following transfer to private contractors. I would like that to be one of the first issues addressed, because I have represented individuals in the health service, particularly ancillary workers, for the past 20 years, and I am well aware of their concerns when they have to transfer to private contractors.

The Convener: I will go out on a limb and say that probably everyone on the committee shares that point of view.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): It would be entirely appropriate for us to examine the staffing issues of PFI. There is no point in our covering the whole agenda, but we all want this committee to be involved in as much consultation with as many so-called experts and as many of the people of Scotland as possible. Many radical health policies suggest that involving as many people as possible must be at the cutting edge of health policy.

We need to address the public health agenda, particularly focusing on health inequalities. That is a big subject, so we may want to narrow it down.

The Convener: That takes care of two years' work.

Malcolm Chisholm: One of my passions is food—not eating it, but talking about it—and food may be one way of addressing public health, for example, with regard to income inequalities.

We want to focus on the health service as well. The present developments in primary care are at an early stage, and quite a lot remains to be resolved. We may want to look at that. There are many other areas to be addressed as well.

The Convener: That is a good point.

Kay Ullrich: I will go along with what appears to be the majority view—that we will not be playing the pivotal role in PFI—but I imagine that this committee will want to examine how PFI affects staff in the health service.

I agree with Malcolm that one of the major issues for this committee over the next few years is addressing Scotland's dreadful record on public health. It will play a pivotal role: almost poverty-proofing legislation from other committees with regard to its impact on public health. That is an important role for us, and I hope that we will assume the role of watchdog for public health to ensure that we move the public health agenda forward. Since the Black report in 1980, all we have done is talk and wring our hands about the state of Scotland's public health. We have a chance to do something about it, and this committee can be pivotal.

The Convener: Do you have any other matters that we should address?

Kay Ullrich: We should address community care. Anyone who has gone through an election campaign knows that that issue is raised time and again on the doorsteps. There are problems with the funding of community care. Local authorities are struggling to fund it. Problems in the interface between social work and the health service must be looked at. I am greatly concerned by service delivery by postcode. The amount of funding that follows the patient into the community can vary hugely between health boards, and there are huge differences in the types of services available, depending on where people stay.

We also have the chance to examine the Sutherland report on the long-term care of the elderly. I am terrified that that report, which was very thorough and which consulted widely for 18 months, is being put on the shelf at Westminster. There are limitations to what we can do, because many of the recommendations are tied to the social security system, which is reserved, but we could start implementing many parts of the report, not least the proposal for a three-month disregard on a person's assets and family home in order to give them a breathing space. We should also tackle respite care, which I have already mentioned in Parliament.

The Convener: That is very good.

14:45

Mary Scanlon (Highlands and Islands) (Con):

This committee is responsible for one third of the Scottish Parliament budget and we have enormous challenges ahead of us. I do not disagree with anything Hugh Henry said; we had an open and honest debate about PFI in the chamber and I do not want to spend the precious time of the committee on number-crunching and deciding on the whys and wherefores of PFI. None the less, I hope that if we feel that a particular PFI project impacts on front-line patient care or that it has taken money away from patient care—it is patients that I am concerned about—members of this committee will make our representations to the Audit Committee. I agree with Hugh Henry: PFI is such a big topic that every committee could spend hours debating it. I would prefer to rise to and meet the challenges that are ahead of us.

I would like to ask the committee to address the dental decay of our under-14-year-olds as a matter of priority. I received information from the British Dental Association about our poor record on dental health and I was amazed to discover that oral cancer and dental decay are the main reasons for hospital admissions for under-14-year-olds. That is an issue that does not necessarily need legislation, but the committee could perhaps work together to improve the situation.

I would like to ask the British Dental Association in Scotland to come and advise us. I do not want to tell members what it told me, but I was alarmed by the extent of the problem and I would like the committee to address it as a priority.

My second concern is drug abuse. I do not have the answers, but I would like to hear what everyone has to say and I hope that, together, the members of the Scottish Parliament will address the issue.

I am being very consensual today

Kay Ullrich: Long may it continue.

