HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 9 February 2000
(*Morning*)

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

Her Majesty's Stationery Office is independent of and separate from the company now trading as The Stationery Office Ltd, which is responsible for printing and publishing Scottish Parliamentary Corporate Body publications.

CONTENTS

Wednesday 9 February 2000

HEALTH AND COMMUNITY CARE COMMITTEE
4th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

Malcolm Chisholm (Edinburgh North and Leith) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Mr Duncan Hamilton (Highlands and Islands) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
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

THE FOLLOWING MEMBERS ALSO ATTENDED:

Paul Martin (Glasgow Springburn) (Lab)
Fiona McLeod (West of Scotland) (SNP)

COMMITTEE CLERK

Jennifer Smart

ASSISTANT CLERK

Irene Fleming

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 9 February 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:30*]

Research

The Convener (Mrs Margaret Smith): Welcome to this meeting of the Health and Community Care Committee.

The first item on our agenda is a paper about committee resources for research. As members know, this is a thorny issue. We have access to the resources of the Scottish Parliament information centre, but a pot of money is also available for external research. We can attempt to access that if we have a good idea or worthwhile proposal.

At a previous meeting, Duncan Hamilton suggested that there was a lack of clarity about which areas of community care were handled by Westminster and which were handled by the Scottish Parliament—what was reserved and what was devolved. Yesterday, I spoke to Iain Gray, the Deputy Minister for Community Care, who seemed to think that there was less lack of clarity than we thought.

Kay Ullrich (West of Scotland) (SNP): I do not see the problem.

The Convener: I suggest that we write to Iain Gray and get a response from the Executive on what it believes to be its remit and what it believes to be Westminster's remit. Iain suggested that employment law and the benefits system would fall into the latter category.

We should be thinking seriously about ways in which we can access research. I ask members to come up with issues that they want to take forward; we can discuss them at a future meeting. In the meantime, I will write to the Executive to get some clarification on the lines between reserved and devolved areas of community care.

It has been brought to my attention that there is another source of funding—social partnership funding. That is not mentioned in the committee's papers, but it amounts to £50,000. The aim is to involve the general public more in our work as committees—to facilitate social partnerships and civic partnership. That means that we should try to get information from people who would not normally participate in our work, by involving them in innovative ways. The Enterprise and Lifelong Committee intends to make use of this funding and has invited business people to the chamber to discuss some of the work that it has been doing.

I ask members to inform the committee clerk of any ideas for research that they think would be useful and any suggestions that they have for social partnership funding. We might be able to make use of that within our community care review and we might be able to do both things at the same time. Is that agreeable to everybody?

Mary Scanlon (Highlands and Islands) (Con): Would it be possible for the sub-groups to consider that?

The Convener: Yes. The external research might be very useful for those groups.

Petition

The Convener: Item 2 on our agenda is a petition with 3,600 signatures from the Scottish Socialist party. It calls on the Parliament to conduct a referendum in Lothians on the method of funding that should be used to build Edinburgh's new royal infirmary. I suggest that the committee takes note of the petition and that we take no further action. Many of us have already raised concerns about aspects of the private finance initiative, but we are being asked to conduct a referendum on a building that is three-quarters built. Contracts have been signed. PFI remains on the committee's list of issues.

Kay Ullrich: It is a substantial petition with many signatures.

Mary Scanlon: I would like my concern noted about the fact that the petition is to stop the privatisation of the infirmary. That is misleading—the fact that private money is being used to build it does not mean that it becomes a private sector hospital. I appreciate that members might have concerns about PFI if it takes money from patient care.

Dr Richard Simpson (Ochil) (Lab): Mary has said what I was going to say. There is an extremely dangerous trend, particularly in relation to the party that is named on the petition, towards going to a constituency and raising issues that are not yet problems. In my constituency, the Scottish Socialist party has raised issues about Falkirk maternity hospital. It has asked for the hospital not to be closed, when that closure is not on the agenda. If one was presented with a petition that asked that the closure of that hospital be stopped, one might sign it through a lack of information and through a lack of understanding that the petition was not relevant. The use of such terminology as "privatised" and references to staff being kicked out of the NHS do not serve the democratic process.

The petition should be rejected, but not on account of the people who have signed it—their fears about PFI are understandable and Parliament must address them. It should be rejected because the use of misleading information is unacceptable. I do not even agree to the petition being noted. We should send it back to the Public Petitions Committee with those comments and ask the committee to examine it seriously.

Kay Ullrich: I agree with much of what Richard says. One of our priorities is to discuss PFIs, but to say that new hospital in Edinburgh is not an issue—

Dr Simpson: I am not saying that.

Kay Ullrich: You did say—

Dr Simpson: No. I am not saying that.

Kay Ullrich: The hospital has caused great concern. The petition should be noted and I hope that the committee will have a full debate about PFI. There are concerns among the work force and among patients about the system of funding new hospitals.

Mary Scanlon: The petition says:

"We believe the Royal Bank of Scotland should not be providing the city's healthcare—this is the responsibility of the National Health Service."

That will always be the responsibility of the health service—the Royal Bank of Scotland is not coming into health care. The petition is misleading and I am seriously concerned about it.

Dr Simpson: May I correct something? If I gave the impression that the PFI issue generally, and specifically in the case of Edinburgh, is not a matter of concern for, and a matter for debate in, this Parliament and the appropriate committee in this Parliament, I wish to correct that. I am concerned about totally misleading language and a total misrepresentation of facts in documents that are being portrayed as public petitions. That damages the petitions process. I want petitions to be an important part of this Parliament, but they must not be used by people to mislead.

The Convener: We have to respond to the Public Petitions Committee. Would it be acceptable to say that we are concerned about the language used and the misrepresentation of the situation in the petition, that we have decided to take no action and that we will discuss the wider issue in due course?

Ben Wallace (North-East Scotland) (Con): I agree with Richard completely. There must be a stronger signal to say that the petition process must not be hijacked and that we will not look at the petition. The petition is an utter disgrace, and it arises from the cheapest political motivation. If it was motivated by concern for the hospital and the people, it would contain facts and not use hysterical language to frighten people. Petitions are not just about gaining signatures; they are about imparting information to those who sign them. We should send the petition back.

The Convener: I will ensure that the committee's strength of feeling is expressed to the Public Petitions Committee for it to pass on. I also will refer that committee to the *Official Report* so that it can see what members of this committee have said on this issue. Beyond that, I will say that we will take no action on the petition. Is that acceptable?

Members *indicated agreement.*

Stobhill Hospital

The Convener: Item 3 on the agenda is a different style of petition. It is the Stobhill hospital petition, which we addressed at one of our previous meetings. Members will recall that, on 2 February, Dr Richard Simpson was appointed as the committee's reporter to examine this issue. Richard's substantial interim report was circulated to us only this morning, so committee members will not have had a chance to read it. However, I will ask Richard to speak to his report, to which we will return in coming weeks.

Dr Simpson: I thank the committee for giving me this task, which represents what the Parliament is about—addressing the genuine concerns of the public. In this case, we are dealing with an important issue for the community around Stobhill hospital.

