HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 8 September 1999
(*Morning*)

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3rd Meeting

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*Mrs Margaret Smith (Edinburgh West) (LD)

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*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Ms Irene Oldfather (Cunninghame South) (Lab)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
*Kay Ullrich (West of Scotland) (SNP)
*Ben Wallace (North-East Scotland) (Con)

*attended

COMMITTEE CLERK:

Jennifer Smart

ASSISTANT CLERK:

Irene Fleming

Scottish Parliament

Health and Community Care Committee

Wednesday 8 September 1999

(*Morning*)

[THE CONVENER *opened the meeting at 09:33*]

The Convener (Mrs Margaret Smith): Good morning, colleagues and visitors in the public galleries. Before we start our business, I will explain why we are here rather than in a committee room. I appreciate that that may cause some difficulties, but this is open and accessible government. As this meeting was scheduled for one of the smaller committee rooms, it would have been impossible for members of the public to have had access to it.

I think that I speak for all committee members in saying that one of our primary functions is to ensure that business is conducted in a way that is as open, accessible and public as possible. I hope that when visitors have heard what members say in the next few hours, they will think that it was a good idea to hold the meeting here.

When you catch my eye and intimate that you want to speak, I will say your full name. It is not that I am being awfully formal, it is simply that it is helpful for the people who operate the sound system if I say, for example, "Hugh Henry", and—

Hugh Henry (Paisley South) (Lab): You are going to be fairly cross-eyed if you want to catch the eye of all the people sitting here.

The Convener: I will swing around in my chair; do not worry.

As I was saying, please wait until you are acknowledged, press your button and then speak.

Priorities

The Convener: The first item on our agenda is to pick up where we left off in our discussion of the committee's priorities, which obviously tie in with our work load. All the committees envisage a very heavy work load. You will see at point 3.3 of the work load briefing that work can come to us from a number of sources. That work can be in the form of bills, reports, and items that come through the Public Petitions Committee, as well as items that we, as a committee, decide that we want to put forward ourselves. It is important that we find a way of striking a balance in all that work, although I am sure that we will not always get it right.

We should try to carve out for ourselves what we see as our agenda, rather than always having a knee-jerk reaction to the previous day's headlines. Such an approach would be more constructive for us as we plan our future work. To say that I am calling for a little restraint would be putting it too strongly, but we will have to try to get a balanced work load in front of us.

The first thing that I want us to talk about is the Arbuthnott report, entitled "The National Review of Resource Allocation for the NHS in Scotland". Why am I asking you to look at that as a matter of urgency? There are a few reasons. We have all received a copy of the report—some of us have three or four, I think, as they seem to breed easily. We have also had a covering letter from the Minister for Health and Community Care, Susan Deacon, asking us to consider the report; and Sir John Arbuthnott himself, who has put together a very comprehensive report, is also keen that we should consider it.

In her letter, which I have in front of me, Susan is quite specific when she says that she is especially interested that we should consider inequalities in health care. She talks about the development of firm proposals for adding an inequalities adjustment to the proposed allocation formula by the end of the consultation period, which, as you know, is in November. That is added value to what is in the Arbuthnott report, taking it a bit further forward.

To tie in with some of the concerns that were raised at our first meeting, I would also like us to consider access to health services in rural areas and the problems associated with that. If we agree to consider Arbuthnott, I would like us to channel our energies into those two broad areas of our remit. I am keen to hear your opinions on that. The benefit of addressing the Arbuthnott report as our first item of business is that it is a specific piece of work with boundaries and confines, but it also picks up on a couple of the issues that the committee has identified as being of interest to us: health inequalities and health delivery in rural areas. We can find ways of adding value to the substantive work that has been done.

We must also work within a specific time frame. Everyone knows that there is no end to what we could be doing with our time, but it will be good discipline for the committee to be required to give a formal response by 14 November and to see whether we can rise to that challenge. Some of the issues have previously been raised. I propose that we deal first with "The National Review of Resource Allocation for the NHS in Scotland", the Arbuthnott report, and that we then go beyond that to deal with other areas. We can either decide today what our priorities will be after the Arbuthnott report or wait until November. I am open to guidance from the committee on that

subject.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I agree that we should not merely go over the whole of the Arbuthnott report, but that we should home in on one or two issues. I also agree with what you said about health inequalities. By chapter 15 of the main part of the report we are almost being invited to look at that issue in greater detail. It would be worth our while doing that with regard to the Arbuthnott report. That will also lead us on to examination of some of our other concerns about health inequalities.

The Arbuthnott report wants distribution of funds to be based more on need. The technical part of the report is at pains to try to disentangle factors relating to supply and demand and those relating to need. We should be careful that when the money is given to health boards, it is spent in line with people's needs and the priorities of addressing health inequality.

I am slightly concerned that the report merely says that this is about distributing money to health boards, and that it says nothing about how those boards spend the money. There seems to be a slight inconsistency. If money is being given out on the basis of need, there should be a monitoring mechanism to ensure that that is the case. That is my fundamental concern.

The Convener: You will see from the list of suggested witnesses that there are people from health boards and other health institutions. That issue is of the kind that we probably want to investigate with them. The reality is that we must know how to deliver that distribution on the basis of need.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I would like to make a point about inviting individuals to committee. I have a particular problem with the names that have been suggested, because the list is not representative of the health service in Scotland. There is a bias towards the east coast of Scotland. As one who comes from the west, I want to ensure that the interests of those who live there are acknowledged. We must also consider those who live in the Highlands and Islands and in the Borders.

We must be careful. If we are to home in on certain issues in the Arbuthnott report, we must speak to Professor Arbuthnott. That report is based on statistics—we must examine the statistical evidence to ensure that it is robust. If it is not, there will be big problems in the next two years. We must tailor the list of those to whom we wish to speak.

The Convener: I would like to pick up on what Margaret said. I asked for a highland name to be on the list, but one was not included. The researchers have come up with a couple of names from the Highland Health Board, but they have not been circulated with your papers. We should invite the director of finance or the chief executive of the Highland Health Board. Their evidence will provide a rural perspective. They will benefit from the changes so it will be interesting to hear from them. Margaret made a good point about considering it from the point of view of the statistics.

09:45

Dorothy-Grace Elder (Glasgow) (SNP): It is right that we should look at long-running issues. Without raising the issue in full today, I would like us to agree to inviting the minister to address the committee on the pressing issue of cardiac surgery at the hospitals for sick children in Glasgow and Edinburgh. There is outrage in Glasgow at the suggestion that the paediatric cardiac surgery unit might be closed. We need to debate that or ask the minister to speak to us before the decision is made.

The Convener: At this time in the discussion, I would like us to remain focused on the issue of Arbuthnott. After that, we can consider other issues.

Dorothy-Grace Elder: Will we have time later?

The Convener: We have three hours.

Mary Scanlon (Highlands and Islands) (Con): Not only do all the people who it is suggested will brief us on Arbuthnott come from the central belt—the rural factor is crucial to the reallocation of resources—but there are no general practitioners among them. I suggest that we invite Dr Colin Hunter of the Royal College of General Practitioners to speak for the GPs of Scotland. We need to keep them firmly in mind. Also, why do we need two representatives from Tayside Health Board?

I know that my filing system is not as efficient as it could be, but I cannot seem to find the list of priorities that we filled out at a previous meeting.

The Convener: That is in the priorities paper that is before us today. Some people suggested not only priorities from the form that was handed out, but priorities that were suggested by letters and so on. We will come to that later, but we will deal with Arbuthnott first.

I agree with your point about the GPs and I cannot recall why we have two representatives from Tayside, although I am sure that there was a reason for it. It was not expected that we would accept all the names. The people who were suggested had expertise in the areas that we want to examine. We should be prepared to adjust the list of people. Perhaps we will ask Colin Hunter to address us, as Mary suggested, as that would

include the GPs' point of view.

Hugh Henry: I have the same concerns about the people who it is suggested will brief us. The list is unbalanced and will have to be reworked. I also have a problem with the number of people that we want to question on Arbuthnott. I do not think that this committee should be another inquiry. We need to be precise about our terms of reference. We should comment on the Arbuthnott report, not do the work of that committee again. Before we decide which people we want to consult, we should work out what we want to achieve. We need someone to speak about the report—I would like to hear about the committee's methodology and thinking—but we should ask what it would be proper for us to comment on. Unless we do that, we will be into a review and a full reporting process before we know it.

Comments have been made about some of the difficulties in rural areas, but when we consider the massive health problems in areas of urban deprivation, we cannot but be aware of where the priorities for tackling ill health and examining resource allocation in Scotland must lie. We must debate public health, to consider not just a reactive approach but a preventive one.

Malcolm Chisholm raised a very important point. It would be a complete waste of our time and of that of the Arbuthnott committee if we made comments in the abstract, only to discover that the people who are charged with the responsibility for allocating resources and overseeing the delivery of services are not doing it in the way that is expected. At some point, whether in the early stages of the process or after it is completed, I would like us to consider the way in which health boards are held to account for distributing resources to communities.

The Convener: It is up to the committee to decide on the remit of any inquiry that it holds. I echo the points made by Hugh and I hope that I made the same points at the beginning of the meeting. We need to add value to work that has already been done. There is no point duplicating the Arbuthnott report, even if we could—it is very detailed. We do not have the time. However, we have been steered in the direction of two issues which are not mutually exclusive. There is a problem of exclusion that goes beyond health inequalities that must be addressed.

If the committee agrees, we can extend our remit into the way in which health boards carry out the work and how that can be monitored. Is that agreed? It is. We will feel our way through the process of deciding our remit, and I am sure that we will get there in the end.

Ben Wallace (North-East Scotland) (Con): To follow on from what Margaret said, it is true that there are winners and losers when it comes to resource allocation. I use the word losers loosely, meaning that there is a percentage change in the resources allocated. I want to see a representative from a health board, such as the Borders or Grampian, which will have to cope with a reduction in resources.

The Convener: Lothian Health is on the list of witnesses and it is facing such a reduction.

Ben Wallace: However, Lothian only has to cope with a 13 per cent reduction, while the Borders will have a 37 per cent reduction and Orkney will experience a 41 per cent drop.

