HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 20 September 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
21st 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

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 4

Scottish Parliament

Health and Community Care Committee

Wednesday 20 September 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:31*]

Items in Private

The Convener (Mrs Margaret Smith): Good morning. Under agenda item 1, we must decide whether to take items 3, 4 and 5 on the agenda in private.

Item 3 is about legislation, the upcoming care bill. It will be a discussion about the procedural aspects of dealing with our first piece of legislation as the lead committee. Taking it in private would allow members of staff to brief us and tell us how we should proceed. There will not be any discussion of the substance of the bill; it will be a procedural noting by the committee of what we have to do from now on. There will be some preparation work for committee members in advance of the legislative process.

Item 4 on the community care inquiry is to hear initial feedback and thoughts from committee members about the visits that we have undertaken. Taking that in private would allow the experts who have been advising us on the inquiry to discuss what they have read of our visits and address the way forward for the inquiry.

Item 5 on committee procedures is to allow committee members to have a go at the convener, or do whatever they want to do, in privacy. We can consider how we have dealt with the first year's work and how we can improve procedures for the coming year.

The reason for asking the committee to take agenda items 3, 4 and 5 in private is that those are mainly procedural discussions and taking them in private will allow members of staff and experts to take part in the discussion. If the discussions were in public, they would have to be limited to members. It would be beneficial, from the point of view of the smooth running of the committee in the coming weeks and months, to hear the input of all those people.

Are there any comments?

Dr Richard Simpson (Ochil) (Lab): I understand that, on item 4, members will want to have interaction with the advisers on what they have seen. However, on item 3, I wonder whether we are precluded from having the staff talk in public. If so, that is fair enough, but otherwise it seems to me that the public should be aware of why we take bills in the way that we take them. This is going to be our first bill. If possible, we should have an open discussion with our support team as to how this committee intends to proceed, so that the public can see how it intends to do so.

The Convener: The members of staff are allowed to talk in public. It is not common practice, but we can do it. It is for the committee to decide. I have told the committee why it was suggested that taking the item in private was the way to proceed. There is nothing to stop us from taking the item in public, but it has not been common practice.

Dr Simpson: Provided that our team is comfortable with that.

Mary Scanlon (Highlands and Islands) (Con): I support items 4 and 5 being taken in private. My thoughts on item 3 are along the same lines as Richard Simpson's. Given that this is our first bill, the public should know the whys and wherefores. They should be part of the process. This is all about openness and accessibility. The advice that Jennifer Smart gives to us on the procedures for scrutiny of legislation should be public.

The Convener: Is the general feeling that we take item 3 in public and items 4 and 5 in private?

Members *indicated agreement.*

Petitions

The Convener: Committee members will remember that we agreed to introduce a new system for the consideration of petitions, because we were probably getting more petitions than almost any other committee in the Parliament.

A range of petitions has been circulated to members for comment. You should also have background papers on all the petitions. Some of the petitions have attracted comments from members. The current position is outlined in the papers. The papers also allude to continuing progress on petitions that we have discussed previously. The recommendation is that, when no comments have been received on the petitions in annexe A, we note those and say that we will take no further action at this stage. We may return to some of them in the future.

Your views are sought on the petitions that we have received, especially those that have received comment, as to what the committee wants to do with them. We will note the current position regarding petitions that are in annexe B and what we decide to do with them. If there are no comments on that, we will move on to annexe A and work our way through the petitions.

The first petition that has received any comments is petition PE192 from Mr Alex Doherty, which calls for the Scottish Parliament to order the Mental Welfare Commission for Scotland to regard all their records as health records and to comply with the Access to Health Records Act 1990 by allowing access to those whom the act defines as being eligible for access.

The comments received are that we should consider this further and write to the Mental Welfare Commission. Does the committee want to write to the Mental Welfare Commission to ask for clarification?

Mary Scanlon: That seems reasonable.

Dr Simpson: We should ask the Mental Welfare Commission for clarification and for its observations. It may be that the present legal restrictions mean that its records should not be disclosed; those may not currently fall within the act. One would like the commission's comments as to whether it feels that that is appropriate and should continue.

The Convener: Is that agreeable to the committee?

Members *indicated agreement.*

The Convener: The next petition is PE203 from the Friends of the Victoria infirmary. One committee member has suggested that we seek further information on this. My view is that our long-standing approach has been that we do not take petitions that are very much local. Those matters should be in the hands of local trusts, health boards and local people as part of decent consultation exercises. The minister would get involved in that only in extreme circumstances. That is the line that has been taken, and I suggest that we take the same line with PE203 and that we write to the petitioners to inform them of our position.