I wish to dwell briefly on the process of petitions, which we have just discussed. We have to balance the need for speed, in order not to hold up important projects, with the opportunity for the public to give their opinions to this committee. I am conscious of the fact that, as the committee asked to have the interim report in two weeks, the public had only a short time in which to respond. Nevertheless, despite the fact that the report was announced in the committee only two weeks ago, and in the press five days after that, there has been a substantial response from the public in the form of letters.

I hope that members do not feel that I am hijacking the committee by mentioning this in a public meeting, but I feel that producing an interim report of this sort—which I have done to the best of my ability—is important. Detailed information that dates back over years has gone into this report, and it has not been possible for many of the respondents to check that information. An interim report gives them time to examine and correct the report's contents. I wish, therefore, to issue a caveat. The public, the health boards and all individuals who responded to me and took time to meet me face to face and talk to me over the telephone—amounting to almost 20 hours of contact—should have the opportunity to come back to me before I produce a final report for the committee.

I have not included conclusions or recommendations for the committee's consideration. I imagine that we will deal with that privately after Easter. That is another reason for putting the report into the public domain now; even though we have not drawn conclusions, people can see where we are heading.

At the risk of boring the committee—

The Convener: Never.

Dr Simpson: Thank you.

It is important to outline briefly the history of NHS structures in relation to this issue. Before the early 1980s, boards consisted of 18 or so people, who were often broadly representative of the local community—trade unions and local authorities were represented as well as people who were appointed by the secretary of state. The Administration decided to change substantially the structure of boards to make them more like those of companies—that was how it was expressed in the debate at the time. The idea was that corporate running of the health service should be undertaken by a group of non-executives working with executives from within the system.

09:45

The system of broad representation and accountability was replaced by a company board structure. The consultation process—even the tacit consultation process—has been affected by that. I think that one of my recommendations will be that this committee debate the accountability of boards. That issue arose when we considered the Stracathro petition. We must examine how boards are accountable to the community as well as upwards, through the management executive, to the minister. The upward line of communication is clear and there is heavy responsibility—board chairmen are now held personally responsible.

The second matter that I addressed was the nature of consultation. As I visited the organisations that I have listed, I became aware that people's perception of the process of consultation varied. Part of the problem in this case derived from that. There is no clarity about consultation. As I say in the introduction to my report, the only guidance on consultation that the researchers or I could find was NHS circular No 1975 (GEN) 46, entitled "Closure and change of use of Health Service premises".

There is no requirement, beyond statutory planning procedures, for consultation about new buildings. Therefore, the answer to whether the board and trust boards have consulted is that they have consulted on new building far more widely than the current guidance requires them to. That is the legalistic answer that I will give at the end of my report. Whether that consultation is satisfactory is another question, which will be answered in due course.

This committee will have to debate the elements that make up the process of involving the community, either when it considers this report or later. We have to make the system accountable.

I will give one illustration of the problem. Many

members of the public to whom I spoke or who wrote to me complained that it was stated that the public meetings that were conducted at the end of this process—between July and January—were about informing rather than consulting. However, the perception was that the public had some sort of veto over the process at those meetings. At many of the meetings, which were extremely well attended—there were 400 people at some, which indicates the public's anxiety—votes were taken at the end. Because those votes were substantially against the project, it was felt that the project would not be pursued. We must be clear that, in the heated atmosphere of such meetings, taking votes from those present is not helpful. It indicates the strength of feeling, and to that extent it is part of the consultation, but it is not a democratic vote because not all the public are represented.

Whatever else comes out of this report, we must achieve clarity of process. We also require clarity of understanding of that process and of the purpose of each element within it—the way in which we inform, engage and consult on NHS developments such as closures, changes and new building. We must also be clear about the roles of those participating in the process, of whom there is a long list. They include: the public, whom we all serve; the board non-executives; the board management; medical and non-medical staff, including the unions; the local authorities; the local authority officials, whom I list separately because, as members will see in my report, there are fracture lines between officials and the board managements; community councils; local health councils; voluntary organisations; patient-user groups; and other public services—in this instance the courts, prisons and police, which are mentioned in a number of the respondents' reports to me.

This is an extremely complicated case. It is not simply a matter of a building being built, a unit being closed or a change of use. This is about the whole concept of a hospital serving its district. The committee will be faced with similar problems as the acute services review proceeds. The resolution of that review will be one of the major political issues to confront us over the coming year.

The Stobhill case involves a particularly vulnerable group of patients. Unfortunately, in the public mind a stigma continues to be attached to mental illness. The problem is compounded by the fact that these patients have offended or have the potential to offend, which raises considerable concerns about public safety. As a society, we have learned about the damage that institutionalisation has done to patients with mental illness and learning disabilities. I feel very proud to be part of a system that has decided to support these vulnerable individuals in a much more fitting way, in our communities rather than in major institutions. That is the hallmark of a modern society in the 21st century. However, the siting of units in the community to support and help such patients is fraught with difficulty.

The primary care trust has kindly agreed to supply me, before the final report is written, with some of the history of units that have been placed in the communities of Glasgow over the years. Such units have often generated opposition, out of fear that mentally ill patients would cause people problems or that house values would be affected. I have also asked the trust to undertake the more difficult task of ascertaining whether, when it has succeeded in placing units in the community, the fears that communities expressed at the time were realised. I believe that we will find that they were not realised. The research evidence that I have read in the past and my experience as a psychiatrist indicate that such fears are based on stigma rather than reality. Mentally ill patients are often far better neighbours than people who are regarded as not having mental illness.

In the initial draft strategy—I will not go into the history that led up to that—Greater Glasgow Health Board was responding to the central Government view that mentally ill offenders should be managed in the community. There is a substantial amount of literature on that, which will not be included in my report. It seems that the consultation on the initial draft strategy, which came out in August 1997 and led to the concluding strategy in December 1997, was handled in an exemplary manner by Greater Glasgow Health Board. I have appended a list of those consulted; there was wide consultation and a record was kept of the views expressed by all the consultees, including community councils, individuals and other health boards.

As I have indicated in my report, the conclusion was that everybody agreed that Glasgow and the west of Scotland needed a medium secure unit. At that point we have no problem; everybody is agreed in theory, but where are we to place the unit? I am sure that the primary care trusts were aware—and a number of the respondents indicated this—that, although there was unanimous support for the strategy, there would be substantial problems when it came to a decision on the siting of the unit in a community. That is not saying anything that anyone involved did not believe.

I have not found any clear documented evidence of a discussion about the strategy for managing public fears proactively by informing, engaging and consulting. There has been information, there has been some engagement and there has been consultation, although it has been incomplete. The fact that there has been no published plan of that

strategy—which has never been a requirement on boards—and no indication of a laid-out process of informing, engaging or consulting means that the public have believed that the board has responded to, rather than dealt with proactively, their requests for information and their fears. I cannot stress too much my belief that that is part of the reason why the community is considerably angered by the process that it has witnessed.