Mary Scanlon: I share Kay's concern.

Margaret Jamieson: So much so that she is going to agree with the SNP.

Mary Scanlon: I am actually going to agree with the SNP. We must consider the care of the elderly; it impacts on many areas, such as bed blocking. There is not as good a relationship between the social work departments and the NHS as there should be and there is also some concern that private nursing homes and council nursing homes are not treated equally. Care of the elderly is a far greater remit than dental decay, but I would like us to address it seriously.

My final point goes back to Duncan's comments. It has been brought to my attention that much of the NHS budget is allocated according to mechanisms such as the deprivation index, which assumes that a person who has a car is wealthy. A person without a car in the Highlands is unable to get out and the cost of keeping the car on the road—the price of petrol—causes deprivation. I want us to consider the criteria for allocating NHS resources.

The Convener: In case members did not mention various items, I made a sweep-up list that I intended to refer to at the end. It includes the issue of rural health services and, as Kay said, health services delivered by postcode and the need to level the playing field for the patients of Scotland no matter where they live.

Margaret Jamieson: I want to pick up on what Kay and Mary said and focus on care in the community. The joint investment fund is an untapped facility that interfaces between acute and primary care. I want to investigate whether we can expand on it. I would be interested primarily in best practice—the way in which it interfaces with social work, voluntary organisations and the health service—because personal experience suggests that it is not working as it was intended to. It is supposed to provide a service. We could gather evidence from all the bodies that fall within the JIF, as it is called, because it is certainly not performing as it should.

I would also like to consider consultation and participation in the widest sense, in two areas in particular. We should consider the consultation with NHS staff that was carried out in the past two years through the Scottish Partnership Forum, to discover where we are, where we are going and the outcomes of that process. Are there lessons to be learned about the inclusion of other organisations? Forgive me for saying so, but there is one organisation outwith the Scottish Partnership Forum that should be consulted, to ensure that all staff are included at the same level.

We should also consider consultation with patients. Last week, I attended a public meeting in Newmilns. The general practitioners who cover Darvel and Newmilns had decided to provide out-of-hours service through Ayrshire Doctors-on-Call. There was no consultation with the patients. Eighty-eight people attended that meeting and obviously it was the bad things about Ayrshire Doctors-on-Call that came out. They fully accepted that doctors had been pushed to the limit in providing seven-day cover for their patients, but felt that they had been denied the right to say what was good about the current service and why they did not want to be passed on to Ayrshire Doctors-on-Call.

We need to consider how we involve patients or potential users—if that is the best description—at a Scottish level, and where services affect patients directly. We are not getting that through local health councils, which we all know are appointed bodies and do not interface with the general

public.

Ms Irene Oldfather (Cunninghame South) (Lab): This committee has a unique opportunity to affect the lives of Scottish people. I hope that we will develop that in a positive and constructive way. Far be it for consensus to break out in the last week before the recess, but it looks as if it might. I am very pleased to be able to agree with my colleagues across the table, Mrs Ullrich and Mrs Scanlon.

One of the major focus points of this committee should be tackling health inequality. I have figures that go up to 1990—there may be more up-to-date evidence—and show that 5,000 lives a year could be saved in Strathclyde if mortality rates there were the same as in the UK. There is a whole agenda relating to tackling inequalities: gender, social class and geography. It will be very difficult to examine all those issues. Perhaps we need to investigate how we focus on some of them. In the first instance, we need some analyses of the problem, and of the problem in Scotland relative to the rest of the United Kingdom and to some areas in Europe, if we are to get a clear picture of how to tackle it.

The Convener: Before the election, some of us spent months going around speaking to various groups, and I am glad to hear what members are saying about continuing that process. When I was speaking to people in Chest, Heart and Stroke Scotland, they pointed out some of the work that was being done in Scandinavian countries such as Finland, which had had similar problems with coronary heart disease and stroke.

This committee must have an open outlook and learn lessons not just from Scotland, but from the wider picture in Europe and the UK. Every member is aware that our health record is not the envy of Europe. If the committee can do anything to change that we will have achieved a fair amount.