The Convener: I suggested to the researcher that he found—

Ben Wallace: A winner and a loser.

The Convener: When I met Margaret Ford, she said that she wanted to see someone from a health board that was likely to win. She seemed keen on Highland Health Board, given that it was both a winner and rural. The converse of that is that Lothian is urban but a loser, in the widest possible sense. There is some crudity in that selection.

To return to the list of witnesses, it is only there as a guide, it is not an exhaustive list. As I have said to many members of the committee, I am concerned about the amount of time that our researcher has in which to work on items for the committee. I raised that matter at the conveners committee yesterday, where everyone who attended echoed it. The names on the list are suggestions and members of the committee should come forward with the names of people that they want to consult.

Hugh Henry: At this point I do not want to argue about the names of those whom we will consult, but I repeat, first can we work out what we want to achieve, and then can we decide who the most appropriate people are to help us achieve it? We should not begin by saying who should be consulted without having an idea of why they should be.

The Convener: I wanted to have a general discussion about Arbuthnott. If everyone was happy that we were going in the correct direction, a sense of what the committee wanted the remit to be with regard to Arbuthnott would become apparent. Having accepted that we wanted to consider Arbuthnott, we then would deal with appendix 3 in the work load priorities document, which deals with how we will do that and who we might want to speak to.

There is a progression of thought through our papers. If members are happy for us to consider Arbuthnott and feel that it is time to move on, we can talk about tightening up the remit, and then

move on to other matters. I was aware that other people wanted to speak, and I was trying to give them the opportunity to speak on whether we should examine Arbuthnott and on the key issues that should be addressed.

Dr Richard Simpson (Ochil) (Lab): We are getting into the right area now. As Hugh said, we must start by stating what we want to achieve. We should not forget that although the Arbuthnott report is huge—it took a lot of work and it is excellent—it is just an updating of Robin Smith's 1977 committee report on Scottish health authorities revenue equalisation. Many other issues that will confront us will seriously damage the health service in the coming six to nine months unless we deal with them. The timetable that we have been offered for Arbuthnott is too long.

I will make a couple of suggestions about the way that we approach this process. I strongly urge that we have an informal briefing. That would be an opportunity for the experts to sit with us—not in front of us—and take us through this complex report and help us understand the difficulties that they faced. I spent most of my three-day summer holiday reading all 500-odd pages of the report. It contains complex arguments, particularly about the statistics. As someone else said, if the basis of those statistics is incorrect, there is a problem with this report.

I suggest strongly that our first step should be an informal briefing and that we should decide who we will have at it. Obviously, we should have Arbuthnott himself, and probably one or two people from the list, for example, Richard Copland and Arthur Midwinter. After that, we should ask the experts to leave us and we should spend a short time in an informal meeting deciding on the issues that should be addressed. We could then move on to calling witnesses for evidence.

Whether we like it or not, we must spend some time on the statistics in the report. I am a medical researcher and I find them complex. I do not know what other members thought, but I found them very difficult. However, it is the weightings on those statistics and how they were worked out that determine the redistribution effect. From reading the report, I am not convinced that they have got it right, because I do not understand it; I admit that freely.

When we get to the point of asking the statisticians on the committee to give evidence to us, I would like us to have experts sit with us. I know that the Parliamentary Bureau has said that they cannot be voting members and that their presence cannot be permanent, but I can suggest the name of someone who should sit with us. Was Richard Copland on the expert committee that produced the report?

Mary Scanlon: Yes, he was part of the steering group.

10:00

Dr Simpson: He could appear before us. I suggest that John Forbes from the University of Edinburgh sit with us. He is a statistician on the chief scientist's health service research committee and is very good at explaining statistics to those of us who find them difficult. He could guide us when we get to that point.

We should also do that in other areas. When we are considering rurality, for example, we need to have someone sitting with us who is an expert on that. Finally, although we are the representatives of the public, we need to have someone from the patients' organisations here—sitting with us rather than giving evidence.

Having said all that, I think that too much time has been allocated for discussing the report. We are spending a huge amount of time on this, but once we have had the briefing, we may be able to deal with it in a couple of sessions. I do not think that we need longer than that. If we take until 14 November, which is the date currently set, we will be into the winter.

I want us to be questioning the Executive very closely on its plans to deal with this winter, because some hospitals, which I will not name, are already on a no-admissions policy. If we are at that stage in September, God knows what will happen in December. We need to question the Executive on that now, not when the emergency arises.

The Convener: From a procedural point of view, I want to pick up what Richard said. It would be a good idea to have an informal briefing. This is a complex subject and it would do us all a great deal of good to be able to ask our questions without prying eyes seeing how complex we are finding it.

However, we have a problem with the timetabling. Appendix 3 sets out the committee's suggested course of action, with dates. I do not envisage that we will go full pelt on Arbuthnott and that nothing else will come before us until November. The process will tail off into things such as the production of the report, which will involve the clerk and me, and then we shall come back to the committee, but most of our time will be taken up with hearing evidence. That is what will happen in September and early October. After that, the amount of work involved for the rest of the committee will diminish; there will probably be two further meetings when we deal with this, although there will be other things on our agenda. It would be useful if other members of the committee could give their views on the points that Richard made.

The suggestion that we appoint a specialist adviser was one that I was going to put to the committee. I believe that any appointments of specialist advisers have to be ratified by the bureau and, possibly, by the Scottish Parliamentary Corporate Body. Such things obviously involve cost, and we would have to say why a specialist adviser was adding value to our work. I am not saying that I am against the idea. It is a good one with a complex issue such as this and is something that we should bear in mind. However, despite what you say, Richard, time is tight, as much of October and November will be taken up with Arbuthnott and other things.

Dr Simpson: If it takes up only part of a meeting, it should be all right. One hour out of a two-and-a-half-hour meeting would be okay.

The Convener: That is what I envisage. The work load might be top heavy and then trail off.

Kay Ullrich (West of Scotland) (SNP): There is general agreement on the course of action that we should take. We should narrow our priorities down to health inequalities and rural issues. I agree with Malcolm about the importance of ensuring that the extra money awarded to health boards is spent on health inequalities and that the boards do not see it as a bonus. We have an important role to play.

On Richard's point, I am a bit concerned about our using the meeting on 15 September to hear evidence from agreed witnesses on Arbuthnott if the minister is unavailable. Surely we do not plan to hear from a whole tranche of witnesses. It is important—as has been mentioned—that we first receive a briefing on the Arbuthnott report from a representative. The time to structure our programme and decide on Arbuthnott is once we have had the briefing. It is a bit premature to be setting dates. Once we have had the briefing, we can decide where to go from there and which witnesses to call.

The Convener: Our first course of action should be to ask the clerk to organise an informal briefing. Time might be a bit tight for us to ask the correct people to come to speak to us.

Kay Ullrich: It is short notice to get people for the meeting on 15 September.

Dr Simpson: The only question is the availability of witnesses. Presumably it was just a suggestion to schedule witnesses for 15 September. We might have to wait a week or two to get them in. The Finance Committee had an initial briefing on the nature and scope of finance—chaired by an economic journalist and attended by professors of economics and others—which was extremely useful. It would be valuable to have a meeting with four or five people, chaired by someone other than Margaret—I do not mean any disrespect—to allow her to be a full participating member. That concept works well and I would certainly recommend that we do that, if the clerks can manage it.

The Convener: We will take that as the way forward and try to organise a briefing. There is also a meeting on 22 September. If we have managed to get anywhere on arrangements for 22 September, we should be able to discuss that informally on 15 September. However, we should retain the meeting on 22 September, as there will be other things on the agenda. We have three hours to fill, so we will have time on 22 September.

Hugh Henry: Are you thinking of holding the informal meeting next week? That is a bit tight.

The Convener: The whole thing is a bit tight, but we are constrained by the timetable.

Hugh Henry: It is all right for us, because we have allocated time for meetings next week and the week after that, but if we want to get key experts in, one week's notice is too short.

The Convener: I appreciate that, but we are constrained at the end of the process, as there is a deadline. We cannot do any more at this point other than ask the clerk to arrange an informal briefing as soon as possible. We have all agreed that Richard's suggestion would be a useful starting point in attacking the issue. We will probably have to reschedule the suggestions that we already have.

Towards the end of the process, I will need time to prepare our report, hold discussions and come back to the committee. That time must be built in; we cannot just take evidence, hold an informal meeting and leave the matter at that. If we want to add something to the consultation, we must produce a report—which it will take time to put together—and agree that we are happy with it.

Kay Ullrich: It is quite a tight time scale to ask somebody to give us a briefing a week from today, but could we try to get someone along? After that, we can act week by week.

The Convener: I think that we should try to get people here as soon as possible. We will make it known to them that we understand that it will be difficult and that we appreciate that we are asking almost the impossible of them, but that we would greatly appreciate it if they could find the time. After that, the matter is in their hands and those of the clerks, and they can tell us a suitable time. As many of us as possible must be ready to take part in that informal briefing when it is organised. Jennifer Smart and her staff will start that today as a matter of urgency.

Dorothy-Grace Elder: As Richard suggested, would a statistician be top of the list? I, too, am always concerned about weightings, as they can

be so deceptive.

The Convener: That has been taken on board.

Ms Irene Oldfather (Cunninghame South) (Lab): Following up Dorothy's point, I would like to be quite clear that the first meeting is an informal briefing. I would like us to identify quickly—perhaps even at the end of that meeting—some clear objectives and targets.

The Arbuthnott report is huge. If we start to discuss the inequalities that emerge from gender, geography, poverty and social class, we must remember that it is a huge subject on its own. The rural service dimension that we have been talking about can be added. It is important for us to set clear objectives and targets early on. After the informal briefing, we can set clear targets. Is not that the stage to bring in statisticians and others to give evidence?

The Convener: I think that a statistician—a person who knows about numbers—

Dorothy-Grace Elder: "Statistician" is not the best word for this time in the morning.

The Convener: If I have understood Dorothy correctly, I think that her point is that the good thing about an informal briefing would be that we could ask questions about the parts of the report that are the most difficult to understand. As many people have said, that relates to the methodology, tables and figures in the report. A statistician—I used it again.

Dorothy-Grace Elder: One of those people.