I said that the case was complex. It is complex because of the history of the Stobhill hospital and its service to the community. The hospital was run by a separate NHS trust until 1999. There is also a history of distrust in the local community about the long-term strategic goals for the hospital in the service of that community. That has not been helped by the process of rationalisation that the board has undertaken and will have to continue to undertake in relation to its estate and assets in the Glasgow area.

Greater Glasgow Health Board is the main authority, with two trusts initially operating on the same site in the Stobhill area. On the one hand there was the Greater Glasgow Community and Mental Health Services NHS Trust, which is now part of the Greater Glasgow Primary Care NHS Trust, and on the other hand there was the Stobhill NHS Trust, which is now part of the North Glasgow University Hospitals NHS Trust.

I have spelled that out in detail because it indicates the other problem—that the Government has undertaken a substantial change in the structures. That change has run alongside the development of the project. We must recognise that the personnel changes and shifts of the past two years have, at the least, not helped the process and may have made matters considerably more difficult.

There has not been consultation and cross-cutting between the two trusts at every level. There have been discussions at senior management level, but there has not been, until late in the process, effective discussion at doctor-doctor level, at nurse-nurse level or at other levels across the two clinical groups working on that site. As there was communication at the top, there should also have been communication down. I will say in my final report where I think fracture lines have occurred.

10:00

Some organisations said that they had been consulted throughout the process. For example, the Royal College of Nursing, which I was at last able to speak to yesterday, was happy with the process. It believed that members of staff were happy with the option appraisals that were undertaken. However, other organisations such as the medical staff association indicated that they felt excluded from the process of discussing the medium secure unit, but had been engaged in the process of discussing the ambulatory care and diagnostic unit. The process of consultation must be vertical and it must be across the community as well.

I will make three comments in conclusion. First, I reiterate my hope that everybody who has responded to me, and any groups who feel that they have not yet been consulted, will provide comments or corrections. I have stated that I have not yet talked to the local authorities, which are important players in this area. I have had a brief conversation with one councillor, but I need to have further conversations with local authorities and community councils, which are the formal representatives of the public. Given the period of two weeks that the convener indicated, I hope that by Thursday 17 February I will have received any further comments or corrections on the interim report, so that I can make my final report.

Secondly, I am glad to say that the committee made clear at the outset in my remit that the purpose of the report is not to indicate whether the medium secure unit should be placed at Stobhill hospital or anywhere else. That remains the responsibility of Greater Glasgow Health Board, which will have the difficulty of continuing with the process of achieving what has been unanimously agreed—a medium secure unit for the Glasgow area.

Thirdly, I thank all those who responded. People have gone out of their way to make time available to talk to me. Some people came to Edinburgh to talk to me in the evening. Without that co-operation I would not have been able to go into such depth. I apologise for the fact that I only tabled my report this morning. I hope that members appreciate that this has not been an easy process. I received pertinent comments and faxes until yesterday morning, when I handed the report in. We were still correcting some points at lunch time yesterday.

The Convener: I put on record the committee's thanks to Richard Simpson for a substantial piece of work, even though it is only an interim report at this stage. Richard has applied himself to this task tenaciously from the day that he was given it. I repeat his thanks to those who contributed to the report. I hope that the committee will be able to contribute to the debate about Stobhill and, as Richard suggested, will be able to raise concerns and comments that the committee has discussed before, for example, in relation to Stracathro hospital.

Richard highlighted the fact that, before he produces the final report, he must speak to people in local authorities and community councils and

give people who have made contributions the chance to make corrections. I believe that a representative of Greater Glasgow Health Board is going to the Public Petitions Committee next week. That may feature in Richard's final report as well. I suggest that the committee receive the final report in time for its meeting on 23 February.

Do members have any comments to make?

Hugh Henry (Paisley South) (Lab): I echo the convener's thanks to Richard Simpson, who produced his report in a very short time. That was an enormous undertaking. It is clear from what Richard has said this morning that he is a real enthusiast for the health service and takes a strong personal interest in many health-related and medical matters.

Richard's contribution to our meeting this morning and the report that he has prepared will stand the Parliament and the committee system in good stead. They form a good example of what parliamentary committees should be doing and what can be achieved. We should not underestimate Richard's contribution to that process. A welcome aspect of Richard's work, which may be an example to others elsewhere, is that he has not sought to score party political points, but has approached the matter objectively. That will assist us in our deliberations.

A number of matters flow from what Richard said this morning. First, he reinforced the view that the people in the community need an early response from the committee. Paul Martin, who has done much work with that community, also needs an early response. The community and Paul deserve nothing less and I appreciate Richard's efforts in trying to facilitate that.

Broader issues are also emerging. Quite rightly, Richard spoke about the need for a clear decision-making process. At the very least, we must examine the systems, processes and procedures for making decisions in the health service. The committee has touched on that subject in previous meetings. That work will have to form part of our programme for the foreseeable future, because unless we get it right, we will face problems such as the situation at Stobhill time and time again. The Parliament can have an influence on the decision-making process and Richard was right to mention the need for problems in that process to be resolved.

Richard also mentioned the acute services review. The committee cannot end up considering petitions and complaints from every single facility and community in Scotland that is affected by that review but, on behalf of those facilities and communities, we can ensure that the processes that are in place are correct, open and responsive. We should not lose sight of that, and it should be a fairly immediate task for the committee.

Richard also touched on the accountability and structure of health boards, about which the committee has spoken on a number of occasions in relation to Stracathro and other issues. I do not know how we can add health board accountability and structure, which cannot be considered separately, to our work programme, but at some point we, on behalf of the Parliament, should initiate some discussion on those subjects, even if the Executive does not plan to do so. We must consider whether Scotland has the right system for the delivery of health care. If Richard's report does nothing else but help us to focus on our previous discussions on that matter, he, along with Paul Martin and others, will have done the people of Scotland a great service.

I do not know whether Richard plans to consider the consultation process in his final report, but I want to mention it today. Richard spoke about how consultation takes place and suggested that, in the case of Stobhill, the health board may have gone beyond the legal requirement but may not have satisfied the democratic aspirations of those who are recipients of, and live in close proximity to, the services. We must examine the consultation process and consider how it will work for facilities that serve a much wider community than the one that is immediately adjacent to them.

Stobhill is just one example of such a facility. Some people live in its immediate vicinity, but the facility will affect many communities in Glasgow and possibly beyond. This type of consultation process should avoid approaching one community at a time, in a piecemeal way, and should engage the wider community of recipients of services and care. We need to reconsider the way in which we engage with ordinary members of the public, recipients of the health service, trade unions and other beneficiaries throughout a wider area. I am not sure how that might be done. I would be interested in any comment that Richard Simpson might have to make on that.

Paul Martin (Glasgow Springburn) (Lab): I have written to every member of the committee, to compile a comprehensive view of local concerns. I hope that members will take in the points that I raised in my correspondence. I want to put on record my appreciation for Richard Simpson's work so far. He has gone out into local communities and has met representatives of local community groups. I look forward to the completion of his report.