Hugh Henry: I think that it is a disgrace that, going into the 21st century, the state of someone's health in Scotland is fundamentally a class issue. There may be other factors to consider, such as education and so on, but the links between poverty and ill health are well documented. We must address that.

It is not just a matter of income: there are wider problems of education and habit to be considered. I would like us to spend time on that, linking in with the Education, Culture and Sport Committee, to encourage a more positive approach to fitness and participation in sport. Participation in sport can improve health as well as academic ability. We should consider not just lecturing and education, but practical measures through the social inclusion partnerships. We might consider projects in deprived areas and encourage initiatives that engage young people in physical activity at a younger and younger age, to improve health and education.

There is another matter that relates to social class, although not exclusively—tobacco consumption. I want the Scottish Parliament to examine its legislative competence to find out whether we can do anything to accelerate the ban on tobacco advertising, even beyond the scope that Westminster is currently considering.

The Convener: In my sweep-up list I had down the one word—addiction. People are concerned not only about tobacco and drugs, which we have mentioned already, but about the devastating effect of alcohol abuse. I agree with Hugh's points about sport and young people, but the issue continues right through people's lives. The Justice and Home Affairs Committee will also have an interest in it because involvement in sport can improve people's self-esteem and so has an impact on wider society.

Dr Simpson: I am concerned that we will try to cover the whole area of health in a very short time. We have to sit down at an early stage to decide on our priorities. Members will notice that the key elements of the proposals in "Partnership for Scotland", which is the basis on which the Executive has laid out its health proposals, are centred on the patient, with increased patient participation and involvement to improve patients' experience of the NHS. That seems likely to be one of the key tests of the organisational performance of the NHS in Scotland and one of our primary functions should be to examine carefully how those aims are being met. If we are simply sloganising about patient participation and it does not mean anything in practice, in four years' time people will be extremely disgruntled with the Parliament.

There are other issues that are more focused and precise. Before the establishment of the Parliament, the Labour Government manifesto included a commitment to reducing waiting lists. As we can see from the most recent quarterly bulletin, that has happened. As the partnership agreement says:

> "We will set and monitor targets to speed treatment and shorten waiting times."

In other words, the Executive proposes to move on from the blunt instrument of waiting lists.

We have an opportunity to examine what happened with waiting lists. I hope that, being a new Parliament, we can do that on a relatively non-partisan basis. We can take evidence about what was good and bad about the waiting list initiatives. There has been a lot of criticism in the press about over-expenditure and the waste of

public money in that area.

The Government appears to have achieved its blunt objective of reducing waiting lists—I think to about 6,000 below the target—and I assume that there will be initiatives over the summer to keep the figure down. If we are to move to waiting times, we should take evidence from interested groups on how we can ensure that the Executive implements that move in a way that is publicly acceptable, based on the problems that we had with waiting lists.

I support Malcolm Chisholm's—

The Convener: Sorry, Richard, I want to let Kay come in on that point.

15:00

Kay Ullrich: I could not agree more about waiting times. For most people, the time spent waiting from the moment of GP referral to the first appointment with the specialist is possibly the most worrying. We must tackle waiting times; waiting lists have undoubtedly gone down, but evidence suggests that while that has been happening, waiting times have gone up.

Dr Simpson: That is not true.

Kay Ullrich: That is what the latest evidence suggests. We should ask the Executive for quarterly reports on waiting time progress. We should also ask for the information to be broken down by health board area and by specialty, because we must find out if there are problems in certain specialties.

Dr Simpson: This is a complex area. If we all agree that we need to examine and establish—in a non-partisan way—the principles by which we want our health service to be judged, we can tell the Executive what we want to hold it to. Kay is quite right: the waiting time for in-patient procedures has dropped, but what does that mean if the patient had to wait to be put on the list in the first place? All sorts of criteria are involved, on which we need, urgently, to establish principles.

Mary Scanlon: I support that, but I want to expand the point. Everyone wants more patients to be treated, but it is not for the Government to decide on priorities; that should be done by clinicians. I do not want waiting lists for minor operations to be slashed while people are having to wait for major operations.