Members *indicated agreement.*

The Convener: The next petition is PE214, which calls for the Scottish Parliament to investigate the current recruitment crisis in the cardiac transplant unit at Glasgow royal infirmary and to establish what action will be taken to re-establish the cardiac transplant service as soon as possible. We could consider this as a local issue; or we could consider that the transplant service is a national service, which would mean that it was within our remit to find out more about the issue or to note an interest.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): The petition is factually incorrect: it talks about re-establishing the cardiac transplant service, but that service has never stopped. We should perhaps ask the department what the present situation is, and then discuss the matter further.

Mary Scanlon: I support that. Although it is a local issue, the unit is Scotland's only heart transplant unit. I heard on the radio last night that there was a three-year waiting list for the unit in Newcastle. We all empathise with the recruitment problems that faced the cardiac unit earlier in the year. An update would be helpful.

Ben Wallace (North-East Scotland) (Con): If we were to do some form of inquiry, we would have to ask whether Scotland warrants an independent cardiac transplant service. It is all very well saying that we must have one, but the critical mass may not be there. Some small countries in Europe are very wealthy, but for us to make it an issue that we should have such a unit just for the sake of having one would not be right.

The Convener: We will write to the Executive for clarification of the present situation of the service. We will also ask for its views on the clinical argument that Ben Wallace has just hinted at.

Dr Simpson: The unit demonstrated that it did not have sufficient people in its previous team for it to be sustainable. However, it may be sustainable if heart and heart-and-lung transplants are transferred to a new unit in Glasgow. We should make that point clear to the Executive.

The Convener: We will ask the Executive to give us an idea of the options that it is considering in order to make the unit sustainable in future.

We come now to a range of petitions, seven in all, calling for the Scottish Parliament to investigate the justification for introducing car parking charges at various hospitals. Committee members have suggested several possible courses of action. Members should also have received a copy of a letter from the Executive. You will see that it is dated 3 February—it was written in response to petitions that came in earlier to the Public Petitions Committee. The letter was also circulated to the chairmen of the health boards.

The Executive line has been to frown on car parking charges when those charges are purely an income generator, but to look at the matter in a different light when hospitals have identified parking problems and are using charges as a means of tackling those problems.

Margaret Jamieson: We should take no action in the light of the minister's letter. This is a local issue, and it is for each trust and health board to reach its own conclusions.

Ben Wallace: If the seven petitions are aimed at individual health boards, there would be nothing wrong in writing to those boards to seek an assurance that the charges are not an income generator. If the hospitals are charging just for upkeep, that is in line with the guidelines issued by the minister.

Dr Simpson: In a sense, that is a matter for the petitioners to take up with their individual health boards. This is becoming a quite vexatious issue, especially for temporary staff coming into the hospital from the community, who are being charged, as well as for staff who have to stay overnight, who are also charged. There are some difficult issues, and I do not think that we should get involved in the matter.

Would it be appropriate for us to write to the Accounts Commission asking whether it would consider the question of car parking and its variation throughout the country? That would not be a major undertaking for the commission. I have serious concerns about the problems faced by community staff, which were demonstrated in the debate on Livingston, where they were having considerable difficulty in getting in and the car parking arrangements for them were not satisfactory.

Mary Scanlon: I would be concerned only if the car parking charges continued to increase and were used for something other than the upkeep of the car parks. We must all be big enough to recognise that it is difficult to park anywhere near a hospital. Even at Ninewells hospital, which has extended its car parking, it is difficult to park and that is a real problem. As long as the money is used to maintain the car park, and to keep it safe, light and trouble free, I have no problem. If the charges were increased to fund health care, I would be concerned, but I am not aware that that is the case at the moment.

Irene Oldfather (Cunninghame South) (Lab): I am opposed to charging in hospital car parks, but I support the principle of subsidiarity—that decisions are made at the most appropriate level. Although I feel that charging disadvantages low-income families who are already disadvantaged through poor health and deprivation—that is a double whammy—the decision to charge must be made by the local health board and trust, and we should not interfere with that.

09:45

The Convener: I echo what Irene Oldfather says. I am opposed to charging in principle; however, it is regarded as a way of dealing with the parking issues at local hospitals. Those decisions are made locally, and the people on the ground should be best placed to make them.

I wonder whether there would be any benefit in writing again to the minister about this matter, asking whether there have been any developments since this letter was written in February. The letter states the official position, but it would be interesting to know whether the Executive has found any health boards or trusts that have not been addressing the matter, and whether any action has been taken to correct that. That might address some of the issues that Richard Simpson has raised, and we would then be able to advise people that the Executive has at least been keeping a watching brief on the situation. We would have an updated position to give them, rather than the position that existed in February. Would that be an agreeable action to take?