I appreciate that we still have to consider the final report, but we must consider the fact that there was no statutory requirement on Greater Glasgow Health Board to consult the local community on the establishment of a medium secure unit. It is not acceptable to say that there is

no statutory requirement for us to consult on the first medium secure unit in Scotland. There was no statutory requirement for this Parliament to set up the Cubie committee, but there was a requirement to consult local constituents on tuition fees. The same issue is raised in the establishment of the medium secure unit: a caring organisation such as a local health board should engage the public to ensure that their views are considered.

I want to make it clear that the meetings that took place were information meetings, not consultation meetings. That fact is made clear in my correspondence and in the documents that I have produced; it was also made clear to Richard Simpson by local people. The only consultation that was sought by the health board was via the statutory obligation through the planning process.

Richard mentioned the veto at the end of the meetings, when we asked for a vote from the members of the public. It would be unfair to say that the public thought that they were involved in vetoing a decision. What was asked for, at the end of each meeting, was a defined public view. At no point were any members of the public under the impression that they were voting for this particular proposal to be withdrawn or accepted. The vote at the end of each meeting was intended to define the view of the public who had attended that meeting.

The Convener: It is part of the dynamics of a public meeting that, at the end, people want to quantify their view, whether they are for or against, and it is difficult to stand against that view. Having attended a public meeting a couple of weeks ago, at which the vote was something like 497:3, I know that feeling.

Paul Martin: Can I finish, please? It is important to make the point that those meetings were arranged by local members of the public, who also led them. They were not intended for Richard Simpson to include in his final report. Hugh Henry mentioned accountability. The fact that these board members have decided not to go ahead with a public consultation exercise is the result of a lack of accountability. Because they are not accountable and have no electoral mandate, the members of the board have been able to approach this issue in an arrogant manner. This committee must reflect on that for the future.

10:15

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I want to pick up on the accountability issue. What Richard Simpson has said this morning and what I have seen of Paul Martin's correspondence indicates that there are similarities between the situations at Stobhill and Stracathro. That in itself indicates that there is a fundamental problem. There is a drive to open things up and to make people accountable, but health boards and, to a certain extent, health trusts still have the barriers and barricades up. It is incumbent on us to draw the Executive's attention to that, which is why I have raised the matter in questions.

The issue of accountability must be addressed, because we are the people who will bear the brunt of whatever decision is taken by these groups of individuals who are, quite clearly, operating in isolation. In many instances, health boards are making decisions—I am not saying that Greater Glasgow Health Board is any different from the rest—that affect our constituents without even advising us as their elected representatives, never mind consulting us. We must indicate to the Scottish Executive that that is not acceptable. If we want to be open and accountable, that must apply to every organisation. If not, it will be the rock on which we perish.

It is unfortunate that this difficulty has arisen in respect of a medium secure unit, which is required in the west of Scotland. I accept that there is no statutory obligation on the health board to consult, but there is a moral obligation. Hugh Henry is correct when he says that we need to address that quickly.

Dorothy-Grace Elder (Glasgow) (SNP): I thank Richard Simpson, Paul Martin and others. I want to reiterate that these public meetings were called for by the public, Mr Martin and local councillors. Blessedly, there is no party politics involved here. We are all united behind the public.

This case shows once again that we need a statutory requirement to consult early in the day. We are too far down the line to rely on a carrot rather than a stick. Trusts and boards now have the mindset that they will act in the same way as private business, under so-called corporate confidentiality. They have forgotten that the NHS belongs to the people. The best way for us to restore the NHS to the people is to insist on early consultation, so that the people do not have to go to the time and expense of organising their own meetings. Everybody in Glasgow should have been consulted on this proposal.

There is a clash here between alleged national interest and definite local interest. The ambulatory care and diagnostic unit is being downgraded in budgetary terms, while the MSU has a large budget. The board has admitted that it is willing to spend £100,000 per patient per year. I would like to mention the Marie Curie hospice, which I visited last week. It is very close to Stobhill and dependent on Stobhill in many ways. The hospice was pinning its hopes on being able to rebuild its inadequate and, in parts, unsafe building. That indicates how much else locally is dependent on

what happens at Stobhill.

I believe that proper local facilities, particularly mental health facilities of a kind that are non-threatening to the public, are desperately needed in the east end of Glasgow; yet that need is being swept aside in favour of this proposal. I detect the deadly hand of political correctitude, given that the board is willing to pay a large sum of money for a unit. I am afraid that the public has some right to be in fear of the type of patient who might be treated there.

The Convener: I welcome Fiona McLeod to the committee.

Fiona McLeod (West of Scotland) (SNP): Thank you for allowing me to speak, convener. I am a West of Scotland MSP and therefore Stobhill is not in my constituency. However, many of my constituents in Bishopbriggs, Kirkintilloch and elsewhere are patients and neighbours of Stobhill hospital.

I want to reiterate many of Paul Martin's comments and to commend the committee for picking up Richard Simpson's comments on the way in which the health service conducts consultation. It became clear from the public meetings that the public felt that it was not being consulted; rather, the public had to drag the health boards and the trust boards out to say what was going to happen in the community. A great degree of fear and, possibly, hostility was evident in many of the meetings, because of the negative start to the situation. It is commendable that the committee is going to examine that issue.

Dorothy-Grace Elder touched on the way in which new facilities within the health board are funded, which is an issue that I think should be examined. While the medium secure unit will be funded as a national priority, the ACAD is also a national priority. Only two years ago, Sir David Carter called for an ACAD pilot project and, within the past year, Sam Galbraith, as the local MP, supported Stobhill's bid to become the European leader in the field. Therefore, we hope that the ACAD will fulfil a national priority. We are looking at funding for two buildings on one site. One should not get priority funding over the other when both will meet national priorities.

Mary Scanlon: As I represent the Highlands and Islands, I am afraid that I cannot speak about Stobhill with any great knowledge or experience. However, the situation at Stobhill is typical of situations elsewhere. I am delighted that both Richard Simpson and Hugh Henry have picked up the point that what is relevant to this situation is relevant elsewhere.

Hugh mentioned the acute services review. Unless clear guidelines are set down as a matter of urgency, I suspect that the committee will be inundated with petitions about lack of consultation and so on. While it is important to listen to the public, unless such guidelines are in place, petitions will set and hijack our agenda for the next few years.

We agreed to refer the Stracathro petitioners to the human resources strategy, "Towards a New Way of Working". Although I was not familiar with the document at the time, I agreed to that course of action; other members sounded so knowledgeable that I just signed up for it. However, I downloaded the document from the web page and really scrutinised it, but could find only a line or two on consultation. The ethos of the document was that one could not disagree with it. Certainly, there is no clarity on consultation within that document.

I repeat: clear guidelines should be introduced as soon as possible.

The Convener: Basically, within the health service there is no culture of consultation per se, whether with the public or with staff. Much remains to be done on consultation.

Kay Ullrich: I agree with Margaret Jamieson. It is fundamental that the committee accept that there is a crying need for a medium secure unit in the west of Scotland. We should certainly support the establishment of such a unit. I do not want to go down the road of comparing the cost of patient care in one section with the cost of patient care in another. My concern is that sufficient resources are invested to make all patient care effective. I do not think that all patient care is sufficiently resourced at present.