The Convener: Yes, one of those people would be useful to have at the informal briefing.

Ms Oldfather: It is not to give evidence?

Ben Wallace: Or for validation?

Ms Oldfather: It is simply to give us a good grounding in the report before moving on. Richard and Irene have both said that, on the back of that informal briefing, we should say what our remit is. Obviously we have talked round that today and have an idea of the direction in which we might go, but after the informal briefing, we can tighten that up.

Dr Simpson: At the informal briefing we need to have a statistician who can take us through the report. We need to have an expert in inequalities, such as Vera Carstairs—although I do not know whether she is still available—or Brian Jarman. That would not deal with the detail of what is happening in Pollok or Castlemilk, but we could talk about how people investigate inequalities in the delivery of a health system strategically, and how the index is created on which people's challenges are based.

The two experts are Carstairs and Jarman—Jarman in England and Carstairs in Scotland; we need someone at that level. We need someone who can investigate ruralities and give us an informal briefing, because the committee quite rightly feels that that is one of the issues that it wants to address.

Then we need an overview. Why are certain health issues and disease processes treated differently in the report? We need someone to deal specifically with health needs assessment, because the report rejects a number of options. We need someone to take us through the reasons why those options were rejected. We need to know not only why they were rejected—I do not want to go into that now—but whether the Arbuthnott report is written in stone or whether a review will be needed soon. Health needs assessment systems that might be better are coming forward. We need to know what flaws there are in the Arbuthnott report. It is not perfect, but it is the best that we can do right now. I suggest that we have that group for the briefing.

10:15

The Convener: I will discuss the matter with the clerks and come up with a list of about five people to approach. I will e-mail those suggestions to members later today; they should tell me as soon as possible what they think of the selection. Time is of the essence and we ought to approach potential witnesses today. Now that we have all had a chance to express our views on the subject, we can move forward. I shall work on that today and contact all of you this afternoon—I hope that you will still be around.

Would members of the committee like to appoint a special adviser? If we want to do that, we will have to find out how it will work in practice. I am not sure whether any other committees have yet appointed advisers.

Malcolm Chisholm: Are you talking about advisers for this particular inquiry, or for more general matters?

The Convener: I mean an adviser for this inquiry. If the committee wants to appoint one, I shall make a couple of suggestions and see what people think. I understand that, because such an appointment has financial consequences, the Parliamentary Bureau will have to agree to it.

Dorothy-Grace Elder: Would the adviser be a civil servant?

The Convener: Not necessarily.

Dr Simpson: There might have to be two people. One would be a statistician, because statistics are central to the report; the other would be a professor of public health. One could help

with the general message of the report and the other could deal with the statistics.

The Convener: I was thinking along those lines rather than about appointing a civil servant.

If nobody has any further comments on the Arbuthnott report, let us discuss other priorities.

At our first meeting, we had a long discussion and identified a list of 16 priorities. I was telling a colleague about the problems of having such a large work load. He said that if we thought our list was long, we should look at the Rural Affairs Committee, which identified a list of 36 subjects for consideration and is already adding to the list. We could have gone on and on, so we were disciplined in limiting ourselves to just 16. Our remit is wide and that number will creep up as more issues are raised.

We have two options. We could deal with the Arbuthnott report and return to our other priorities afterwards, or—and I think that this is a better idea—we could charge on and discuss what we can tackle immediately after our consideration of Arbuthnott. As I said to Richard, the Arbuthnott report will probably be dealt with in a few weeks' time, and we will be moving into the next part of our work anyway. That will allow us to pre-plan our research back-up and our work with witnesses and rapporteurs.

A range of issues for discussion have been listed in the priorities briefing. Some of those issues, such as health inequalities and the rural dimension, are touched on in the Arbuthnott report. Other issues that have arisen over the summer recess, such as letters from people about priorities, have been added to the list. Some issues have had quite a high profile. Hugh Henry's press coverage on the smoking issue has put the rest of us to shame. Tobacco smoking is a high-priority public health issue for the committee as it is a No 1 cause of ill health.

We have been told that the committee will be the secondary committee on the adults with incapacity bill, but we do not have the timetable for that. We will of course be given the timetable when it suits others to do so, but the bureau will also give us a date by which we will have to make our submissions. However, because we do not yet have that date, we have to be aware that the matter will have to be slotted into our schedule at some point.

Committee members need to be aware that, because of the nature of the subject, we will have to react to serious areas of public concern. Over the next few weeks, I hope to have private discussions with all of you about how you think the committee should react to such issues. I hope that we shall be able to reach an understanding among ourselves about whether we should discuss a certain issue. Although it would be easy for us to be blown off course, we must react to any areas of public concern that might arise.

Is everyone happy to make progress on the next tranche of priorities?

Hugh Henry: Before we discuss specific topics, it would be helpful to clarify the process for reacting to events and areas of concern. Any committee member who had concerns about a specific issue, which they wanted to be included in the agenda, could notify you as the convener in advance, which would allow you to have some semblance of order in meetings. If we simply throw our concerns into the discussion at the end of a meeting, it is the nature of politics to have four or five committee members raising four or five important issues that are dear to them. There is no sense of order. I would be much happier with a system whereby, if I felt strongly about an issue, I could write to you asking to slot the matter into the agenda. That would give prior warning without having to go through a process of notification.

The Convener: I echo that, Hugh. I want to get a sense of how members feel that we should deal with this. Hugh is right that if a member wants a matter to be discussed, they should contact me and we can decide what to do. Apparently there can be no "any other business" item—notice must be given. Hugh was right, as usual. Although we do not want to look as if we are not listening to what is happening out there, we have a tight work programme, and it will take time to produce results on big issues. I welcome the opportunity for us to discuss that more informally.

Dr Simpson: I agree with Hugh. We must decide the process before we discuss the myriad subjects that we would love to tackle. We are talking about a programme for three and a half years until the next election, so we must pace ourselves. There are different levels—for example, Arbuthnott must be dealt with, as there is a timetable for consultation. The adults with incapacity bill must be scheduled, but as we are the secondary committee, the timetable will depend on the Justice and Home Affairs Committee. We should group the other matters that we must examine.

The second level is reports that we receive. We must schedule when we deal with them. I will mention three. We have had two Accounts Commission reports this year: "Full House: Theatre Utilisation in Scottish Hospitals", and "Implementation of Evidence Based Health Care in Scottish Health Boards". I presume that we will get a report on cervical screening, which will meet both of Margaret's criteria and must be scheduled. That report will come out in October, so we should take evidence from the health boards then.

We must discuss the timetable for examining those reports with the Executive, because there is no point in considering a report on theatre utilisation immediately. The report will contain much information, so we must give the Executive and the health service management executive time, which they should to some extent determine, in which to consider the report and implement its proposals. We should come back a year later and say, "It is a year since that report—what is being done about it?"

The third level is matters that it is imperative we tackle as a matter of urgency before a crisis arises. Every winter, the health service has a winter emergency admissions crisis. Every winter for the past six years, successive Governments have produced a tranche of money late in the year to deal with a crisis that the health service is already dealing with. Every year, those in the health service say to us, "How the hell do we open wards, appoint staff and deal with a crisis that we are already two thirds of the way into?" That is one issue; we must consider whether there are other issues where the timetable is forced on us, because we must deal with them.

The Convener: I spoke to the minister last week about reports that were going through the Executive and were behind the scenes. We know about some of them, but will probably not know about others, because reports are always under way on all sorts of issues.

I asked Susan Deacon to give me an idea of what is in the pipeline because of the committee's work load and priority planning. I followed up that request with a letter in which I apologised for the short notice, but said that we would need to know what reports were in the pipeline so that we could take them into consideration. It was a last-minute request and possibly I should have thought of it before the recess, but I did not. We will probably receive the information fairly swiftly so that we can include it in our thinking. Rather than setting priorities and dates today, we might have to be more fluid and be prepared to slot things in once we have that information.

Richard made a good point about urgent issues. Committee members must let me know the issues that they consider to be urgent, because I will receive letters from committee members and other MSPs and, if we do not have a system of benchmarking, I might end up making arbitrary decisions that members do not agree with.

Richard also mentioned cervical screening, about which I wrote to the minister, who replied that an interim report would be available in October. Later we will discuss the minister coming to talk to us on a range of issues; I have told her that I want to talk to her about cervical screening in particular. The minister's attendance at the committee will probably be after the publication of the interim report, so we will be able to ask questions about it. We might also want to speak to other people about that report.

10:30

Mr Duncan Hamilton (Highlands and Islands) (SNP): As Richard said, we must impose some order on our list of priorities because it is a hotch-potch of issues. We should try to differentiate between individual issues, such as passive smoking, and subject areas. At the moment, the subject areas seem to be much of a muchness.

I do not know members' views on, or the position of the standing orders in relation to, the establishment of smaller groups to consider specific issues. I would welcome clarification on that, because in view of the burden of work that we are outlining today, working in smaller groups might be a way of making progress.

If we can make progress in smaller groups, we should bear in mind that there is a difference between the self-contained topics on our list, which may also have a defined time line, and the open-ended ones, such as public health. With that differentiation in mind, we could get some advice on how to progress.

Hugh Henry: I wanted to make a similar suggestion. Irene and I have been involved with the Committee of the Regions and we have some knowledge of the European system of rapporteurs. We could either split into smaller groups formally or have up to three reporters working on the same topic. The group, or the reporters, would then report back to the committee, without any prejudice to the committee's final conclusions.

The beauty of that system is that it would allow a number of people to work in their own time, in parallel with the work of the committee, and much more work would get done. It would allow a range of members to be involved with topics that are of special interest to them. The committee could have a debate, when the report was presented, about how to progress the matter. There is a lot to commend the system.

The Convener: Can I come back on that one?

There was a discussion at the conveners committee about the formation of sub-committees. As with a lot of things that the committees do, the establishment of sub-committees has to be passed to the Parliamentary Bureau for its point of view. However, it was said that there was nothing to stop conveners asking individual committee members to consider something and report back. I know that Hugh, for example, is keen to examine the issue of smoking. Standing orders allow us to have one competent reporter on an issue. There is

no reason why we cannot have a reporter working with a couple of other committee members. If we want to take forward in that way issues that arise in the next part of our discussion, we should do so—if we are challenged, so be it. My understanding, though, is that that would be fine.