Members *indicated agreement.*

The Convener: The next petition is petition PE217, from Glenorchy and Innishail community council, calling on the Scottish Parliament to take account of the work load and general circumstances of a single general practitioner in the parish of Glenorchy and Innishail and to appoint an additional part-time partner.

My earlier comments on local issues stand in relation to this petition. I was present at the meeting of the Public Petitions Committee at which these people petitioned. I said that I was happy for the petition to be passed to this committee so that we could either note it or comment on the fact that we are aware of the difficulties that single-handed general practices face. That is not to say that I presumed that we

would have an inquiry as a result of the petition, but it is worth noting that rural communities in Scotland face those difficulties. I ask committee members for comments on the petition.

Mary Scanlon: Duncan Hamilton has come in at the appropriate time.

I read through some of the documentation last night and I am concerned about the Scottish Medical Practices Committee's criteria for calculating eligibility for additional part-time partners. I will not go through them, but they include the distance to the nearest hospital and the accident and emergency role of general practitioners. That part of the west of Scotland receives enormous coach parties and the work load of GPs increases greatly during the summer.

I go along with the point that the convener and Pauline McNeill made at the end of the Public Petitions Committee's meeting. I propose that we write to the SMPC to ask whether it will re-examine the criteria used for part-time partners in remote and rural areas.

Dr Simpson: Rurality is not the only question, although the petition refers mainly to that. I am not absolutely sure, but I think that the SMPC does not take deprivation into account. The committee should be aware that the English plan proposes abolishing the English equivalent, which will be taken over by a new body. I suggest that broader issues are involved. The particularity of the local practice is one thing, but there are broader issues to consider, as I think the convener said at the meeting of the Public Petitions Committee.

The committee could use the petition as what I think Duncan Hamilton called an indicative case. I strongly recommend that it is appropriate for the committee to ask the Minister for Health and Community Care what her intentions are for the future of the SMPC and/or to appoint a reporter to examine the functioning of the SMPC in respect of medical appointments, particularly with regard to deprivation and rurality.

Irene Oldfather: I understand what Richard Simpson is saying about the broader issues, but the petition is from only one community council. The committee has discussed the principle of extracting broader issues from individual petitions before, and I think that, last time, we decided not to do that. We should be clear that we could be setting a precedent. I think that we need to consider the specifics of the petition.

The Convener: Can I ask for clarification that the petitioners did not lodge a further petition on the general issue?

Mr Duncan Hamilton (Highlands and Islands) (SNP): That is right.

Margaret Jamieson: I echo what Irene Oldfather said. We receive petitions that are specific to local areas. If we are to be consistent, we must continue to follow our earlier decision. I take account of what Richard Simpson said, but that is something for another day. It is fine if an organisation wants the broader issues to be addressed—we would do that—but the petition refers to one practice, and we would be taking a dangerous road if we discussed more than that.

Ben Wallace: I am always careful of the word precedent. The luxury of the committee—if it is a luxury—is that we can examine issues case by case. We do not have to set precedents or avoid precedents. We should be flexible enough to consider issues on their merits. The petition is indicative of a continuing issue. In the light of Arbuthnott and its impact on some budgets and general medical services in rural areas, it is a good time to use the petition as an example. In my view, there is no such thing as a precedent. If a lousy example comes up next week, we do not have to proceed with it. That is the point of the committee.

Mr Hamilton: My first point relates to the nature of this petition and follows on from what Ben Wallace and Richard Simpson have said. The evidence that was taken by the Public Petitions Committee indicated that this is a national problem. I draw the committee's attention to the statement that I made at that meeting. I said:

"In view of the previous discussion, I want to emphasise that we have been down all other possible avenues. This is a national problem—a national formula."—[*Official Report*, *Public Petitions Committee*, 20 June 2000; c 501.]

The petition relates to a specific local situation, and that should not surprise us, as it comes from a local community. If we say that we can deal only with national petitions, we are saying to local communities that they do not have a wider picture of what is happening throughout Scotland and that we are not prepared to proceed on the basis of what is happening in their area. The committee must show discretion and be able to say that if the petition relates to a national problem, we will deal with it.

Richard Simpson made the crucial point that this is about rural communities. More important, it is about the national formula. If we consider that other parts of the formula are deficient, it would be spot on for us to use the petition as a way into examining the formula.

My final point relates to the action that we should take. The letter from Steve Farrell, the clerk to the Public Petitions Committee, indicates that the SMPC has already been asked to give a response. My papers do not include that response, which suggests to me that there has not been one. That may be an issue in itself. However, Mary Scanlon is right to say that we need to get a

response. If we were to appoint a reporter to investigate this problem on the basis of the formula, which touches on a number of other issues, that would be a timeous and important step.