There is movement in the health service towards openness and transparency, but there is a long-standing culture of secrecy. We are aware of that from staff who call us to complain about something but are afraid to give their names. I agree with everyone who has spoken that we must break down that culture of secrecy. The health service belongs to, and should be accountable to, the public.

A question that intrigues me is whether the health board ever explained why it decided to place the unit at Stobhill.

Paul Martin: Stobhill was selected through an option appraisal process. However, members will see from my correspondence that that process has been questioned. Also, I am on record as telling this committee that the so-called independent adviser was involved in a tender. As the adviser had tendered for the ACAD proposal and was asked to comment on that proposal at a later stage, I have questioned his independence.

The option appraisal process and the comments of the independent adviser resulted in the

selection of Stobhill, but the issue that I have raised in correspondence—and hope to raise again when we have the final report—is that the way in which Stobhill was selected was not as open, transparent or accurate as it should have been. Another site might have been selected.

At the previous meeting of this committee that I attended I said that I supported the proposal to build a secure unit in the Greater Glasgow Health Board area. However, I believe that the option appraisal process was flawed and I am concerned that an independent adviser was paid about £750 a day, plus expenses—I have included details in the correspondence—to say that ACAD and the secure unit could be built on the same site.

Dr Simpson: I urge people to read about the matter, which is extremely complex. Paul Martin, the local MSP, made some good points about public perception, and I do not dispute much of what has been said. However, this is by no means the worst consultation process. I rate highly many aspects of what has been done by Greater Glasgow Health Board and the primary care trust—almost as models. The option appraisal process, which was gone through twice, engaged widely with officials from all the local councils, but what happened afterwards? The process also engaged with staff—the Royal College of Nursing and Unison were represented—but there was still staff unhappiness afterwards. The fracture lines are not easy to detect and should not be regarded as entirely the responsibility of the trust and the board. There must be balance, although that will be difficult to achieve.

I will comment on the public meetings, which have been mentioned twice. The second set of public meetings was undoubtedly called by public groups, which set the agenda. After the first option appraisal, there was an attempt to brief both the local MPs, one of whom accepted the invitation. The MP who did not accept the briefing suggested a public meeting instead, which the board agreed to have after consultation. Although the board perhaps did not consult as widely as one might have wanted, it did consult a number of community councils on the issue in meetings that it organised. Therefore, there is evidence that, if the public had not organised those meetings—

Paul Martin *indicated disagreement.*

Dr Simpson: Paul Martin may shake his head, but the historical record shows that the board went through a consultation process on the first option appraisal. The process was suspended after the events of September 1998. Therefore, it is unprovable to say that the board would not have consulted. However, it is a fact that the board did not consult and that the public organised the second set of meetings, which led to the public perception that the board had to be dragged to the meetings. I was not at any of the meetings, but my impression is that, because the meetings were quite heated, people were seen to be reacting arrogantly. The board probably felt under enormous pressure at the meetings.

10:30

However, those are items of detail. My report will eventually show that there was a consultation process of sorts. I doubt that, with hindsight, even the board and the trust would now say that they would have tackled the situation in the way that they did. I hope that their comments on my final report—or even the interim report—will indicate where things did not go right and will help the committee to devise a process to ensure that the situation is not repeated.

Consultation will not be cheap. The process of genuinely informing people about these matters, and of genuinely engaging and consulting them, will be expensive, and will have to be part of any development in the health service. If we believe in this process, we will have to fund it, which is a point that the Scottish Executive will have to take on board. Even the two option appraisal days, which involved 20-odd people and an independent facilitator, must have cost thousands of pounds. Although, as Paul Martin said, the option appraisal process was flawed, it engaged many officials from many communities. If they failed to represent the views of those communities, that is a problem with the system that we must examine.

The fact is that two option appraisals were undertaken on the sites. However, the people on the ACAD and Stobhill side were not engaged in the consultation on the medium secure unit, which caused another fracture line in the case. My final report and recommendations will clearly lay out those fracture lines. I should stress that, with the benefit of hindsight, I will attempt to be critical of the consultation process, because it was not perfect.

The Convener: Thank you very much. I want to bring this item to a conclusion, but we will return to the issue on 23 February, when we will have Dr Simpson's final report. By that time, members of the health board will also have made representations to the Public Petitions Committee, and members of this committee will obviously be able to attend that meeting to hear them.

Paul Martin: I have some factual information—

The Convener: Perhaps you could circulate it to other members. We must move on.

Dr Simpson: If members have any comments on areas that they feel that I have not covered in the report, I would be grateful if they could e-mail me.

The Convener: On 23 February, we will discuss Richard Simpson's report both as part of the agenda item on Stobhill hospital and as part of the committee's future work programme.

Outside Organisations (Contacts)

The Convener: The fourth item on the agenda concerns contacts between the committee and outside organisations.

I know that all members of the committee attend meetings with groups and health service staff from facilities in their constituencies and throughout Scotland. As convener, I meet a number of groups every week. This paper lists some of the approaches that have been made to us by different organisations. I do not want to go through them all line by line, but a variety of people have offered us information, presentations, possible inquiry topics, visits and so on. I would like committee members to look at the paper and offer comments. If the committee agrees, I can come to a future meeting with possible suggestions as to how we take this forward.

I see some merit in taking briefings from some of the organisations that have offered us information. I do not wish to pick anyone out, but the paper lists groups such as the Common Services Agency, which covers a range of issues including the Scottish National Blood Transfusion Service and the Scottish Centre for Infection and Environmental Health. Also listed is the NHS Confederation in Scotland, which wants to talk to us about the issue of clinical governance.

Would it be acceptable to come to a future meeting with a couple of suggested dates for briefing by those organisations? At the same time, we must be aware that some of the issues raised will feature in other reviews and reports that we are putting together. For example, Perth and Kinross Council has asked to speak to us about its invest to save project in relation to the community care inquiry. I have already suggested that we should take oral evidence from the council.

At various points in our work, we will come into contact with some of the organisations listed. I am aware of the pressure on members' time, but it would be useful if we could put together briefings from those organisations. If members have any comments or suggestions, they should e-mail them to the committee clerk, so that we can suggest some dates for briefing. Is that agreed?

Members *indicated agreement.*

Dr Simpson: Could we link some of the items with the letter that we received on the Executive's work programme?

The Convener: Yes.

Forward Work Plan

The Convener: The community care inquiry is our next piece of work. We have sought written views on community care and held an informal briefing session. I found that useful, and I hope that other members did, too. I would like to put on record our thanks to the individuals and organisations who provided us with information.

Because we have always envisaged that our inquiry into community care would take some time to complete, we will try to dovetail it, where possible, with other work. At various points, that might mean drawing up a short interim report to feed into the on-going work that the Executive has made us aware of. We suggest that the committee should meet fortnightly to consider the inquiry, with alternate weeks being used, as and when required, to consider other items of business. That will keep our focus on what we are meant to be doing when we are dealing with community care. It would be asking too much of members if we were jumping about all over the place.