Mr Hamilton: It is true that we can get round the rules, but if we decide to use sub-committees, it is important that, rather than trying to outfox the bureau, you express clearly to the bureau that we want that method of working to be approved.

The Convener: I intend to report briefly later from the conveners committee. Without going into detail now, I can say that there are a number of issues on which the conveners committee is keen to clarify the position of committees, such as the relationship between committees and between committee conveners and the bureau. The conveners committee is actively considering the issue of sub-committees.

Malcolm Chisholm: I agree that we should conduct inquiries into more than one area at a time; that is the proviso with which we accept the Arbuthnott timetable.

I agree that we need sub-groups. I understand the difficulty about sub-committees, but the Equal Opportunities Committee established yesterday that its basis of working will be in small groups, so there cannot be a problem with sub-groups.

The Convener: I do not think that there is a problem with sub-groups.

Malcolm Chisholm: That will facilitate more work being done.

I take Richard's point that a lot of what we do will be reactive—a lot of issues will arise over the winter—but I am concerned that we should address the bigger picture as well and do some creative thinking. Health inequalities, which have been highlighted, are an issue on which we want to do on-going work but will probably not produce a report on before Christmas, or even Easter. We know that the issue of health inequalities is being discussed and is a priority, but there is an awful lot of work to be done. It is at the cutting edge of radical thinking and it is an area in which we can make a contribution.

I will highlight two other priorities on which I think we should do something—perhaps a more limited report. Patient participation is also at the cutting edge of new radical thinking; to some extent we could set the agenda on that, although the Executive is making positive noises about it. We must also address community care soon, because it includes a lot of the new health service and it is where a lot of problems arise. Work on patient participation and on community care must be set in motion before Christmas. I know that that will be very difficult, but sub-groups will facilitate it.

The Convener: At some point we have to take our foot off the gas and realise that we are just human and cannot keep going at our present pace. I will not push members to go into sub-groups to report back in a fortnight.

Malcolm is absolutely right. One of the key things that we must be able to do—as well as undertake our scrutinising role and react to events—is take a few steps back, look at the big health issues across Scotland and do solid, in-depth work. That takes time and resources and I echo what Malcolm said about that.

Ms Oldfather: I agree. We have a huge agenda and we could probably meet every day of the week in every week of the year and still have work to do. It is important to target and focus. The point that I wanted to make relates to the reporter system, which was mentioned in the consultative steering group report. I hope that we can find a way of taking that forward. It is different from a sub-committee system, because it frees up members more.

One, two or three people work on an issue, but not as a formal committee and they do not meet every week. They work together in partnership to achieve a common aim. Hugh and I have both acted as reporters in Europe and it is a system that I commend to the committee. It would not tie up individual members other than in the specialist areas in which they are interested. That is an advantage over setting up a sub-committee, which might regularly tie up four members and perhaps committee clerks too.

The Convener: The idea of sub-groups and reporters is a much better way to go than formal sub-committees. The situation is fluid and our views may change on the basis of knowledge that we glean and decisions that we take, but at this stage, that is the way we should go.

Kay Ullrich: I agree with what Malcolm said about the necessity of our watching community care. As I recall, the most raised issues during the election campaign were to do with community care, the lack of resources and people's inability to access resources.

I was disappointed, convener—I hope that it was an omission—that when you listed community care as a work priority and included bedblocking and mental health, no mention was made of the Sutherland report. We cannot look at community care without looking at that report. I am concerned that, although it is widely seen as the way forward, the report has disappeared. It is almost becoming the report that dare not speak its name.

I know that there are problems because some of Sutherland's recommendations are linked to social

security benefits, which are in Westminster's remit, but there are recommendations that we could consider and that could do something to reduce bedblocking—I am thinking of the three-month disregard—and improve assistance for carers. I hope that that was just an omission, Margaret. We cannot look at community care without looking at the Sutherland report; people would be very disappointed in us.

The Convener: It was definitely in there somewhere—I remember seeing it.

Kay Ullrich: It is on the additional list—that is what worried me. It was not included with community care.

The Convener: I accept the point, Kay. At all times you can take the list of priorities as the starting point for our discussions. Your point is well made.

Mary Scanlon: We are looking to find some order here. Seven key areas are listed on the work load paper, which are the result of the prioritising that we did over the summer. We are going to discuss Arbuthnott, which would seem to take care of quite a lot. Arbuthnott also covers a considerable range—although not all—of health inequalities.

Adults with incapacity is a matter that we will deal with in any case—it is timetabled. I do not want to enter the issue of the private finance initiative, as other committees are dealing with it—we will leave that one.

We should get down to reality and return to the points made by Kay and Malcolm. Community care really is a top priority. I am not just talking about this year and last year—the situation is getting worse and I believe that there is a crisis that the committee has to address responsibly, professionally, honestly and openly. If all we do outwith the set agenda is address that huge issue, it would be wonderful.

10:45

I suggest that, apart from our statutory obligations, we concentrate on community care and addiction. I know that I have a thing about dental decay, which did not come up in the seven priorities, but it is not a dreadfully complicated issue to cover. It could be included in the priorities that the committee, with a degree of consensus, has identified. That would give us a bit of order on which to build our programme for the year.

The Convener: That is a good point for moving the discussion to its final stage. I am allowing this part of the discussion to overrun a little because I have been timetabled to report on the conveners committee for 30 minutes—I will not bore you for 30 minutes on that. I think that it is important for us to set off in the right direction on all these matters. I ask members to make comments along the same lines as those of Mary, to tie together our opinions on what we want to take forward. We should think in terms of the issues to advance using sub-groups and reporters who will do the initial work and return to the committee later. That will be easier for some matters than for others.

Ben Wallace: I want to underline what Richard said earlier. Yet again, we are starting to drift into the topic. Before we come to a topic, it is important that we identify how we stream this committee's roles of scrutiny and dealing with advice and reports—which is what Richard was talking about. We should decide now how we divide those streams up.

The Convener: It is difficult to do that because we have not been told what reports the Executive will throw at us. That should not, however, hold this committee back from setting, say, two priority areas that we want to investigate, in sub-groups, using reporters and so on, so that we can proceed with our agenda as well as with that of the Executive.

My gut reaction is that we can cope with two pieces of work at this stage, along with what is likely to come from the Executive and the other things that we have on our plate. We could sit every day of the week and debate everything, but we should put a self-denying ordnance on ourselves.

Richard's point on theatre utilisation illustrates the sort of structural change that will happen and which this committee should look back at a year or so down the line. The committee has a part to play in judging how primary care, health care co-operatives and so on have worked—or not—in practice, but we cannot do that until some time in the future. We have to move our discussions along on several fronts as effectively as we can. It will be a job for us, but we should not step back from setting out a couple of priorities of our own. We can then set people to work on them in the background. As I said before, we should not rush to conclusions, but aim for quality and value.

Dorothy-Grace Elder: It is me next.

The Convener: Ben, I sort of interrupted.

Ben Wallace: That is all right.

Dorothy-Grace Elder: Let us rewind. I have been trying to get in on the debate for some time. I am concerned that we might be tying ourselves up in long reports when something immediate happens. The Scottish public has a right to fast access to committees as well as to the Parliament. That is our big improvement on Westminster: people can raise an issue fairly quickly. For instance, as Richard pointed out, there will be the

inevitable winter crisis—November and December never being foreseen by the health service—and the situation of the two children's hospitals has suddenly blown up without any of us knowing about it. All sorts of things are happening.

Convener, you said that we could submit requests. How quickly could that be done? Could requests be submitted the night before a meeting, whether of the committee or a sub-committee?

The Convener: The night before may be too short notice.

Dorothy-Grace Elder: It depends on when a situation arises.

The Convener: It must ultimately rest with my judgment on whether the matter is crucial. If, for example, there were a sudden risk to public health in the water supply, we would discuss that, but there are different levels of priority. Some decisions will have to rest with my judgment.

One of the things that the conveners committee made clear was that clerks can speak in committee meetings, so Jennifer can tell us what the procedure is.

Jennifer Smart (Committee Clerk): It is important to give proper notice, so that the committee is open and accessible to everyone. When members put an item on the agenda, notice of it appears in the business bulletin. That is the deadline for submitting items. The other place to air issues is the chamber.

Dorothy-Grace Elder: The deadline is the day before, but members should consult Margaret?

Jennifer Smart: Yes, an item would have to be agreed by the convener and the committee before it could be put on a supplementary agenda for this committee to consider. Items cannot be raised without notice having been given.

Dorothy-Grace Elder: The public would rightly get angry if it saw us developing into yet another of those bodies that go on and on without the public being able to raise a big issue—such as the closure of a local hospital—very quickly.

The Convener: The other source from which we will receive business is the Public Petitions Committee. Anybody can petition that committee, from individuals and organisations to groups of thousands of people. The public has that way in, and the Public Petitions Committee will deliver items to us with a time scale for consideration. That committee will discuss the matter with me and with the clerk to clarify our work load.

From initial discussions, it seems that we will have to respond to such business within two cycles of our meetings. Depending on how the meetings of this committee go, that may end up being a matter of only a fortnight. We will have an incredible work load problem because of that, but that is the public being able to gain access to Parliament as quickly and in as businesslike a way as anybody could justifiably expect. We must put certain parts of our business in train so that we can give a considered view on petitions and issues that come before us. We must be able to react, but we must know how to do that.

Margaret Jamieson: Concern will be expressed in Glasgow about Yorkhill, but all members of this committee and every member of this Parliament will have a particular issue to raise. This is not the place for that. The question of Yorkhill is a matter for that area of Glasgow and for the clinicians in the health service to consider. We are not here in place of the Scottish health service; we are here to ensure that that service deals with things in an appropriate way.

The Greater Glasgow Health Board is charged with examining the matter that Dorothy raised, under the direction of Geoff Scaife and his team. We need to be careful that we do not pick up issues that are not entirely in our remit. The issue might come before us at some point, but we would destroy democracy if we jumped in first.

Dorothy-Grace Elder: I am not going to consider the issue in detail at the moment—there will be another opportunity—but the suggestion that child cardiac surgery for the whole of Scotland should be confined to just one hospital is of great importance and must be dealt with soon.