Dorothy-Grace Elder (Glasgow) (SNP): Representatives of the British Medical Association and the Royal College of Nursing are here today and might like to comment on that in a moment.

I hope that the public does not get the impression that we will all sit round this table for four years being consensual, like good little boys and girls, and that we do not have fundamental questions about how things are run.

We cannot escape the question of PFI. It dominates the minds of those who work in the health service, and of the public. Surely, for each case that we consider, we will investigate every possible link with PFI. I see no problem in getting the facts and figures on PFI and debating them here, just as the Education, Culture and Sport Committee will do in relation to schools. To a large extent, PFI will dictate staffing numbers and how hospitals are run and those aspects will not escape discussion in this committee.

On the wider subject of care in the community, we heard the great buzz words "social inclusion" throughout the election and, in fact, throughout the past two or three years. I have seen very little sign of it in relation to people who need to be consulted and socially included.

Every week I visit organisations where I hear of tragic cases in which people have not been consulted. Last week, I sat in a room at Easterhill day centre in Baillieston village. The centre, which seems quite pleasant, is run for people with profound disabilities, who have been together as a family for 20 years. Some of those people are 50 and have parents who are now over 80. They were being told by three social workers that the centre is to close.

The parents replied that the social workers had told them that they would be consulted about where their families were going. They are to be moved to three different centres, which are for people with different grades of disability. The parents were worried about abuse and they had not been consulted. Even the meeting was held at a time that made it awkward for the parents to attend.

The social workers claimed that there was something wrong with the building. I asked to see an engineer's report but they could not show me one and simply said that the council must save money. We must query why the council is being cut so hard by the Government that people are in such a plight.

I have witnessed three other such cases in just one corner of one constituency. That is not good enough and it is not good enough to use the term social inclusion when in reality it describes people who are being excluded.

Margaret Jamieson: On a point of clarification—

The Convener: We are now only 10 minutes from the end of our meeting. Six members want to speak and there are a couple of other matters that we must get through. Unless members feel that they have a burning contribution to make at this

point, I ask them to make their comments brief.

Margaret Jamieson: On a point of clarification—

The Convener: We are getting into a specific issue, and it is best if we move on—

Margaret Jamieson: No, I need clarification. Was Dorothy-Grace Elder talking about a health service provision or a local authority provision? She needs to be specific.

Dorothy-Grace Elder: I was talking about local authority care in the community. I suggest that over the next few weeks, we think about encouraging whistleblowing in the social services and the national health service.

Margaret Jamieson: We have whistleblowing already. It is up to people to use it.

Dorothy-Grace Elder: It is not used enough. Some awful things are happening and we need to encourage staff to come forward and tell us about those things, without fear for their jobs.

The Convener: People should be able to do that at the moment, although whether they actually do so might be a different matter.

Dorothy-Grace Elder: They do not feel confident.

The Convener: We are running out of time. I know that Duncan, Malcolm, Irene and Ben—in that order—still want to speak. If we left it at that, they would all have a minute each.

Mr Hamilton: I need less than a minute. First, on how the committee works with reference to obtaining further breakdowns of waiting list times and so on, there is an important point to make about the committee having access to information that is not currently available. Can we have a guarantee that the committee will be able to request the information that it wants and that it will get it?

Secondly, on the committee's work and its priorities, there is no health bill, but that is not to say that there are no health implications in the other bills. Presumably, the committee will keep a close watch over the transport bill and the incapable adults bill, on which we will have a huge input. Let us not assume that the lack of a bill means a lack of legislative input.

The Convener: Absolutely. We will have access to information through our clerks and we have a researcher working in the information centre. However, at my initial meeting with the Executive last week, at which a senior health department official was present, I asked specifically about access to information and was given assurances that there would be a large degree of openness.

Mr Hamilton: I am talking not just about information that is available; much of it is not collated in the way that we would want it to be.

The Convener: I am all for pushing back those barriers as well, Duncan. For us to do our job properly, we must have access to all the information that we require.

