HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 12 December 2000
(*Morning*)

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HEALTH AND COMMUNITY CARE COMMITTEE
27th Meeting 2000, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
*Hugh Henry (Paisley South) (Lab)
*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)
*Mr Frank McAveety (Glasgow Shettleston) (Lab)
*Irene Oldfather (Cunninghame South) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Nicola Sturgeon (Glasgow) (SNP)
*Dr Richard Simpson (Ochil) (Lab)
*Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Malcolm Chisholm (Deputy Minister for Health and Community Care)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Irene Fleming

ASSISTANT CLERK

Joanna Hardy

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Tuesday 12 December 2000

(*Morning*)

[THE CONVENER *opened the meeting at 09:35*]

The Convener (Mrs Margaret Smith): I welcome members to this morning's meeting of the Health and Community Care Committee.

Is the committee happy to consider item 9 on today's agenda, the discussion of witness lists for the regulation of care bill, in private?

Members *indicated agreement.*

Subordinate Legislation

The Convener: If members want to have a debate on the statutory instruments on amnesic shellfish poisoning, we can set a time limit for that debate.

Mary Scanlon (Highlands and Islands) (Con): Before we begin, I have one question on this matter. Will amnesic shellfish poisoning continue to be monitored? We are still hearing about issues such as end testing.

The Convener: We will make that point to the deputy minister. Monitoring of the situation would be useful. It would also help the committee if the Executive could provide us with a brief summary of what the current situation is and what work the Food Standards Agency has done in the past year or 18 months. Periodically, we are given such information for parts of the country.

I welcome the Deputy Minister for Health and Community Care, Malcolm Chisholm, to the committee to deal with the emergency affirmative instruments on amnesic shellfish poisoning. I ask him to move formally the motions on the two orders.

Motions moved,

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.5) (Scotland) Order 2000 (SSI 2000/409) recommend that the order be approved.

That the Parliament's Health and Community Care Committee in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.6) (Scotland) Order 2000 (SSI 2000/428) recommend that the order be approved.—[*Malcolm Chisholm*.]

Motions agreed to.

The Deputy Minister for Health and Community Care (Malcolm Chisholm): On the point that you made earlier, convener, we will provide a briefing note to the committee, as there are some important developments in relation to the possibility of establishing a tiered regime for the scallop industry. I do not want to get too technical, but some parts of the scallop have a higher concentration of amnesic shellfish poisoning than others. Moves are afoot in Europe and Scotland to accommodate that.

Dorothy-Grace Elder (Glasgow) (SNP): I want to repeat a request that I made to your predecessors more than a year ago. We know that the order has to use the generic term "shellfish" but, to protect the industry, will you continue to monitor the publicity that the Executive is sending out to make it clear to the public that only some types of scallops are affected?

Malcolm Chisholm: I guarantee that the Food Standards Agency will take that on board and ensure that what you suggest happens.

Complaints System (Public Sector Ombudsmen)

The Convener: The next item on the agenda relates to the modernisation of the complaints system. The Executive is consulting on the role of ombudsmen in the complaints system in Scotland. We have taken written evidence from a number of organisations and members should have been issued with information—which arrived on Friday—from the Scottish Association of Health Councils. The question is whether we wish to take further evidence or whether we are happy to formulate a response on the basis of our discussion today and the written evidence that we already have.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Given that we received some information rather late on—Customer Management Consultancy, for example, provided a detailed response—we should consider the matter differently. Other committees are involved. I have a problem with some of the responses that have come in, primarily from organisations involved in the health sector, because they have taken a narrow approach. Some groups are trying to protect their areas, rather than considering how to meet the needs of the individual. Mary Scanlon and I had a brief chat before the meeting about the matter. It might be helpful if we talked to the other committees that are involved, perhaps forming a cross-committee group to consider the issue.

The Convener: The response would have to be finalised at our meeting on 10 January to fit in with the consultation. If members wanted the committee to undertake additional work, that would have to be carried out in the recess and certainly before the meeting on 10 January.

Mary Scanlon: I did not download this on Friday because I was up north. However, from a quick glance, the CMC paper appears to be excellent. Paragraph 2.2 contains nine points of concern. We should take it seriously. We should not rush into this, because the proposals on the ombudsman are important not only for us, but to the whole system of openness, transparency and accountability.