Margaret Jamieson: Equally, Dorothy, I did not come to the committee and ask for special consideration for the cochlear implant service, which is currently being reviewed. Such things go through a process and I am happy for that to be the case. When the process is completed, I will ask further questions.

Dorothy-Grace Elder: I understand, but the point that I am trying to make is that there might be many occasions when this committee has no chance to inform a minister of its views before a minister makes a decision. We want to avoid that happening.

The Convener: The issue of child cardiac surgery is of concern to all of us. We will have to look at acute services reviews and other such things. We are all learning about what is the best way for us to function in this Parliament and to work for our constituents. We will have to suck it and see.

I would like to turn the discussion back towards the working priorities.

Dr Simpson: Margaret, you might rule me out of order, but I think that Dorothy's point is important. This committee must not start jumping in to react to various issues. If I have a problem with, for

example, cervical screening, I talk to my health board chairman. Once the Executive decides to set up an inquiry—as it has on cervical screening—our job is to question that inquiry and examine its report.

If we jump up and down about every issue, even if it is of national importance, the committee will not function. We have other methods at our disposal, such as petitions. We can use parliamentary questions to ask precisely what the Executive plans to do about one matter or another. I do not want this committee to second guess the Executive before it has had a chance to tackle the problem.

I will return to the issue at hand. We have said that we have to tackle any bills that we are required to examine and that we have to tackle reports in a logical order. We have prioritised three reports: the Arbuthnott report, the cervical screening report, which is timetabled for October, and the report of the Sutherland committee, which relates to another area.

We have topics—such as tobacco—and we have issues. The issue that I suggest we consider is community care, which includes bed-blocking and winter emergencies. That is an issue that we have to tackle immediately.

We should discuss in about a month's time where the other things that we have listed should be slotted in. By that time, we will have had notice from the Executive of all the other reports, so we will be able to review the situation. If, in the case of the junior doctors—I come back to Dorothy's point—the negotiations proceed to a point where we wish to make an input, that is when we should do so.

11:00

The Convener: I had community care and smoking in mind.

Dr Simpson: I have one last point. I would like to make a recommendation on addiction. We need to tell the bureau that addiction is such an important issue and is relevant to so many committees—the Justice and Home Affairs Committee, the Social Inclusion, Housing and Voluntary Sector Committee, the Health and Community Care Committee and the Education, Culture and Sport Committee—that it requires a separate committee. Unless Scotland tackles the drugs issue as a major priority, and it is recognised by the Parliament with a separate, specific committee on drugs, it will be dealt with badly in each committee.

The Convener: What I wanted to say is that during this Parliament the committee should examine the different aspects of addiction—addiction to drugs, smoking and alcohol—that have a terrible impact on Scotland.

I hear what Dr Simpson is saying about drugs. At the moment, all committees are trying to do the same thing as we are—set their priorities and see how the reports that they must handle dovetail. When we talk about cross-cutting and committees working together, drugs is an issue that keeps coming up. I would not like to jump the gun by setting up a separate committee until we have worked with others to decide what is the most effective way to examine the issue. We should be ready to work on the issue to the same timetable and alongside other committees. However, it will take at least a few months before all the committees can arrange a time when they can do that.

I am keen that we consider the smoking issue. I am not pre-empting our decision or saying that there should be a ban—I am not saying anything of the sort—but smoking is the No 1 public health issue and the committee has to make it very clear that that is its view.

Dorothy-Grace Elder: No 1? I would not say that.

The Convener: I think that it is the No 1 public health issue, although it is not necessarily the No 1 issue.

Dorothy-Grace Elder: What about housing?

Kay Ullrich: Poverty is the number one health issue.

The Convener: We are looking at health inequalities, and I accept what Malcolm says: that health inequalities and poverty will run through everything else that we do. We should make sure of that. We will try to cover our spread, and I hope that members will bear with me.

We would do best to address the drugs issue in a much more integrated way, rather than jumping into it immediately. It is not that I do not want us to tackle it, but my view is based on discussions with other conveners. We cannot forget the question of alcohol; we should come to it at some point in our programme.

I agree with the points that have been made about community care and the Sutherland report, and the points that Richard has just made. We should be ready to consider a programme for dealing with addiction, but we should kick it off with either smoking or alcohol rather than with drugs, for the reasons that I have just outlined.

Mr Hamilton: I am very comfortable with the structure that Richard has proposed, and I think that that applies to most members of the committee.

I wonder whether you could clear up one point

about Arbuthnott. There is a difference between the methodology that produces a particular resolution and other substantive issues. Many of the issues surrounding rural health, for example, are not dealt with. The same applies to the question of health inequalities—it is linked to Arbuthnott, but it is not covered explicitly. To take up Malcolm's earlier point, I hope that we will extend our consideration to such areas.

My substantive point concerns the private finance initiative. Perhaps you intend to say something about that later, convener. I do not think that it is sustainable for this committee not to consider the health implications of PFI in Scotland. In terms of public confidence, it is not sellable for the Health and Community Care Committee of the Scottish Parliament not to consider what is a burning issue for both the public and political parties. We cannot go down that route. I would welcome an early indication that we will be discussing the subject.

I do not know the details of your conversations with other conveners but, having talked to colleagues on various committees, I know that no committee—including the Finance Committee—is going to consider PFI in the same way as this committee can. Other committees will be comparing PFI and other means of funding in terms of value for money. They will not be looking at PFI in terms of what it will mean for the health service. I look forward to your comments on that.

The Convener: I certainly would not rule out discussing PFI, which is going to be one of the key issues in the health service in the coming years. I have written to the conveners of both the Finance Committee and the Audit Committee about it, as the issue has been raised with me by members of this committee and by other members of the Parliament. My view is that it would probably be better to tackle it in a more integrated way, in which we would put a particular slant on it. Whereas the Finance Committee would look at it from the point of view of value for money—and as public servants, we all have to have a regard for value for money—this committee would look at it in terms of provision of service and staff conditions, for example.

PFI is on the list because a number of us have concerns about it, but I think that it may not be looked at until next year. The Finance Committee and the Audit Committee will be looking at it, too, so we must talk to one another.

Mr Hamilton: Why will it be looked at next year? Is not PFI a perfect example of a self-contained topic that could be looked at initially?

The Convener: As I said, we have to be realistic about what we can do with our time. I am not saying that PFI is not important, but members of this committee thought that community care and addiction were more important. Those issues can possibly be taken forward more effectively by us alone; other issues will be tackled more effectively in conjunction with other committees. As we are setting things up, and as all committees are considering how they are going to tackle their work load, I have suggested to other conveners that, if we want to get the full picture, the committees must work together on the two issues of drugs and PFI.

Mr Hamilton: Will you bring back to the committee the resolution of discussions with other conveners, so that we can plan ahead?

The Convener: Yes. A lot of it is down to other people setting the same sort of priorities and then working together. I do not rule out the possibility that, following discussions in the conveners committee, I may say to this committee: "A particular issue has arisen and two other committees are considering it. Although we have said that we would consider something else, we should try, for the sake of joined-up government and working together as productively as possible, to slot this issue in, as it has a health aspect." I am open to that way of working—it is part of the great learning curve.

We are coming to the end of this part of our meeting, so I will call Margaret and then Hugh before winding up.

Margaret Jamieson: I want to talk about community care, and about how we will work with our colleagues on the Local Government Committee, because community care impinges on social work departments. I have to be honest: in my previous life, PFI was the burning issue, but it is not the burning issue with the electorate that I serve—community care is. How are we to kick off the process of engaging with our colleagues in local government? Nine times out of 10, those are the people who are carrying out the assessment.

Kay Ullrich mentioned her previous life, too. We need to ensure that the health and social services are interlinked and that health boards are committed to providing funding. The system of resource transfer is not working and we must consider in detail why that is the case. It works in some local authority areas and not in others, which has a knock-on effect. Should we examine that problem from a health perspective, to assess what the health gain could be? Will it reduce bedblocking, or will the health service claim that it is an issue for local government?

We must be careful how we pull together all the strands of this problem. The public are aware that there is not a seamless transition between departments with responsibility for community care. We need to hone in on that.

Kay Ullrich: I agree with everything that Margaret says. The Health and Community Care Committee has to consider every aspect of service delivery and resource transfer between health boards and social work departments.

Dorothy-Grace Elder: I agree with Kay and with Margaret. Poverty and community care, rather than a single issue such as smoking, should be at the top of our agenda. We could almost write the smoking report in advance. All it would say is, "Smoking is a bad thing." How much would be spent on that?

If we widen our scope to include the problem of poverty, we will include smoking and other specific health issues, but we will also include community care. Most of the recipients of so-called community care are people who have been reduced to poverty because of their disabilities. There is enormous need, and it is all due to poverty and poor housing.

Hugh Henry: There has been a good discussion about how we ought to focus on various priority issues. I am glad that Margaret Jamieson raised the subject of community care. There is a danger that the Executive and this committee may look at the issue simply from a medical perspective. We must not forget the role that social workers and local authorities have to play.

Duncan Hamilton mentioned the structure of the national health service, which raises a number of important questions. Who is responsible for the delivery of community care? How is integration with local authority services arranged? Who is responsible for bedblocking? Who is responsible for distribution of funds? If we are to achieve anything over the next four years, we must scrutinise the structures, methods of operation and effectiveness of the health boards. We may not have time to do it today, but we must at some point come back to the question of how to ensure that the health board system is the best way of achieving what is necessary.

Although we will be busy dealing with reports and legislation, I do not want to lose sight of the issue that Richard Simpson raised. We are anticipating what we will be working on during the winter and it would be remiss of us to mention things now and forget to follow them through for the next couple of months.

The rapporteur system will allow work on a number of issues to continue. Ben Wallace raised some points about health promotion, sport and health education, and such issues could be worked on. Is it possible to set aside time every meeting—or every second meeting—for rapporteurs to report back to the committee? That would allow us to carry out a range of work and to have the opportunity to report back—at the discretion of the convener—and hold a short discussion. It would allow us to timetable work more productively and to do much more work than we would otherwise. It would almost allow every member to go away and work on a range of issues.