Mary Scanlon: If we deny local communities the right to highlight national issues, we will be setting a dangerous precedent. As Duncan Hamilton said, the petitioners have been all round the houses. As you noted, convener, they did not come to us as their first port of call. They had an exhaustive trawl of the health board and others before coming to the Parliament. They did everything right. Nobody has a monopoly on identifying problems. Surely this Parliament has a responsibility to respond to people who identify national issues that they cannot deal with. It would be very dangerous for the Scottish Parliament to say that no local community has the right to identify a problem that is experienced locally but can only be dealt with nationally.

Irene Oldfather: The penultimate paragraph of the members briefing for petition PE217 states:

"It is clearly not the role of the Parliament to become involved in matters that are the responsibility of the SMPC. The petitioners are not suggesting a change to this Formula but clearly want a review of their individual case."

The Convener: That is the briefing note that was issued to members of the Public Petitions Committee. It does not reflect what the petitioners said at the committee's meeting. That may be how the Public Petitions Committee staff interpreted the petition as lodged, but after the petitioners had spoken about how they had tried other avenues, it became clear that they would not be the only people to find themselves in this position.

This problem is not confined to the parish of Glenorchy and Innishail. It is a problem that people across Scotland are likely to face if they have a single-handed general practice. That is what emerged from the discussion that took place in the Public Petitions Committee. I am not saying that the comment in the briefing is wrong, but it was made before the petitioners had an opportunity to put their case to the Public Petitions Committee.

Dr Simpson: I am sure that if we do not take action on PE217, the British Medical Association or the general practitioners committee will organise another dozen petitions. I know of two applications from practices in my area—one rural and one urban—that have been rejected because the formula that was used to assess them was devised without taking into account rurality or deprivation. The formula was determined in the days when general practice was competitive, yet all the other GPs in that area thought that one of those practices, which was operating in one of the most deprived areas in Stirling, had been badly treated by the formula.

10:00

This is a national issue and there is unfairness in the provision of health services. If Arbuthnott is to be effective, it must be implemented. If we are to implement it, we cannot apply the formulae in the way in which they appear to be being applied at the moment. That is why we need a reporter to investigate the matter.

Margaret Jamieson: We must consider the wording of the petition, which asks the Scottish Parliament to appoint an additional part-time partner. We are not the employer, so we do not have that right. The petition goes on to suggest that the formula could be amended. The petitioners are asking us to deal with two different issues.

Richard Simpson mentioned Arbuthnott. A decision has not yet been taken on whether Arbuthnott will be implemented. We must wait to find out what direction the department takes on that, because that could impact on how we deal with the petition.

The Convener: I will make a final comment before asking the committee for a decision.

Margaret Jamieson raised a question about the wording of the petition. That is a general issue that has been addressed by the Public Petitions Committee and its staff; petitioners are now given guidelines that give them a clearer idea of what is within the abilities of the Parliament and the Public Petitions Committee. The Public Petitions Committee learned many lessons over the first year of the Parliament and, over time, petitioners have begun to realise that they need to be more specific in what they ask the Parliament to do.

During the past year, we have discussed petitions by massaging the nub of the problem out of what had been written in the petition. Much work has been done to help people who wish to petition the Parliament to make their point clearly. People have not had those guidelines before.

As a committee, we need guidelines on how to deal with petitions. We have established a clear point about identifying local issues and the fact that they should be dealt with locally. However, on Stracathro and Stobhill, we took the view that, sometimes, local issues are indicative of a national problem. We would be lacking if we suggested that national problems happen only at a national level—they are national problems because they happen all over the place. National problems touch people's lives every day and it is our job to address such problems.

I suggest that we appoint a reporter, who could liaise with the Executive on Arbuthnott and find out

where single-handed general practices fit in with the policy of addressing the problems relating to rurality and deprivation. The majority of the committee seems to be in favour of appointing a reporter to examine the issue. The reporter could question the Executive about its view on the future of the SMPC, find out whether the Public Petitions Committee has received a response to its initial letter and attempt to link the petition to Arbuthnott and the commitment to tackle deprivation and health inequalities. A reporter would be ideally placed to pull those issues together and we could come back to the matter when we have a bit more information to hand about an issue that has been identified by one community council but that affects communities across Scotland.

I would prefer the committee to agree without going to a vote. Do we agree to appoint a reporter with that remit?

Members *indicated agreement.*

The Convener: Anyone who wants to volunteer can e-mail the clerks.

Are we agreed to note the other petitions and take no further action?

Members *indicated agreement.*

The Convener: I refer the committee to annexe B of the list of petitions. Are there any comments?

Dr Simpson: I want to deal with PE45.