If members look at the proposed agenda and the suggested forward work plan from today, they will notice that there will be a number of evidence sessions for community care throughout March. That is the earliest that we can have the sessions as it will obviously take us some time to organise witnesses' visits.

We have also agreed to have a health board allocations briefing and a finance briefing from the Scottish Executive, which has been arranged for 23 February. On that day, we will also be considering Scottish statutory instruments and hearing Richard Simpson's report on Stobhill hospital. If members agree with that, that gives us two weeks before the next meeting—as things stand, it means that we will not meet next Wednesday.

In addition, a health economics briefing has been offered to us by the University of Glasgow. That would be useful for committee members, particularly as we will scrutinise the budget proposals for health in April and May. As an individual, I am happy to accept assistance on health economics from anybody between now and 26 April, when we will begin to examine the budget proposals for health.

The one question mark over the health economics briefing on 1 March is that the Justice and Home Affairs Committee will be considering part 5 of the Adults with Incapacity (Scotland) Bill on that day. I for one will have to give evidence to the Justice and Home Affairs Committee on that matter, because amendments are lodged in my name. Richard Simpson will also probably have to do so, and other members of the committee might have to do so as well. The health economics briefing might not, therefore, be on 1 March, and we might have to put it back. It is important, however, that all members of the committee are able to attend that meeting of the Justice and Home Affairs Committee if they so wish.

Margaret Jamieson: On the briefing from the University of Glasgow, I am conscious that different organisations have different views on how the health service should be funded. We should home in on the Accounts Commission. Several reports have come out indicating good practice and necessary changes to practice. That should be considered when we examine the budget proposals. I do not think that we should be pinning everything on one group. We need to hear from a mixture of people.

The Convener: The university wondered whether committee members would find it useful to have a briefing on health economics—it was an individual approach to us. As we will examine the budget proposals soon, I think that that would be useful. That is not to say that I disagree with Margaret Jamieson in any way.

I had a meeting with the Accounts Commission last week on its report, "Temporary measures: managing bank and agency nursing staff". It has been coming up with high-quality reports, pointing out areas in the system where we can make changes that would improve patient care and that might save the service money.

I have indicated that I personally want to hear more about the general work of the Accounts Commission. That might be added to a general briefing day.

Dr Simpson: Robert Black, who was head of the Accounts Commission at the time, spoke, I think, to this committee, or perhaps to the Finance Committee.

The Convener: Yes, we did meet him.

Dr Simpson: I suggested that the Accounts Commission, when making reports in future, should indicate the point at which this committee—for health matters—should revisit reports. In other words, we must give the boards and trusts time to implement the changes and to come into line with best practice.

It would be useful to get the Accounts Commission's view on which of its reports are relevant to the current budgeting round. It might just be a matter of the Accounts Commission making a 20-minute presentation to us, so that we do not have to read all the reports again, but read just the ones that we need to read.

I should like to return to the previous agenda item for a second. The acute services review

concerns me. I do not know the timetable for that—there has been some slippage. The original idea was that the boards had to report on the local interpretation of the acute services review by December—I hear that that might have slipped to March. Taking Hugh Henry's point, I should like to ask what consultation is occurring. We could be faced with enormous problems in the summer if people do not feel that they have been adequately consulted about that process before the minister is presented with the responses on the acute services review.

We should at least ask the minister or the management executive of the health service to indicate what their expectations are on the timing of the process and what consultation they expected the boards to undertake, on behalf of the management executive in their locality, in considering the acute services review.

10:45

The Convener: I agree—we can note that and follow up on it.

There are three sections to this agenda item. One is the general proposed agenda for the forward work plan, which is acceptable to everybody. If members have any suggestions or comments about that, please e-mail them to me.

The second section concerns the process for the community care inquiry. We have a list of witnesses; others have been added. Malcolm Chisholm has suggested the Consultation and Advocacy Promotion Service. If members have any other suggestions, they should e-mail them to the clerk and me.

Kay Ullrich: The following is included in the list:

"Scottish Council for Independent Care (perhaps a rep. from a residential care home)".

Do you mean a residential care home or a nursing home?

The Convener: I did not write it, so I am not sure about the thought process behind it.

Kay Ullrich: The list should include somebody from the nursing home side. I would suggest John Downie, from the Federation of Small Businesses, who takes care of that area.

The Convener: I confess that, given the size of the written submissions, I am still finishing them off. Once I reach the end, I intend to go through them again, and to decide on the people from whom we should hear oral submissions. When we were considering the Arbuthnott report and had received about two dozen submissions, it was relatively easy to remember whose written submission had made a notable impact. However, when one has been reading written submissions for weeks, it is less easy to remember that.

I suggest that we take oral submissions from any of the people whose written submissions have raised issues for me—I am sure that other members will feel the same. This is by no means an exhaustive list, which is one of the main reasons why we need to spend time on it. Let us not rush—we should ensure that we do the job properly. If that means that we have to take a bit more evidence, which might take us a few more days, so be it. Let us ensure that we get it right.

Hugh Henry: I make two general points, the first of which concerns the list of witnesses and where we might end up on that. For example, the list includes Perth and Kinross Council. I hesitate to start going down that road, although there might be a particular project there—

The Convener: There is.

Hugh Henry: But I could identify projects within my own council area—

The Convener: Well, it is—

Hugh Henry: Just let me finish the point.

I know of a number of good and innovative projects in the Glasgow City Council area. The same could apply across the country. We need to take care that we do not end up in a bidding war, in which we feel that we have to consider every authority. I counsel caution, because I will be adding to that list, now that I see that it could include individual councils. We should think about where we will end up if we start doing that.

The Convener: Let me clarify that. The list contains a catch-all category of local authorities, and the issue concerns the way in which we tender for experts to assist us. A pilot scheme has been introduced in Perth and Kinross Council, which, if successful, might be a good move for the future. In the written submissions that we have received, other local authorities have interesting things to say. That is why the category of local authorities is there.

Another action that we have agreed, in principle, is to visit certain projects on the ground. The people who work alongside us as expert advisers will have a big part to play in saying to us, "Here's what I would suggest. Here are the areas that I think you should be looking at. Here's an area where this has been tried," and so on. I frankly do not know what is going on, in terms of community care, in every local authority area in Scotland. The category is simply there as a benchmark. I am happy for any member of the committee, or of the Parliament, or anybody, to come forward with suggestions.

Perth and Kinross Council seemed to me, when I read about it, and through comments from other

people, to be in a different situation. It is being funded for a three-year innovative pilot scheme. However, other people in other councils are doing such work, as I know from having read the written submissions. Rather than not mention local authorities at all, I instructed the committee clerk to include local authorities. We should open up the debate and include the other councils at the suggestion of other members or of expert advisers, when we have them on board. That will be a big part of what we do. When we make our visits, I suggest that they should be to several local authorities.

Hugh Henry: I would like to be able to finish the point that I was making, convener.