We need to examine the standing orders to see whether they specify that a committee should have one reporter. We need some flexibility, because in some cases it would benefit the committee if a couple of members worked on an issue.

11:15

The Convener: It is always better from the point of view of balance to have two reporters. I will speak to the clerks in order to clarify that point.

Ms Oldfather: I know that you want to finish up, but I have another point about the additional priorities list. There is a clear theme relating to public health. I do not disagree with any of the priorities that we have identified in terms of community care—we all know how important that is. However, although health inequalities are on the priority list, that is a little different from the public health agenda, which includes the prevention of ill health and the promotion of good health.

We must consider the screening programmes. We have talked about the cervical screening programme, but there is also important work on extending the age limits for breast screening to consider. The public health agenda should also be on our priorities list.

The Convener: I want to be firm at this point. We must bring this part of the agenda to a close.

To pick up on Hugh's point, we should investigate the role of rapporteurs and sub-groups. We will have to deal with the Arbuthnott report, the incapable adults bill and statutory instruments—as we discovered yesterday. Moreover, the convener of the Public Petitions Committee will hold a press conference to tell everyone in Scotland that that committee exists, which will mean that all the health issues in which people are interested will come to our attention in that way. We must be reactive.

Over and above the things that we know that we will have to deal with, there are two broad areas of interest that we want to pursue in the immediate short term: community care and addiction. I suggest that the clerks and I come back to the next meeting with a report on our options in terms of sub-groups and reporters. I ask members to consider not only what topics they would like to be included in the remit of the sub-groups dealing with community care and addiction, but the membership of those sub-groups. At the next

meeting we will be able to focus on those parts of our work load, having had some clarification of our remit.

Kay Ullrich: We need clarification. When we are talking about addiction, we must be clear what we mean, because from what you said previously, our programme would exclude drugs. It would be wrong to use the term "addiction" because, to the public, addiction means drugs, crime and poverty.

The Convener: Can I get a steer from the committee? Given what I said earlier about drugs, are we happy to come back to the community care aspect? Taking on board what Margaret said, I will contact the relevant conveners as a matter of urgency and let them know that that is how our minds are working. On the addiction side, we will focus first on smoking.

Hugh Henry: I am happy with that. On the broader matter of drugs, Kay is right. There is a range of substances—

The Convener: Let us not go down that route today. If people want to go beyond smoking and to talk about other addictions, we can consider that at the next meeting.

Hugh Henry: My point is about procedure. Richard suggested a separate committee to deal with some of the work, which, frankly, I had not thought about. I do not know whether at an early meeting—it is a bit early for the next meeting—there could be a paper considering ways to move the matter forward. At least then we would have something before us that laid out the options—either the Health and Community Care Committee deals with it, there is a separate cross-cutting committee or there is a separate committee.

The Convener: The conveners committee is considering cross-cutting committees and discussions.

Hugh Henry: But this is a specific matter.

The Convener: All of us must be allowed to take forward issues—drugs is one that we will be interested in. There will be several, and the standing orders must give us the flexibility to produce good work.

Kay Ullrich: When we talk about smoking, we should not use the term "addiction". We should talk about tobacco, otherwise we will be misconstrued. People think addiction and then think drugs.

The Convener: I took your comment on board, Kay. I asked everybody whether they were happy to go forward using the term "smoking", and they said yes, so the issue is now smoking.

There are issues for us to consider for our remit on community care and smoking, such as how to take those areas forward most productively and cross-cutting with other committees, particularly on community care. That will give members a chance to think about those issues and their behind-the-scenes involvement in the initial work load before the matter comes back formally to the committee. Planning to revisit community care and smoking at a future meeting takes us forward on those issues.

Dorothy-Grace Elder: The public is much more interested in saving people from heroin. There have already been 100 heroin deaths in the first eight months of this year. Should we, as a new committee, focus on just smoking—I hate to use that term—when the drugs menace is ravaging parts of Scotland?

The Convener: I have been quite clear on the procedural reasons that lead me to think that more valuable work will be done on that important issue by the Parliament if we exercise a bit of restraint. In a few months, I hope that we will be able to come back to that issue and work in a much more effective and integrated way.

I do not think that any member of this committee would consider drugs not to be a key current issue for Scotland. To ensure that we handle it well, we must be prepared to wait until we settle into our committees and until we know the best way for us to work together in tackling the problem. There might be the option of setting up an ad hoc committee. There has to be some cross-committee work; the conveners committee is starting to think along those lines. We need to allow ourselves some time to ensure that we tackle the matter properly. I assure members that we will not in any way forget about the issue.

Mr Hamilton: What you are saying is that the issue of drugs will be taken forward across committees. The private finance initiative is another. Is that correct?

The Convener: Yes. I do not know whether you are trying to trick me, Duncan.

Mr Hamilton: I am not. I just did not hear PFI being mentioned.

The Convener: You do not need to trick me into mentioning it again, Duncan. PFI is an important issue for the people who work in the health service. It is important for all of us that we have the buildings and services in place to give the people of Scotland a world-class health service in the years ahead. I made it clear at the beginning that PFI was an important issue.

If everybody is happy with where we are, I want to thank everyone for a good discussion. That completes only the first item on the agenda, but it has been suggested that we should take a short comfort break.

11:26

Meeting suspended.

11:38

On resuming—

Health Minister (Invitation)

The Convener: Item 2 on the agenda is an invitation to the Minister for Health and Community Care to come to speak to us. We had a good meeting yesterday. Susan answered all our questions very well and it was good to be able to have her at a committee meeting so early, although the situation was slightly unusual in comparison with what we are discussing now. We are inviting her to talk on a wide spectrum of health issues and to tell us how she views her role in carrying out the Executive's work plan and in working with the committee.

I want to ask two questions. We have invited the minister, but does the committee want Iain Gray, the junior minister, to come with her? I see from the number of members nodding that the answer is yes, so we will extend an invitation to him.

Kay Ullrich: Part of his remit is community care.

The Convener: Yes.

We have full diaries, so we will probably not be able to do that soon. Susan Deacon will be here on 6 October to discuss the Arbuthnott report, so she will have been to see us twice before she comes formally to discuss wider issues. That is not a bad thing for the committee because it will give us a chance to get an idea of what we really want to ask her.

Hugh Henry: The minister was here for the debate on amnesic shellfish poisoning. Are you saying that she will also be here to discuss the Arbuthnott report?

The Convener: Yes. She invited herself to both meetings because of the circumstances.

Hugh Henry: It might be useful to have the minister here to discuss amnesic shellfish poisoning and other such specific issues, but I am not sure that there is much value in inviting the minister in for general discussions. Having heard this morning's discussion and thinking about our individual interests, we could end up going round in circles. I might want to address an issue that is of interest to me, and someone else might want to go down a different route.

It would be more beneficial—in terms of holding the Executive to account—for us to give ministers specific subjects on which we want to question them. That would allow us to go into those subjects in much greater depth and would also allow the ministers to focus better.

The Convener: Susan Deacon will get advance notice of the issues that we want to discuss. The discussion will be free-ranging. We want to raise issues such as cervical cancer screening—the minister has already been told that we will probably want to ask her about it.

Hugh Henry: That is important. I raised with you the question of cervical cancer screening because I wanted to know that there would be an opportunity for us to discuss that. I am content to hear you say that there will be a report, which we can examine and question as appropriate.

If, however, we simply say to the minister that we would like to discuss community care, addiction, drugs or whatever, things will get out of hand. We must say to the minister that we want her to come to the committee to represent the Executive on specific issues.

As Mary said earlier, community care is such a wide-ranging topic that the discussion could go anywhere. We need to decide what we are not happy with. I would rather that the minister was brought in to say what the Executive intends to do about the potential crisis in the NHS during the winter. The committee would be more productive if we could tease out a range of things.

The danger is that the broader the issue, the less accountable the Executive becomes.

The Convener: My take on that is that there are two things that we must consider. The first is that there are several years ahead of us, and no doubt there will be any number of occasions on which we will call the minister in to talk to us about particular issues.

It would be good for the committee to kick off with a general discussion with Susan Deacon about how she sees the programme being put into practice. We would be able to raise some of the issues that we have talked about among ourselves. We have to give her prior notice, so that she can find spaces in her diary.

11:45

An element of courtesy is involved in such a discussion with the minister, but it does not mean that we will not be able to ask her to talk to us about issues that we might be concerned about in future. This is the starting point for a relationship between the committee and the Minister for Health and Community Care and the Deputy Minister for Community Care. I am not setting up the meeting as some great panacea, but I feel that an initial meeting with the minister will be a useful exercise for both sides. In that respect, it will be a one-off. In the future, we will call her to talk to us about particular issues.

Dorothy-Grace Elder: Yesterday was useful, in that we met the minister and got to know her a bit better. However, frankly, it was not really necessary to have a minister of her high rank there for a non-controversial issue. We were not going to vote against the shellfish ban.

The Convener: The minister had to be there.

Dorothy-Grace Elder: The highest-ranking minister needed to be there?

The Convener: It was the minister's motion, and our understanding was that she had to be there as a matter of procedure. It was her request that it be done that way, and we had to follow that due process. We did not ask her to meet us on the shellfish issue; it was quite the other way round.

Dorothy-Grace Elder: I thought that a more junior minister could have been present in such circumstances. However, it was good to meet the most senior minister as the kick-off. In future, we do not want the highest-ranking minister to be called in on non-contentious issues. We want them to be present when we are discussing a contentious issue and when the Executive has to explain itself. I repeat my fear that we could have ministers coming before the Parliament to say that something is a done deal—that a decision has been taken. We do not want that—we want discussion beforehand.

Ben Wallace: On a point of order. Is the procedure that the senior minister should attend? I was aware that a minister had to attend, but should it be the senior minister?

Jennifer Smart: It was the minister's choice to attend—she came at her own invitation to speak to the statutory instruments. It was not a decision for the committee to take—the minister decided that she would come to the meeting to speak to those instruments, and that is how it was left.

The Convener: I, for one, will not turn down the minister when she feels that she wants to speak to us. A key part of our job is to hold the Executive to account, to scrutinise the minister and to ensure that she is ever mindful of the fact that we exist. However, it is also part of our job to work with her to deliver the best possible health care. A good relationship between the committee and the minister, established at an early stage, is to be encouraged.