The Convener: PE45 is from the west of Scotland group of the Haemophilia Society and deals with haemophilia and hepatitis C. The committee entered into correspondence with the Executive on the petition and the Executive indicated, in a letter dated 13 June, that it would publish its report prior to the recess. We know that it did not do that and that the report is still not available. The committee sent out reminders in June, August and September but we are still waiting for the report and we still do not have an answer from the Executive.

Mary Scanlon: Has an indication been given for the reason for the delay?

The Convener: We have had no response to our reminders.

Ben Wallace: Has the Executive confirmed that there is a completed report?

The Convener: No.

Ben Wallace: During the recess, I heard an announcement to the effect that people in Scotland with hepatitis C will be treated differently from those in England, who will get legal aid for their cases. The way that the Scottish sufferers have been treated is quite shameless.

Dr Simpson: I do not think that that has been decided on yet. We should receive the report now. We should make a further formal statement to the minister saying that we expect the report now. If there is a reason for its delay, we should receive an explanation now. The situation has gone on for long enough—we were promised the report in July, then in the recess and now we are well into the new parliamentary term. The committee is being treated with some disrespect.

Ben Wallace: Can we call in the Deputy Minister for Community Care?

Dr Simpson: That is what I was going to suggest. If we get neither the report, nor a satisfactory explanation of why the report has been delayed, we should schedule a request for one of the ministers to appear before us before the October recess. I know that that would impact on our calendar.

Margaret Jamieson: On petition PE185, which relates to people with hepatitis C, it is unacceptable that compensation will not be considered for those who contracted hepatitis C through blood transfusion unless they also suffer from haemophilia. That is absolutely appalling.

The Convener: We wrote for clarification on that point in July. We have not received a reply.

Margaret Jamieson: We need to pursue those issues.

The Convener: It is clear from colleagues' comments that they share my deep concern at the manner in which the Executive has dealt with our requests for information. Richard Simpson said that we had been treated with disrespect. I consider the treatment to be disrespectful, not only to the committee but to the people in Scotland who suffer from hepatitis C and those who have been involved in the issue regarding blood supplies. To treat them and us in this manner is totally unacceptable.

For the record, the previous letter that we sent to the Executive was extremely strongly worded at my request—we did not simply note that we still had not received the information. There is no doubt that we require the information. If the committee agrees, we will write in the terms that Richard Simpson outlined and say that either we receive the information or we will call one of the ministers in front of us to discuss the matter in due course.

Members *indicated agreement.*

Mary Scanlon: I am not sure about "in due course."

The Convener: I mean prior to the recess. I think that we have a space. We will write to the Executive in those terms.

Petition PE123 concerns fuel poverty. We

appointed Malcolm Chisholm as our reporter, and he is preparing his report. He said that he would like to find a slot prior to the recess to consider the matter and we will try to facilitate that. We would all welcome the announcement that was made in the past few days on warm homes initiatives for pensioners in Scotland. That has been welcomed warmly across the political spectrum.

Petition PE145 is on measles, mumps and rubella vaccines and autism. If members have read the newspapers—sometimes I try not to, but I cannot help myself—they will be aware that over the past weeks and months there have been a number of reports and some developments on this subject. The Scottish Parliament information centre has prepared a research note, which members should have received by e-mail yesterday. I am afraid that I have not received mine, so I am not sure whether the system has worked for everybody else.

Those developments are on-going and there is public concern. The committee does not wish to be part of anything that causes concern, if that concern is unjustified, but there seems to be anecdotal evidence on, and scientific discussion about, the safety of the MMR vaccine. We ought to look at that. I invite members' comments on how we should proceed.

Mr Hamilton: Our papers say that the Executive was given until 15 September to answer the points that were raised by the committee. Am I right in saying that there has been no response?

The Convener: There has been no response.

Mr Hamilton: I see a pattern developing.

The Convener: Yes. I wonder why and how—given the differences in resourcing between the Parliament's committee system and the Executive—we manage to get through our work and give prior copies of reports to the Executive, but such courtesy and respect is not forthcoming in the opposite direction. Given the David-and-Goliath situation that exists in resourcing, that is unfortunate to say the least.

10:15

Dr Simpson: Members may have noticed that I have been engaged in correspondence on this matter over the summer. Two new papers, by Dr Singh and Dr Wakefield, were presented at one of the two recent conferences on autism. One of the conferences still does not think that there is a link with the MMR vaccine; the other one does. We must continue to be cautious, and the convener's careful comments should be commended.

Even with our resources, I do not think that we can evaluate the two papers, which have not yet been published. They are abstracts, and the level of proof that is required for an abstract is considerably lower than that required for a peer-reviewed publication, which is what I have kept harping on about. We should ask for the Medical Research Council to review the abstracts to see whether there is any stronger evidence that might lead to a proper survey or study.