I support Margaret Jamieson's point about an all-party, cross-committee group. On reading the paper, I have decided that I would favour a debate in the Parliament to clarify, scrutinise and pull the strands together—we are talking about creating a one-stop shop. The issue would lend itself to a full debate.

I have two major concerns. First, we have talked about simplification and clarity, but the submissions from the health boards go in the opposite direction. We have an opportunity to make the system simple and easily understood so that the communication channel is good. Secondly, we are talking about setting up a new organisation on top of the Scottish Health Advisory Service and the Mental Welfare Commission for Scotland, but no one knows what their role would be in relation to the office of the ombudsman. If a person has a problem with a mental health issue, should they go to the Mental Welfare Commission or the ombudsman? Recent reports by SHAS and the Mental Welfare Commission point out that the problems that they highlighted 10 years ago still exist. The ombudsman might have a little more clout. I want to know how the organisations will interact and whether they will be integrated.

The Convener: Presumably the remit of the Mental Welfare Commission for Scotland is under review, in relation to the work of the Millan committee. It will be difficult to get a definitive decision on how the organisations will fit together.

Mary Scanlon: That point is mentioned throughout the submissions. We do not want too many organisations, because that would become confusing.

The committee should discuss family health services. Will the system be the same for general practitioners? Do people go to the General Medical Council, the British Medical Association or some other organisation?

The debate should be slightly wider. I want to know how the arrangements will impact on existing organisations. In that respect, I favour an all-party cross-committee group to examine the situation. More than that, I want clarity in the debate.

09:45

The Convener: Given the time of year, we have to deal with the issue of timing. To fit into the consultation process, our response to the paper must be finalised at the committee meeting on 10 January. We can find out whether we can put that back by a week—I do not think that that will kill anyone. However, Mary Scanlon raised wider questions about committee briefings on the current procedure of dealing with complaints about the health service and how the different organisations that deal with complaints fit together. For example, we can only conjecture what is going to happen to organisations such as the MWC. It would be useful for the committee to have such information so that we can consider the issue on 10 January.

If members have any other concerns or requests for information on the consultation document, they should let the clerks know by 19 December; that will enable the clerks to pull together information for members to read over the recess.

We need to find out what the impact of a one-stop-shop ombudsman would be not only on health but on local government issues. The Local Government Committee is taking evidence on the matter this afternoon; over the next few days, I will talk to the convener of that committee about its plans and whether we can link our work and make available the information in the written submissions that we have received. In that way, we will be better placed to pull together some thoughts when we discuss the issue on 10 January.

The key points have been summarised in the written submissions. The questions that members will want to consider include whether a one-stop shop would be beneficial; whether the remit should be limited to maladministration—indeed, from the evidence of constituents who have come to me over the years, it might have been helpful for ombudsmen to have shown some latitude on that issue; how people submit complaints; how those complaints are investigated; and, finally, the thorny issue of enforcement.

An appendix to one of the submissions focuses on what happens in other countries and indicates a fair split between countries where ombudsman systems do not have rights of enforcement and others where they do. In a wonderful example, the Spanish call their ombudsmen "the defenders of the people"; ombudsmen there seem to have considerable powers. Whether we want a defender of the people is one thing; however, it is a moot point whether we want a new one-stop-shop ombudsman to have powers of enforcement. If members come up with comments on those issues, we can pull together a report on 10 January.

Mary Scanlon: If we are seeking clarity before 10 January, one point gives me some concern. Page 6 of the Scottish Parliament information centre paper says:

"The Ombudsman can investigate complaints against hospitals, community health services or family health services"

over the

"failure to purchase or provide a service you are entitled to receive".

I may think that I am entitled to a facelift on the NHS.

The Convener: This is the point at which everybody else is supposed to say, "Oh no, not at all."

Mary Scanlon: The crucial point is the difference between what we think we are entitled to and what the NHS can provide. It is has to be clear what we are entitled to on the NHS. Entitlement is at the heart of most problems in the service. I do not want a facelift, by the way—I am happy with what I have.

The Convener: We will pick up on the issue that Mary Scanlon has raised. Members should e-mail other points that they would like clarified to the clerks before 19 December. The clerks can pull together that information and circulate it to members over the next few weeks, so that we can deal with it at our meeting of 10 January. In the meantime, I will ask the convener of the Local Government Committee about what that committee is doing. Is everybody happy with that?