Mary Scanlon: While it is important to have a positive and constructive relationship with the minister, from what has been said this morning I fear that we are trying to be a bit too prescriptive. I do not want things to be sanitised—I would like to think that we could be evolutionary in our approach, and try out ideas. Convener, you suggested in our first meeting that we should suck it and see, and sometimes I think we just have to do that. We cannot sit down and say that this is precisely what we should or should not have.

I agree with Hugh that it is important to make good use of the minister's time. With a degree of good will and flexibility, the convener can use her discretion. It would be wrong to be too bureaucratic and rigorous. There should be flexibility, to take into account some of the issues that Dorothy raised earlier.

Margaret Jamieson: Following the documents that have been published in the past two and a half years, we could ask the minister to find out about the health service's performance in terms of implementation. For example, where are we in terms of "Towards a Healthier Scotland"? Is good practice emerging? Is someone running ahead of the rest? We should be taking stock. Where are we? Where are we going? Are there problem areas? How does the action that has been taken meet the objectives that the minister and the Executive set this week? We will know whether there are problems in meeting those objectives in our areas. We should have the opportunity to talk to Geoff Scaife, who has to implement the objectives.

I would like us to talk to Susan Deacon about an area that has caused the health service concern for many years, which is that it receives money only year on year. The budget is not indicated for the following years, so planning is a problem. Those in the health service should have an idea of funding for the next five years.

Ms Oldfather: It is three now.

Margaret Jamieson: The period is three now, but is that sufficient? We need to ask the service whether that is enough time, because year on year was not helpful. Three years is a bit better.

Hugh Henry: You are talking about meeting Susan Deacon a few weeks hence.

The Convener: Yes, I am talking about the beginning of November.

Hugh Henry: May I suggest that each of us has the opportunity to lodge a question through you?

The Convener: I was going to ask whether we are happy for Susan Deacon to speak to us. At some point we must decide which areas we want to examine, so I ask each member to make a suggestion. The minister has intimated that she would be happy to refer to a couple of the issues that I mentioned to her over the summer. We have covered cervical cancer screening. The other issue that cropped up over the recess was the heat treatment of blood. It is of great concern to haemophiliacs, and Susan Deacon and I discussed it in the recess.

If everybody can make suggestions to me, we

can give the minister prior notice of the areas that we want her to talk to us about. That will give her officials a chance to brief her. Is everybody happy with that? Ben Wallace has caught my eye—did you want to add anything?

Ben Wallace: I agree with Henry—

Hugh Henry: That's all right, Wallace.

Ben Wallace: I agree that we have to be specific in order to hold the minister to account. Apart from the first time, I would not like her to come to our meetings too many times for general reasons.

The Convener: I saw it as a courtesy invite from the committee—a setting in train of what I hope will be a good working relationship, given the parameters within which we all work. Beyond that, Susan Deacon's visits to the committee will result from specific issues that arise in our work load. We do not have the time constantly to have general chats with people, and certainly nor does she. I am happy to put that on record. Are we happy with that decision?

Dorothy-Grace Elder: What is not clear to me is whether Susan Deacon would consider handling a mixed bag of subjects on some occasions. If she is to come about a specific subject, we might tend to drag it out because a minister is here.

The Convener: We have to take matters as they arise. On some occasions we might feel that there is one issue that we want to discuss with the minister. However, after a recess—particularly the summer recess, which is quite a long period when the committee does not meet—a few issues might have backed up. We are in a learning process.

Dorothy-Grace Elder: I do not want to hammer something too much, but yesterday I asked Susan Deacon whether she would come before us to speak about the children's hospital.

The Convener: You are hammering it, Dorothy. I will not allow that.

Dorothy-Grace Elder: She said that she would make a decision within a few weeks.

The Convener: I am watching the time. If everybody is happy that we invite Susan Deacon and Iain Gray, we will probably meet them at the beginning of November. However, Susan Deacon will be here before that, to speak on Arbuthnott.

Amnesic Shellfish Poisoning

The Convener: We now turn to item 3 on the agenda, amnesic shellfish poisoning. The Rural Affairs Committee had a meeting on 31 August. Its members were concerned about the impact of the amnesic shellfish ban on scallop fishing. The convener and the clerk of that committee told me that they had invited the chief medical officer for Scotland to talk to them about some of the aspects of amnesic shellfish poisoning and the beef-on-the-bone ban. They asked if we were interested in attending their meeting to ask questions of the CMO on those two matters.

I thought that we would be interested. Resources can be rationalised if our committees deal with those issues together, so there is something to be gained. We touched on the issue of co-operation yesterday. The edges of our remits are blurred on these matters, and, as someone told me, life is not in little boxes. Rather than expecting the whole committee to attend the Rural Affairs Committee, I suggest that I and one representative from each of the political parties go along. We could ask questions and participate in that part of their meeting on 5 October. Does that meet with the approval of the committee? It does. Excellent. That is the type of debate that we should have.

Item 4 is the report from the meeting of the conveners group. I will not need the half-hour that has been allocated to this matter.

Dr Simpson: With regard to questioning the CMO, the Rural Affairs Committee can deal with whatever it wants, but the issue of new-variant CJD and how it relates to BSE is a detailed and technical subject, and there are many related issues, such as the unit in Edinburgh, how it is funded, how long it will exist, and what predictions can be made. I can think of a good half-hour of questioning on the health issue alone that I would like to ask. I am slightly concerned. We have dealt with the medical aspects of shellfish.

The Convener: Quite exhaustively.

Dr Simpson: Yes. I am concerned that the issues might be mixed up. I understand that the Rural Affairs Committee is dealing with the impact—

The Convener: Obviously, this was passed in their committee, and then they had to come to us.

Dr Simpson: I do not see what they will question the CMO about.

Hugh Henry: The issue is, which is the lead committee for dealing with beef on the bone?

The Convener: The Rural Affairs Committee is under the impression that it is.

Hugh Henry: On health issues relating to that matter?

The Convener: No, we deal with that.

Jennifer Smart: We deal with food safety because it is within the remit of this committee. When considering these matters, our role is to examine aspects of food safety.

Dr Simpson: The CMO and the Rural Affairs Committee should come to us for this issue. That is not being territorial. The whole of this committee may want to question the CMO on the health and public safety issues.

The Convener: You can understand that I am in a slightly difficult position, because the Rural Affairs Committee has already gone through its committee process. Prior to their meeting, nobody intimated that they would take that decision. If the mood of the committee is that we say we will not go along, and that we should invite the CMO separately, we will do so, but I was reacting to an invite after the fact.

Hugh Henry: We are dealing with a matter of principle, which also applies to other issues. The economic consequences of the beef-on-the-bone ban for rural areas—for example, how they are affected by it and how they can be protected—is a legitimate area for the Rural Affairs Committee to address. The medical question as to whether the ban should be lifted, however, is a matter for this committee, as is any other medical issue. Other committees should not be making decisions about medical matters.

12:00

Dr Simpson: I strongly agree. This is a procedural issue which the clerk should be asked to take away. This committee has priority, and if the Rural Affairs Committee wishes to call the CMO at a later point, it can do so. If, however, it wants to ask questions on food safety and on public health safety, it is infringing on the prerogative of this committee.

The Convener: We can ask the clerk to take this up. The request came from the convener and the clerk of the Rural Affairs Committee, as if this was a procedure that was acceptable. If the clerk can investigate that for us, we can revisit the matter. Their meeting is not until 5 October, so we have time.

Ben Wallace: I think that we would be doing a disservice to the chief medical officer to allow that to happen. It would damage the integrity of this committee. We hope that, if we ever call him, it will be on important issues. It is unfair to have him disappear off to the Rural Affairs Committee.

The Convener: The request has been made. I do not know whether he has accepted it. We will leave it with the clerk and she can report back to us. I have taken note of the committee's views; obviously, I was being far too soft.

Conveners Group Meeting

The Convener: Item 4 deals with the conveners liaison group, where I am not soft. The conveners have had two very useful meetings. The first was quite long and provided a good exchange of experience. As you might imagine, the conveners of the committees, like all of us, are on a learning curve. It is a good forum in which to share working practice and we will share new experiences as we make use of the full range of mechanisms available to us, such as reporters and sub-groups, setting agendas and working together in a cross-cutting way.

I will run through the kinds of things that we have been discussing, many of which are in a state of flux. Some items are confidential because they have financial implications, and to allow negotiations to the benefit of the committee structure I will respect that. I will run through the issues, and if there are any questions of a similar nature that you come up against, as a committee member, and that you would like me to take to the conveners committee, I will be happy to do that. Obviously, you all have members of your own parties represented on that committee and you may prefer to go that way.

We have been looking at the standing orders. For example, the conveners committee is informal and we are wondering if that is the best arrangement. Committee accommodation is another question. We are in the chamber today because of the constraints placed on us by the buildings in which we currently work. I am not prepared to hold meetings of this committee in rooms to which the general public does not have access. I think that that is the view of all conveners, particularly if they know that members of the public are keen to attend.

We are looking at how committees travel, and at how to ensure that we do not meet only in Edinburgh or the central belt. If we travel, we must do that effectively, openly, and within budget. There has also been discussion about the appointment of sub-committees and working groups—the kinds of things that we were discussing earlier. We are awaiting a report on that.

We discussed cross-cutting issues and the best way to work together across committees. We discussed the use of advisers on committees. The consultative steering group had been keen that advisers should be co-opted to committees and given voting rights, but that was lost in the Scotland Act 1998, so we now have advisers without voting rights.

I am happy to say that the role of committee clerks was discussed. It was clarified that our clerk, Jennifer Smart, and all the other clerks were capable of speech directly to you, without interpretation by me. I take responsibility if I pick one of a range of options that are put to the committee by the clerk, but I think that you should

be made aware of all the options that are before us.

As well as the question of the substantive nature of the conveners group as a committee, the big issue on the agenda yesterday was the work load of committees and how we ensured that we did what we were meant to do. That ties in with our discussion earlier. I am happy to take forward on your behalf to the conveners committee any bigger issues about how the committee structure is working.