Dr Wakefield, one of the proponents of the existence of a link, believes strongly that there is also a link between the MMR vaccine and Crohn's disease. Again, that link has not been proven, but Dr Wakefield claims new evidence, which needs to be examined. The committee should go on record as saying, as it did originally, that it will continue to examine the evolving story, but that it has not as yet received sufficient evidence to propose any changes to the minister.

Mr Hamilton: How does Richard Simpson's recommendation—for the MRC to look at the abstracts and determine whether further research is required—relate to what the MRC says it has done? The SPICe research note on the matter says:

"On 3 April 2000, the MRC announced that it would 'fund one of the largest studies of autism ever attempted.'"

Dr Simpson: I do not know the terms of the study on autism or whether it would encompass the question of a link to the MMR vaccine. As I understand it, the study did not aim specifically to prove or disprove a link with MMR, but was based on the fact that there had been a rise in autism over the past decade and that that rise was coincidental with the introduction of MMR, but was not causally linked to it. That is an important distinction. The MRC has been invited to examine the possible causes of a rise in autism; I have gone on record, both in Parliament and in the press, as commending that. Those causes should be investigated, but we should remain very cautious about determining a causal link.

Mary Scanlon: Committee members are having difficulties with this, and we must empathise with the parents who see both the scaremongering and the relevant, empirical research evidence. The subject is difficult for us, but for parents it is horrendously difficult to decide whether their children should have the vaccine. We must try to find answers fairly soon. No sooner is one report published to say that there is no possible causal link but another report is published that contradicts that finding. Somehow, the Parliament must seek reasonable guidance.

I am concerned that uptake of the MMR vaccination is lower than 90 per cent in five Scottish health board areas. I believe that 90 per cent is the crucial level that is required to avoid an epidemic. Serious problems are building up for us.

I realise that we are due to meet the Health

Technology Board for Scotland, but while we are struggling over correct and sound evidence, I am disappointed that we cannot get some steer or advice from the new board. Annexe B of our advice note says:

"The Health Technology Board of Scotland has indicated that this is not a matter that would fall under its remit."

I appreciate that we are not dealing with a new medicine, but surely someone among all the new organisations in Scotland can give us a steer on the matter.

The Convener: The Health Technology Board for Scotland suggested that we contact the Committee on Safety of Medicines. We wrote to that committee during the summer recess.

Mary Scanlon's point is well made, and in the vacuum of contradiction, people will make up their own minds about their children's safety. If people believe that there is any possibility of a risk, they will err on the side of what they consider to be safety for their children when making decisions. That brings with it the difficulties that Mary Scanlon outlined, such as vaccination rates falling to lower than 90 per cent, which might lead to epidemics. We are not at a standstill, because the parents of Scotland will decide and we will have to act on that. We are dealing with something highly technical. None of us is up to the task of deciding whether the MMR vaccine should be used or recalled.

The one thing on which we all agree is that there is public concern, and concern in the committee, about the issue. I look to members for what they consider to be the best course of action for the committee. Richard Simpson has suggested that we write to the MRC to ask it to consider the two new papers and whether further testing of the theories behind those papers should be carried out.

The committee should be aware that the situation is developing and that it may take time before we get a scientific answer. As a result, we may have to deal with the consequences of parents making their own decisions on gut instinct.

Dr Simpson: A number of different groups are involved. We have written to the Committee on Safety of Medicines. The Joint Committee on Vaccination and Immunisation is also involved.

In Ireland, where doubts about the vaccine have been raised quite forcefully over the past couple of years, the immunisation rate has dropped and deaths from measles are occurring again. Like many medical decisions, such decisions are not free from risk on either side. Measles can cause death, mumps can cause infertility and rubella can cause profound disability in growing foetuses. That is the reality that the MMR vaccine was designed to prevent. The reduction in the number of cases of problems and complications from measles, mumps and rubella has been significant, ranging from 50 per cent to 90 per cent. Fewer people suffer from encephalitis and serious brain problems as a result of the highly effective immunisation programme.

As the convener has tried repeatedly to do from the chair, we must send a very cautious message. The parents of Scotland have a right to have us consider the matter seriously. We should do that and keep on considering whatever evidence is produced. The headlines in the press are unhelpful to say the least. They scare people and are not balanced by the opposite, which is that measles can cause death.

The Convener: That balance is missing partly because of what is unknown. I ask members whether it would be worth while appointing a reporter. The reporter's job would be to keep a watching brief on the matter, to report back and to work alongside the SPICe researcher who has done the paper for us. We ought to consider the subject again after the October recess. By that time, we might have further information and a clear steer about what we ought to do. I would appreciate committee members' thoughts on that.