Malcolm Chisholm: We should decide what we are doing with regard to relationships with other committees. We will relate to all the committees, but most of all, perhaps, to the Social Inclusion, Housing and Voluntary Sector Committee. It might be appropriate, at times, to have a joint sub-committee or joint meetings. My view is that we should be relaxed, for example, if the Social Inclusion, Housing and Voluntary Sector Committee wants to do a study on drugs, or if we want to do a study on the health aspects of housing. We should not feel that we cannot do that.

The Convener: On that point, I have discussed the idea of having a committee of conveners, in which members could inform others of the direction in which their committees were going. Such a committee would be an early indication of our being able to work across committees to undertake such studies.

In terms of time management, one committee might want to do three or four inquiries, whereas it would be more sensible for another to undertake some of that work because its work load was not so heavy. Informal working between conveners would have a number of benefits.

Ms Oldfather: Already, from each of us identifying one or two areas of policy in which we are interested, it seems that we have a weighty work load. Does the convener have any thoughts on how to prioritise that work? I am quite clear about my priorities and I should like the issue of tackling inequalities and the link between poverty, class and health to be high on the agenda.

The Convener: I have heard what everyone has had to say—I will come to Ben in a minute—and have an idea of what members are interested in. It would be helpful if members put their thoughts on priorities in writing. Before the end of the committee, I intended to ask members to delegate authority to me, based on the views that I have heard and on what members put in writing to me, to agree the initial programme and identify some of the first speakers whom we want to brief us. If members are happy for me to do that, I can make progress during the recess.

Ms Oldfather: May I make one additional point? The briefing note that we received mentioned the weighted capitation formula and the fact that it is being reviewed in relation to how funds are distributed to health boards. That formula has

been in place since 1977 and I expect that the results of the review, which will be produced in June, will be interesting to the committee. Perhaps we could examine those results soon after the recess.

The Convener: I understand that the Arbuthnott report might come to the committee so that we can work on it. I assume that that is the report you mean?

Ms Oldfather: Yes.

Ben Wallace (North-East Scotland) (Con): In the Army, I used to take young men and women from all over Scotland, of all classes and from all social and health backgrounds, and make them fit. We used to say that a fit body meant a fit mind, and vice versa, and was better for people's well-being. I agree with Hugh about the important role of sport and fitness for the young, in terms of prevention.

My second point, which fits in with point 7 of our remit, concerns how a UK moratorium or European legislation affects certain health issues in Scotland when it comes to medical research. There is an current issue on the use of animal tissue, which is subject to a UK moratorium. Some parts of the medical research community feel that that is holding them up. We might be doing ourselves a disservice, in Scotland, by having such moratoriums. Medical research is related to prevention and, while we have other pressing matters to consider, preventive medicine must be given almost equal weight in our overall diary.

The Convener: Health groups have spoken to me about the lack of funding for research. They feel that many of the funds raised on their behalf go into research, when there are pressing practical issues—such as those that Dorothy mentioned—on which they want to use the money. They feel that the Government should play a greater role in research.

Mary Scanlon: When will the committee meet, and could it be at a regular time, for example, on Tuesday afternoons? That would be better for our diaries. Also, we have all come up with different ideas today; I mentioned dental decay. Will the convener clarify whether she will decide on the priorities? If we give her a wish list, for example, a request that the British Dental Association come to address us, who will decide on that?

15:15

The Convener: My understanding is that I will take what members give me and produce proposals. However, I should not like us to lose the possibility of having a few things organised in advance, because I hope that we can hit the ground running when we come back after the recess.

I am keen to discuss the idea of having a meeting—not exactly a committee meeting, but perhaps a day of briefings—during the recess. We could spend a day on that and use lunchtime to get to know one another a little better, so that we can work together better as a unit.

We have run out of time, but I would like an idea of when members might be available during July. Obviously, not everyone can be available. What I have in mind is a day of background briefings on some of the issues raised today; we would be able to ask some of the main players in the civil service to talk to us. Susan Deacon and Iain Gray are also keen to meet committee members. We have to build up relationships between committee members, between ourselves and other people with whom we have to work and between ourselves and people in the community who have access to more expertise on this subject than most of us—and I do not include Richard in that.