I counsel caution in that process. Notwithstanding the fact that you have listed COSLA as a potential witness, to represent all Scottish local authorities, I can think of several authorities that are providing innovative care, which have the legitimate aspiration to be heard by the committee. If we start the process in this way, we must be aware of where we will end up, in respect of the demands that are being made on the committee. I am not sure that we could cope with them, as every authority will want to demonstrate to the committee—

The Convener: We have to be selective.

Hugh Henry: That may be, but we have mentioned only one authority. We may have to be selective, but if we start the process in that way, we will become involved in an argument about our selection.

The broader point that I want to make concerns the way in which we cope with what is before us. You have spoken about visiting several projects. I do not think that we should replicate what other committees do, but sometimes we could learn from the useful way in which they use their time. The Enterprise and Lifelong Learning Committee sent out only two representatives to my constituency, to interview several organisations on behalf of the committee. Those representatives then reported back to the committee. I can see groupings—

The Convener: Yes. We decided that we would have roughly three groups, which would visit different parts of the country.

Hugh Henry: We must not only start to list organisations, but start grouping.

The Convener: At the moment, we are in a tendering process for people to assist us. I am concerned that the committee is expected to set remits, work out lists of witnesses, work out the direction of reviews, decide where they are going, and define the groupings for visits before we have on board the people whose expertise we should partly rely on, to ensure that we cover all the ground that we ought to cover.

There are a number of organisations from which we could take oral evidence earlier on in the process. My view is that it would be more useful to the committee and to our report if we undertook the visits after some of the initial oral evidence. The visits should certainly take place after we have had experts assisting us and pointing us towards the areas in which they think it would be useful for us to see what people are doing on the ground.

Hugh Henry: Maybe I am not explaining myself well. That is the very point that I am concerned about. I do not think that it would necessarily be helpful for us to interview an exhaustive list of organisations as a committee and then go out in small groups to visit individual organisations, facilities or projects throughout the country. That is how we should undertake the process from the start.

We are being collectively unrealistic about what we can cope with. From time to time, items such as the work on Stobhill, which Richard Simpson has been asked to undertake on behalf of the committee, will crop up. We are adding unnecessarily to the burden of the committee by considering an exhaustive list. Eventually, we may select from that list to interview witnesses, but I think that, at the start of the process, we should divide up all the projects and decide which we want to visit in small groups before reporting back to the committee. If we invite people in to give evidence before we go to visit them, we will duplicate our work unnecessarily.

The Convener: My vision was not that we would go out to see the same people from whom we had heard oral evidence. The organisations that are listed as sources of potential witnesses include the Royal College of Psychiatrists, the Royal College of Nursing, the Royal College of General Practitioners and the Association of Directors of Social Work. I do not think that we will go out to see them on the ground. I was hoping to see some real nurses and social workers or real people who are having their houses adapted. I hoped that we could see things at a different level from what we normally see. With the best will in the world—they are a great bunch of people and we rely on them heavily—I do not want always to hear from the Royal College of Nursing or the British Medical Association. There are two different sides to the issue.

Ben, you have been trying to get in for some time. I apologise.

Ben Wallace: I have two points. First, I agree that national strategies and initiatives must be viewed by the whole committee, but our groups

could go out to look at local initiatives. There will be a difference between those two levels of inquiry. We must understand the national strategy, because that is where we have gone wrong in the past.

My second point is that I proposed the visit to Perth and Kinross and I think that I should defend that proposal. It is self-selecting. It is, I understand, the only Executive-funded pilot in Scotland that is investigating seamless—or zipped-up—community care. The Perth and Kinross area contains both urban and rural communities, so it is a more representative case study than a Glasgow-based project might be.

I have spoken to some of the civil servants from the health department. They have said that if the Perth and Kinross project works, the Executive could consider basing its policy on that model. That is an important reason for us to look at that project; it would avoid duplication and would help us to understand the Government's thinking. That is why Perth and Kinross is on the list—because it is the only Executive-funded pilot that is considering zipped-up community care and social work.

Dr Simpson: Hugh Henry has a point. The list, which is said not to be exhaustive, is already extremely long. We must go through a logical process. We need to interview the major players, and there may be quite a limited number of them. With the written information, that should enable us to identify the perceived problems.

We should then interview many of the other interested parties. That could be done in groups, because we do not have time to do them all separately. That might give us information about projects that we might want to visit and report back on. There is a logical progression. However, if we do not approach it logically, we will be completely overwhelmed.

I have already had a presentation on the Perth and Kinross project at the primary care trust, which is one of the partners. Ben Wallace was there too and he will confirm that it was an excellent presentation. When we get our adviser on board, one of the things they should be asked to do is sift the projects and tell us which ones the whole committee should consider and which ones a group should consider. That would allow us to form a logical work plan.

Margaret Jamieson: I recall that we had a similar conversation before Christmas. I thought we had agreed to consider three different areas: users of services, providers of services and service planners. The fact that the list is not organised into those categories causes difficulty. We agreed the three main categories and if we were to organise matters in that way it might address the issues raised by Hugh Henry.

11:00

The Convener: We would not see all those people at the same time—the process must have some structure. The list was simply an indication of the people we might want to hear from, to give committee members a chance to comment and suggest additions.

Advisers are crucial to the process. We need assistance to ensure that we do not waste our time and that we ask the right questions and speak to the right people. The committee has agreed to appoint two advisers for this inquiry and a request has been submitted to the Parliamentary Bureau. Once that request has been approved, a request will be submitted to the SPCB, because there will be funding implications. If successful, the procurement department will secure the appointment of advisers. After the meeting, I will discuss names and so on with members. As we are in the middle of the tendering process, we cannot do that in the public meeting. Such problems will persist if committees are so far into an inquiry before they can get expert advisers on board.

Expert advisers can give us good advice about marshalling lists of witnesses and the projects that the committee should visit. It seems as though we have to put the cart before the horse because of the way in which the system operates. We encountered the same problem during the Arbuthnott inquiry. I have raised it as an issue because it is the wrong way to make use of expert advisers. It does not allow us to get the best out of them.

Members have a paper on committee business in the Parliament. Five half days are available for committee business during the remainder of the parliamentary year. One of them is on the day of the Ayr by-election, so we might want to disregard that one. It would be good to initiate a debate in the chamber on community care as part of our work. I have been told that the committee business should relate to reports that committees have already completed. That would mean our reports on Arbuthnott, Stracathro and Stobhill, which will be finished by then. I would like members to consider whether there is any committee business that they would like to be discussed in the Parliament.

Mary Scanlon: In the interests of openness and accountability, we should use Richard's report on Stobhill. What he is saying warrants further public debate. I would like the chamber to unite behind this concern. That would set an excellent example.

Hugh Henry: I am not sure that I would like to have a debate on Stobhill in the chamber, nor do I

think that we should waste our time producing a report that responds to something that the Executive has asked us to do. This committee has touched on some fundamental issues that the Executive will have to consider. I would like Richard's report to lead on to a supplementary report that deals with consultation, accountability and health board structures. The debate could put a marker down for the Executive.