Mr Hamilton: To pick up on my previous point about writing to the MRC, can we ask it to outline the specific research that is being done at the moment, before we consider additional research?

We should be careful about defining the committee's job and expertise, and about how we proceed. The committee's role is to try to give some momentum to the research and to try to relay the sense of urgency that has been relayed to us. It would be wrong for the committee to think that it can do more than other agencies.

I am happy to appoint a reporter who would have the specific and exclusive responsibility of monitoring the progress of the research; but I would be slightly nervous about our reporter taking a more active role.

Mary Scanlon: I would go along with that. Richard Simpson would appear to be an appropriate choice, as he takes an interest in such matters and is likely to read most of what comes his way.

The Convener: And understand it.

Mary Scanlon: Yes—he did a wonderful report on Stobhill hospital.

Would it also be appropriate for us to ask for advice and judgment from our new chief medical officer?

The Convener: I was going to make that point. If we decide to have a reporter on the subject

continuously, the views of the new chief medical officer ought to be sought at an early stage.

I think that we should have a reporter, on the terms that Duncan Hamilton outlined. Politicians do not know everything—we in this room understand that more than most. On the MMR vaccine, we must put up our hands and admit that we do not have the expertise or knowledge. However, we have real concern about the situation and about the fact that it may lead to problems with immunisation rates in Scotland. Our reporter's job will be to monitor the situation and—as Duncan Hamilton said—to add momentum to the research, which must be done timeously. We must protect our children from MMR, but we must also put parents' minds at rest over the fear of autism.

Members *indicated agreement.*

The Convener: Do we have a volunteer to be our reporter on MMR? Will anyone fight Richard Simpson for that role?

Dr Simpson: I am deeply involved in something that we will discuss in private session—organ donation—so I would prefer it if someone else were prepared to take on the MMR reporter role.

The Convener: If any other member is interested, they should e-mail the clerks. I am sure that Richard Simpson would be available to assist if anyone needed information on any medical points.

Dr Simpson: I would be happy to assist.

The Convener: I am sure that the SPICe researcher would also be available to assist in building up lists of who we should contact and how we should go about the monitoring. I appreciate that reporting on the subject will be a fairly daunting task for anyone who is not medically trained, but he or she will not be alone.

Legislation

10:30

The Convener: We move to agenda item 3, the intention of which is to give us an idea of the procedures that we ought to follow when we scrutinise the legislation on the regulation of the care and social services work force.

Committee members had a taster of what is involved in the scrutiny of legislation through the work that we did on the Adults with Incapacity (Scotland) Act 2000. However, that work involved only taking evidence at stage 1 and stage 2; we did not deal with amendments or with the minister coming along and putting across a different point of view.

In the paper that has been presented to members, the clerks have outlined exactly what is involved and emphasised to members the importance of the bill, which has been broadly welcomed across the chamber. The bill will have a big impact, not only on nursing and residential homes but on children's homes.

Three or four parliamentary committees are likely to be interested in having a say on the bill. I have instructed our clerk that, from day one of the procedure, our approach is to be inclusive, in terms of our relationship—the committee's and my own—with the other conveners and committees that will have an opinion on the bill. I think that the Local Government Committee, the Education, Culture and Sport Committee, the Equal Opportunities Committee and others will want some input, whether by taking evidence or by lodging amendments following discussion in committee meetings.

All our information, such as informal briefings, research notes and other work on the bill, will be made available to the conveners, if not to the members, of other committees that are interested. All members of the Health and Community Care Committee remember how frustrating it was to deal with the difficulties that we faced, as a secondary committee, when we dealt with the Adults with Incapacity (Scotland) Act 2000. I want to assure members that we will bear that experience in mind in our treatment of other committees.

Margaret Jamieson: Bearing in mind what happened to us, it may also be helpful to attach reporters from this committee to the other committees, so that those links are established from day one. Other committees have tried that approach and I understand that it has worked to their advantage. Perhaps we could consider that approach.

The Convener: Are there other comments on the paper?

Ben Wallace: My comment ties in with the paper on committee business, which we will discuss later, and concerns time scales. The paper refers to the following factor:

"The ideal amount of time to be allocated to inquiries".

It continues:

"It will not always be possible for the Committee to be allocated the time that it seeks."

The Scottish Parliament does not have a reviewing chamber, and it is for the Executive to decide to push motions through the committees, if it so wishes and if it does not think that the committees are meeting its time scale.