Hugh Henry: Through the other committee on which I serve, I have become aware of issues such as the question of where responsibility lies for different matters. We had a good example earlier in the beef-on-the-bone ban.

It is early days in the life of the Parliament, and everybody is keen to throw themselves into work. However, there are potential problems with that enthusiasm if members stray beyond the remits of their committees, even though a matter is of burning interest and is one that we know should be addressed by the Parliament somewhere. The conveners group should resolve that problem so that each committee is aware of what it can and cannot discuss. If members overstep the boundaries, the clerk and convener should haul them back. Otherwise, if we discuss every subject, no matter how peripheral an interest the committee may have in it, we will get nowhere.

I am clear what this committee is about, but I am aware of the dangers. In some other committees, members are straying into the territory of other committees. For example, in the European Committee people started to raise issues that were more the prerogative of the Enterprise and Lifelong Learning Committee.

Mr Hamilton: I have two quick points for you to take back to the conveners group. The concept of hearing evidence outside the central belt and certainly outside Edinburgh is vital, particularly on the rural health agenda that both Mary and I are interested in. To risk the wrath of the *Daily Record,* I say that it is important that we do not run down that taking of evidence to a bare minimum, as has been suggested. If we believe that it is worth hearing that evidence, it must have equality of treatment and be heard by more people rather than fewer.

The Convener: The feeling on that might be that we are damned if we do, damned if we don't.

Mr Hamilton: In that case let us be damned on the side of information.

The Convener: We will be slagged off by the *Daily Record* irrespective of what we do, so let us do what we want.

Mr Hamilton: Fortunately, I gave up reading it a long time ago.

The second issue is the research resources available to the committee. I know that poor Murray McVicar strives manfully to provide all the evidence that we need, but the situation might become ridiculous. The committee should not be short of information because we are short of research capacity. We need adequate resources.

The Convener: Hugh, who was at yesterday's meeting, will agree that I made that point quite forcefully. In terms of research, we have at our disposal one half of two thirds of a person. My maths is not good enough to come up with a precise figure, but that is not enough for us to do the job that is outlined at the top of today's agenda. I know that members will spend hours looking into the subject themselves—we all do that sort of work and will always do so, no matter how many researchers we have—but we need a research capacity that allows the committee structure in this Parliament to function as it is intended to function and in the way in which members of the committees and the conveners want it to function.

We cannot hold to account an Executive that has hundreds of civil servants at its disposal and all sorts of reports being done on its behalf, at arm's length from the health and community care department, when we have so little research back-up. I raised the issue last night at a meeting with the First Minister. Duncan can rely on my chuntering on about that issue.

Mary Scanlon: I wanted to make a similar point, convener, which will not surprise you. It was mentioned this morning that Parliament is centralised in the east of Scotland. I want the Health and Community Care Committee to visit the west and the Highlands, as so much of Arbuthnott focuses on rural issues.

I have read in the *Daily Record* and elsewhere that there is a problem with money. However, various consultation meetings are going on throughout the country. Jim Wallace, for example, is in Inverness tomorrow night to discuss land reform, and I fully support that. However, if there is a budget for ministers to go round the country to listen to what people have to say about land reform, tourism and other matters, money should be allocated for us as a committee to meet people in other areas of Scotland.

I do not want to go only to places such as the council chambers in Glasgow. It is important that we visit health providers. That could include visits to drugs rehabilitation centres or to hospitals. We should not always sit as a committee, but should be at the chalkface of health provision. That would be very helpful.

The Convener: Before we move on, I should

say that I have been made aware of the fact that some staff members from Stracathro hospital, Angus, are in the public gallery. I welcome them on behalf of the Health and Community Care Committee. They were not here at the beginning of our meeting, and we are sorry that we were not able to join them earlier for theirs, because we had a prior engagement. We are here because the other committee room that was available to us would not have allowed access for members of the public. Single-handedly, the staff of Stracathro hospital have ensured that we make the right decision.

Dr Simpson: I have two points. Once we get our work schedules organised—that is to be discussed at the conveners meeting—is there a general intention that they should be publicised? That affects how the public can get to us, as individuals and collectively. If we decide that in the spring we will deal with local health care co-operatives, their representatives and their function, having that published on a general schedule would allow the public to contact us. That is another way of doing what Mary was suggesting that does not involve our travelling.

I have already received an e-mail from our colleagues at Stracathro and have replied to it—I am sure that we have all had such an e-mail, even if we have not yet replied. Accessibility—electronically and in other ways—is absolutely crucial.

The Convener: It is my view that the work schedule of this committee should be made public. I have not raised the issue elsewhere, but I am happy to discuss it with other conveners.

We want to ensure that a range of things happen. One of the key spin-offs of the lack of research facilities available to the committee is that we will be beholden to organisations and professionals in the fields that we want to investigate. Many organisations have already sent us a lot of information and we are grateful for their interest in our work. It will be useful for them to know in advance that we want to consider certain areas, so that they can raise issues for us to consider.

12:15

Dorothy-Grace Elder: I notice that there are several dozen people in the public gallery who have come from Angus, no doubt at their own expense. I hope that, in future, representatives of the committee, if not the whole committee, can be sent to Angus to find out what is happening. Visits to destinations further afield would involve an overnight stay, and we do not know whether money is available for that.

I am mindful of what has been written in the *Daily Record*. I do not think that the *Daily Record* is always wrong, but I agree that we should be living at a humble, boarding-house level when we travel round Scotland. It is essential that we are seen to be a Scottish Parliament and not an Edinburgh Parliament, as is perceived by most of the public outside Edinburgh.

The Convener: All the points that members are raising have been mentioned in the conveners committee. We are aware of our limitations, but we are also aware of the fact that we have to deliver a service across Scotland.

When we make visits that involve an overnight stay, we must be responsible about our choice of accommodation. We must add as much value to such visits as we can. Our visits must be as productive as possible, giving members of the committee hands-on experience and involving people who work in the areas with which we are dealing. We could even hold public meetings as well as holding a committee meeting. That would impose a heavy work load on us for the day of the visit, but it would be in our interests to do that to make the best use of the Parliament's time and money, regardless of what the *Daily Record* says. Members from all parties agree that the Parliament should not concentrate on Edinburgh.

Hugh Henry: We must be careful about moving out of Edinburgh. Not everyone is convinced of the merits of holding committee meetings throughout Scotland simply for the sake of it. Many organisations would like to give evidence to the committee, and it would do no good to have committees and organisations passing each other on the roads and motorways of Scotland.

We must consider what we can humanly cope with. Expense is not the only important issue. We must think about how we can physically accommodate the other work that we have to do in Parliament. Some of us have the luxury of being members of only one committee, but others sit on two committees and have other responsibilities. We cannot simply name a destination for a two-day visit; there are other things that need to be done. Some of us also have constituency responsibilities.

The Convener: We all have constituency responsibilities.

Hugh Henry: We need to take a range of things into account. I do not think that we can take it for granted that there is unanimity about how holding meetings elsewhere can be done—there are concerns about it.

The Convener: As with most things in life, Hugh, it is a question of balance. I think that we can accommodate all the things that you mention.

Jennifer has reminded me that I have to watch

the time, so I will do so.

I thank my colleagues for their comments, which I will take back to the next conveners meeting, which is, I think, in three weeks' time.

Lothian Health

The Convener: Our final agenda item is the invitation to the committee from Lothian Health to have a meeting with its representatives and talk through some of the issues currently affecting health boards.

To explain the background to this invitation, I am not only the convener of this committee, but the Edinburgh West MSP, and I discuss a range of issues with Lothian Health. We all end up reading the *Edinburgh Evening News*, whether we like it or not, because we hear what Lothian Health is up to no matter what part of Scotland we are from. I pointed out to Lothian Health's representatives that their organisation has been under scrutiny more than any other in health care.

They felt that a wider briefing on how health boards work and what the crucial areas are might be useful for the committee. They said that they would be happy to have a meeting with the committees on those wider issues, given that they are close at hand. How does the committee feel about that?

Margaret Jamieson: I have a particular problem with that. We are representing the whole of Scotland and have civil servants who are quite able to tell us how health boards, local health care co-operatives and trusts operate. If we want to provide an appropriate service to the people of Scotland, we must be independent. We would lose that independence if we took advice from one particular health board, and I do not approve of that.

The Convener: I would see taking advice from one health board in the same way as taking advice from all sorts of organisations. I spent the summer meeting about 30 or 40 health groups. I have listened to all of them. That does not mean that I shut out what others are saying just because I have listened to one.

Margaret Jamieson: It is about perceptions as well.

The Convener: The invitation is there; it is in good faith. I do not think that they are saying that they have first call on resources or anything like that—quite the opposite, given our previous conversation.

Kay Ullrich: I concur with Margaret on this. I do not think that it is appropriate if one health board invites itself along, although I know that it has been done with all the best will in the world. We have all been at briefings from the local health boards in our constituencies, and in other constituencies for those of us who are health spokespersons. It is important to maintain the balance—we are here for all the people of Scotland. Where would it end: Edinburgh this week, Glasgow the next week? We are on a tight schedule anyway.

The Convener: Is that the general feeling of the committee? If that is the general feeling—

Malcolm Chisholm: I have my hand up, Margaret. I agree as far as the time scale is concerned, but this point connects with what we were saying before. Part of our job is to hold health boards to account and to ensure that they are delivering the priorities on health inequalities. We will be examining that issue at some point, and it may be appropriate to meet the board as part of our monitoring of the effectiveness of health boards in implementing the strategic priority on health inequalities. It may be easier to put our response in that context, rather that saying that we will never talk to them again.

The Convener: I am sure that they will take it in the manner in which it is meant.

I will bring the committee's proceedings to a close at this point. I would like, however, to have a word afterwards with party spokespeople on a procedural issue which the clerk has brought up with me. I will also attempt, as will some of the rest of us, to speak to some of the members of the public not only in the gallery behind me but in the one to my right. Could those members of the public who wish to speak to us please make that known to the security guard. As many of us as possible will also try to speak to the representatives of Stracathro hospital who are present.

I thank the members of the public for their attendance and thank committee members for their attendance and contributions.

Meeting closed at 12:24.

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