Dr Simpson: This may seem strange, but I welcome the proposal. Although I have been in the health service for a long time, it would still be useful to have briefings on certain issues. I am just concerned about spoiling our image with the *Daily Record* if we start meeting during the vacation.

The Convener: That sounds like a very good reason for doing it.

Dr Simpson: Reporters might then realise that some of us have packed diaries and are not on holiday, but working in our constituencies; we already have many fixed diary dates. As a result, we need to fix a date as soon as possible.

The Convener: I appreciate the difficulty in what I am asking committee members to do, but the exercise would be quite useful for us. Afterwards, members could head off to sunnier climes with all sorts of information to read up on over the long recess.

Hugh Henry: This is supposed to be a family-friendly Parliament. It is not like Westminster, where the holiday period starts in August. For most of us with families, we need July to spend time with our children. Furthermore, because we are so close to July, some of us have already made commitments for the part of that month when we are not on holiday. It would be more realistic to have the briefing day in early August as August is a proper working month for most of us.

The Convener: I think that all of us will have the same problem and, with respect, I will use my casting vote as convener as my holidays are in August.

It will be impossible to find a day that will suit everyone, but is there general agreement to set up a day of briefings so that we are heading in the

right direction? We can make sure that briefing papers are available for those of us who are unable to make it.

Dr Simpson: If there are problems with getting members together on one day, it might be better to have two half-days so that we do not all miss everything.

Margaret Jamieson: We could have a back-up briefing.

The Convener: If committee members give me an idea of available dates, we can see how difficult it will be to arrange things. If no one can make it, we will not go ahead; if the majority of members can come, we will set up the meeting.

Committee members can write to me about other issues that I was hoping to tease out today, but it sounds as if that will be a very long letter. One such issue is the committee's location and whether committee members are happy to go out and have public meetings. The committee could go to another part of Scotland and have a meeting that might involve a fact-finding mission somewhere in the locality. We could also have a public meeting on the evening of that day or the day before, to talk about a health issue with people in that area. It would be a matter not of travelling just to have a committee meeting—which can be pretty dull despite the fact that the committee members are all interesting people—but of expanding beyond that.

Do members have any other ideas on making the committee function as effectively and as openly as possible, so that we can forge good links with the people we represent, with the people who have access to more expertise and information than we do and with the patients of Scotland, who are the main issue? I see that time is against us—

Hugh Henry: Can we come back and have another discussion on that last point? I have some reservations about the notion of a travelling circus. I do not mind the idea of meeting outwith Edinburgh where it is appropriate and where it will assist our work, but I am also the convener of a committee that might meet weekly. We need to examine how to fit our other commitments into travelling outside Edinburgh. By all means, let us travel elsewhere if it adds value to what we are doing, but I do not want a committee that travels the length and breadth of Scotland just for the sake of it.

Dorothy-Grace Elder: I am worried about the public expense of meeting elsewhere. If we have to do that, we should cut out overnight stays and have a very long day somewhere instead. Besides, Glasgow has the worst health problems and it is very easy to get there and back.

The Convener: This committee has a role not just to talk about health but to go out and see how people on the ground work. Dorothy's point about the public purse is important. If we made the best possible use of a day by rolling a few different items together, that would minimise the effect of time wasted going somewhere and coming back. An important part of our job is not just to talk about health and to listen to one another—which is interesting and valuable up to a point—but to ask people to speak to us and to go out and see how people work in health and community care services and in social work services. That would also be valuable to us.

I do not expect that that would happen very often. However, committee members are beholden to show openness and the flexibility to have an on-going relationship with other people. I would welcome any other comments about that.

As far as I am concerned, nothing is set in stone. I think that we are all getting used to the fact that this is an evolving process and that we are making it up as we go along—which I hope does not show too much. We will try things that will not work, but I do not want us to say that we will not be open, flexible or different just because we are afraid to make a mistake. We need to find different ways of working, to make this an effective committee for the patients and people of Scotland, and I hope that we are all agreed on that.

Meeting closed at 15:23.

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