The Convener: I take it that that is what other members were going to say. I see a lot of nodding around the table.

Mr Duncan Hamilton (Highlands and Islands) (SNP): I do not disagree with that but I think that we should put down a marker on Arbuthnott. I presume that the Executive will revisit the matter. We should have a debate on it at that time.

The Convener: I would like to know whether the Executive will have a debate on that. We would have to bid for that committee time—five half days are available for committee debates and there are considerably more than five committees.

Like Hugh and others, I think that we should have a debate on consultation, accountability and health board structures. I value our colleagues' comments on those matters.

Mr Hamilton: I am not saying that that would not be important, but if the Executive does not decide to have a debate on Arbuthnott, we should arrange for one to take place. The issue is too important to ignore.

The Convener: I will seek clarification on the matter.

I have received the Executive's interim response to our report on Arbuthnott but have not yet had a chance to study it in detail. I have asked the committee clerk to contact John Forbes so that he can have a look at its response to our response before we make our response to its response to our response.

Ben Wallace: You said that as if you knew what you meant.

Are there five half days for this committee's debates in the chamber?

The Convener: No. That time is for all committees.

Ben Wallace: If we were able to have another debate in the chamber, the subject of the budget would be a good one. I do not think that there will be time to cover the issues in the half-day debate on the budget.

The Convener: There will be other opportunities to raise relevant issues. For instance, there is a budget debate tomorrow. The Executive and the Opposition have a substantial amount of time to decide business and initiate debates in the chamber, but there are 16 committees and only five half days for committee debate. We should use any time we have in the chamber to deal with matters that are tied in to the work of the committee.

Dorothy-Grace Elder: If we want to consider accountability, we should examine not only the NHS but the social services that are related to community care.

Margaret Jamieson: I do not know why you say that, Dorothy, because the individuals who are delivering social care via social work departments are democratically elected. We are talking about organisations—trusts or health boards—that are not elected. We need to be careful that we are not just dragging people in because we think that they should be here.

Dorothy-Grace Elder: No. I am talking about, for example, heads of departments who are not elected at all, and who, in some instances, have behaved badly toward social workers.

Margaret Jamieson: But they work under the direction of those who are elected.

The Convener: I suggest that we hold this matter in abeyance until we have—[*Interruption.*] I have just been told that we have a deadline. Is it acceptable that we flag up the fact that we would like to take forward the issue of accountability and consultation? I was going to say that we should hold this matter in abeyance because we should wait until we have Richard's full report, and then we could say, "This is a report that we have done, and we are moving forward." However, if we have to tell the Parliamentary Bureau by 15 February, I will indicate to it where we are coming from and inform it of the fact that our stance has grown out of two committee reports on Stobhill and Stracathro.

Hugh Henry: Convener, would it be unwise to include the issue of structures in the supplementary report, or is that a separate matter?

The Convener: I do not know how other people feel, but I do not see how the issue of accountability can be addressed without questioning structures.

Hugh Henry: I am happy with that.

The Convener: Structures would have to come into the report. We would be setting down a request for Parliament to debate an issue, and we both know, Hugh, that once a motion is down, people will take the debate wherever they wish to go, so they will discuss structures before you know it.

Mary Scanlon: Another point keeps coming to my attention. I do not want to muddy the waters, but in a spirit of openness can we include the complaints procedure? I am concerned by the length of time that procedure takes and by its secrecy.

The Convener: That is a reasonable point to include with regard to accountability.

Mary Scanlon: I am talking about the process.

The Convener: The issue of complaints came up previously in a petition from Mr Ooms, if my memory serves me correctly, and we are still awaiting a response from the Executive. We have asked for a response again.

Work Load Priorities

The Convener: We will probably have to keep revisiting this item at future meetings. It will be useful not only for committee members, but for people who, from time to time, want to follow some of the issues that have been raised in the committee. The fourth item in the list of priorities identified by members is the performance, accountability and funding of health boards, so we have flagged up that issue already. The issue of work load priorities is on the agenda and will be on it from time to time to make members aware of comments and to pull together some of the ideas that we have touched on. Is it agreed that we note those work load priorities?

Members *indicated agreement.*

The Convener: I thank committee members for their attendance this morning.

Meeting closed at 11:13.

Members who would like a printed copy of the Official Report to be forwarded to them should give notice at the Document Supply Centre.

Members who would like a copy of the bound volume should also give notice at the Document Supply Centre.

No proofs of the *Official Report* can be supplied. Members who want to suggest corrections for the bound volume should mark them clearly in the daily edition, and send it to the Official Report, Parliamentary Headquarters, George IV Bridge, Edinburgh EH99 1SP. Suggested corrections in any other form cannot be accepted.

The deadline for corrections to this edition is:

Friday 18 February 2000

Members who want reprints of their speeches (within one month of the date of publication) may obtain request forms and further details from the Central Distribution Office, the Document Supply Centre or the Official Report.

PRICES AND SUBSCRIPTION RATES

DAILY EDITIONS

Single copies: £5
Annual subscriptions: £640

BOUND VOLUMES OF DEBATES are issued periodically during the session.

Single copies: £70

Standing orders will be accepted at the Document Supply Centre.

WHAT'S HAPPENING IN THE SCOTTISH PARLIAMENT, compiled by the Scottish Parliament Information Centre, contains details of past and forthcoming business and of the work of committees and gives general information on legislation and other parliamentary activity.

Single copies: £2.50
Special issue price: £5
Annual subscriptions: £82.50

WRITTEN ANSWERS TO PARLIAMENTARY QUESTIONS weekly compilation

Single copies: £2.50
Annual subscriptions: £80

Published in Edinburgh by The Stationery Office Limited and available from:

The Stationery Office Bookshop
71 Lothian Road
Edinburgh EH3 9AZ
0131 228 4181 Fax 0131 622 7017

The Stationery Office Bookshops at:
123 Kingsway, London WC2B 6PQ
Tel 0171 242 6393 Fax 0171 242 6394
68-69 Bull Street, Birmingham B4 6AD
Tel 0121 236 9696 Fax 0121 236 9699
33 Wine Street, Bristol BS1 2BQ
Tel 01179 264306 Fax 01179 294515
9-21 Princess Street, Manchester M60 8AS
Tel 0161 834 7201 Fax 0161 833 0634
16 Arthur Street, Belfast BT1 4GD
Tel 01232 238451 Fax 01232 235401
The Stationery Office Oriel Bookshop,
18-19 High Street, Cardiff CF12BZ
Tel 01222 395548 Fax 01222 384347

The Stationery Office Scottish Parliament Documentation Helpline may be able to assist with additional information on publications of or about the Scottish Parliament, their availability and cost:

Telephone orders and inquiries
0870 606 5566

Fax orders
0870 606 5588

The Scottish Parliament Shop
George IV Bridge
EH99 1SP
Telephone orders 0131 348 5412

sp.info@scottish.parliament.uk

www.scottish.parliament.uk

Accredited Agents
(see Yellow Pages)

and through good booksellers

Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178