The committee must decide the amount of time that it requires, whether or not that time scale is to the liking of the Minister for Parliament. At Westminster, there is a tacit agreement that a committee will have a minimum of 100 hours for legislation, and it is for the Government to change that time scale. The committee will agree with that strong principle on time.

We are all responsible people—we are not here to be childish about holding up legislation. It is for the Executive to decide whether it wants to rush through legislation, not us.

The Convener: I agree with you totally, Ben.

On a point of clarification, the Executive will take its request to the Parliamentary Bureau. I will be at the bureau to represent the committee. We have moved on from the original procedure and, as a result of what happened to us, other relevant conveners will also be present to discuss timetabling the legislation. That meeting will involve all conveners putting across their points of view on the amount of work that they foresee their committees undertaking. Secondary and tertiary committees, or whatever, will have to feed into our stage 1 report.

At that stage, I can put forward the view of the committee and the committee clerks on how much time the committee wishes to spend on full scrutiny at stage 1 and stage 2. The question will arise of how our work dovetails with that of the secondary and tertiary committees, which will need to be completed before we can produce our stage 1 reports.

Ben Wallace: We should set some basic parameters. For example, will we be able to hold extra meetings if they are needed? Will you be able to tell the Parliamentary Bureau that the committee will not meet on a Monday morning? I think that the Justice and Home Affairs Committee met on two extra occasions.

The Convener: The Rural Affairs Committee had to meet in the evening and hold extra meetings when it was scrutinising the National Parks (Scotland) Bill.

Ben Wallace: We should decide now whether we are prepared to do that.

Mary Scanlon: Our first meeting on the legislation is due to take place on 22 November. Will we receive a draft of the bill before then?

Jennifer Smart (Clerk to the Committee): As far as we are aware, we will receive the bill when it is introduced in December.

Mary Scanlon: So the introduction of the bill is scheduled for 6 December and that is when we will first see the bill.

Jennifer Smart: I propose that we ask the Executive to give us a background briefing before then, so that we have more time to prepare our list of witnesses and to decide what issues we want to examine in more detail.

Dr Simpson: I have been through the process a couple of times with the Finance Committee. It would be helpful to receive the initial SPICe research note on policy and background fairly quickly. We have received a helpful table that shows all the relevant documents, and I hope that we will gain ready access to them. Once we have that information, we can prepare ourselves for a relatively early briefing from the Executive officials. From my experience on the Finance Committee, I know that there may be things that we want to influence informally before the final drafting is done. The process of interaction should begin soon after the recess, if that is feasible, as that would leave a reasonable length of time before the publication of the bill in December.

The Convener: The SPICe research note is almost complete, as work has been done on it over the recess.

Irene Oldfather: I presume that the list of suggested witnesses will be brought to the committee along with the proposed timetable, so that the committee can exercise some influence on the choice of witnesses. I feel that the community care inquiry has gone on too long and that, in the light of that experience, we should exercise some judgment on the witnesses who are recommended.

The Convener: The list of witnesses and the timetable will be brought to the committee.

Ben Wallace: It often takes considerable time to get permission to engage expert witnesses, or we have to go through hoops to get them. Could we propose that the committee should have more control over its budget? It is not helpful if we have to wait three or four weeks for the Parliamentary

Bureau to decide whether we can have the expert advice that we need.

The Convener: The process has been refined and streamlined over the past year as committees have identified problems with it. Ben Wallace's point is valid. After we receive the briefing as soon as possible after the recess, we may decide that we need expert input into our consideration of the bill. There is no reason for us not to have an adviser. One of the questions that we should ask ourselves after we have had the initial informal briefing is whether we need one.

Ben Wallace: I think that we should decide that before the briefing.

Jennifer Smart: If the committee feels that it is appropriate that it should have an adviser, it could take a decision now that we investigate that.

The Convener: Should we investigate that with a view to identifying possible names? Are members saying that they definitely want to have an adviser, or are they happy for us to identify possible candidates and to come back to the issue at a later date?

Dr Simpson: I believe that we should have an adviser and, if possible, appoint that person before the informal briefing. There is a considerable amount of documentation and background information that needs to be sifted through. It would be helpful if we could get an adviser in place quickly.

Mary Scanlon: There should certainly be an investigation of possible names, so that before appointing someone we can discuss who would be appropriate for our deliberations.

The Convener: We will ask the clerks and research staff to provide us with a list of possible advisers. We can revisit the matter before the October recess—[*Interruption.*] I have been informed that it would better if the committee made the decision in principle that it wishes to appoint an adviser. That would allow the staff to follow through with the action that we have proposed. Does the committee wish to appoint an adviser?

Members *indicated agreement.*

The Convener: That brings the public part of today's proceedings to a close. We move into private session.

10:42

Meeting continued in private until 12:15.

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