Mary Scanlon: Do we agree to suggest a full debate on this matter?

The Convener: We can clarify that. I agree that we would benefit from a debate on this issue at some point. However, the Parliamentary Bureau may already be planning one, because a consultation exercise is under way. If a debate is not already planned and members agree, we can suggest that this would be a suitable topic for a debate. Is everyone happy with that approach?

Members *indicated agreement.*

Dr Richard Simpson (Ochil) (Lab): There are some further complications. One of the questions that I would like to ask when we deal with the care regulation bill that is about to be introduced is how people can make complaints against non-NHS hospitals and nursing homes. At the moment they can do that only if the care is paid for by the NHS. Private purchasers have no complaints mechanism. That issue needs to be addressed.

The Convener: We can ask whether the Executive intends to follow up that suggestion.

Margaret Jamieson: The issue is wider than that. There is no mechanism for individuals to make a complaint against dentists who operate in the private sector and do not undertake national health service work.

The Convener: We can clarify whether the Executive intends to widen the remit of the ombudsman to cover any health care that is provided to an individual, irrespective of whether it comes from a private or a public source. We must ensure that people have protection and that they are able to make complaints about a service that has failed them.

Ben Wallace (North-East Scotland) (Con): In the case of dentists, there is already a facility for people to make complaints, through the professional bodies.

Mary Scanlon: The same applies to doctors, through the GMC. That is the point that we need to clarify.

Margaret Jamieson: It is difficult for constituents to make complaints via that route.

The Convener: This relates to the point that Mary Scanlon made earlier. We will ask the clerks and the researchers in SPICe to find out what complaint mechanisms exist for private patients of private dentists and for patients who have operations in national health service hospitals. If we cover all the areas that people would expect the committee to cover—nursing homes, community care services and health services—so that we know how the current system works, by 10 January we will be in a much better position to make comments on the proposal for establishing an ombudsman.

Dorothy-Grace Elder: Might the ombudsman's remit extend to unqualified people practising various forms of so-called alternative medicine?

The Convener: That is an interesting point, on which we can ask the researchers to come back to us. We may decide in January that we do not want to pursue it, but it would be worth our while raising it with the Executive. That sector is expanding, and the Executive may want to consider the point that Dorothy-Grace Elder has made.

Dorothy-Grace Elder: Alternative medicine is almost uncontrolled at the moment.

Dr Simpson: My other question is to do with appointments. It is fundamental that the individual—or group of individuals—appointed is perceived to be independent. Could SPICe find out how ombudsmen are appointed in other countries? We have a good note from SPICe on the functions of ombudsmen in other countries, but I would like to know how they are appointed and their relationships with their national Parliaments or, as in the case of Spain, with their regional Parliaments. Is there any interplay between the Spanish ombudsman and the regional and national Parliaments in Spain?

The Convener: That will give our researchers quite a lot to be getting on with in the run-up to Christmas. Are there any other points, or are members happy with that?

Mary Scanlon: I have a query about point 49 in the document "Joint Response from Scottish Parliamentary Commissioner for Administration, Health Service Commissioner for Scotland and Commissioner for Local Administration in Scotland". Should the staff of the new office be in the UK civil service or should they be in the Scottish civil service? I know that that is a contentious issue, but I would have thought that, as the staff will be answerable to the Scottish Executive, they should be employed as members of the Scottish civil service.

The Convener: I believe that the contract of Scottish civil service staff advises them that they are still part of the UK civil service. Please put that question in writing, so that we—

Mary Scanlon: It is in the document at either point 4.9 or 49.

The Convener: If members have other points for clarification, they should send them to the clerks by 19 December.

Mary Scanlon: The point on which I would like clarification can be found in the joint response document under section K, which is headed "Finance and Staffing". Point 49 says:

> "It will be necessary to specify in the legislation what the status of the staff of any new institution is to be – whether members of the UK Civil Service or employees of a separate body".

The Convener: While we can clarify that point, I think that you will find that Scottish Executive civil servants are still bound by a contract that says that they are part of the UK civil service. That is probably what point 49 means.

Europe Familiarisation Scheme

The Convener: Item 5 is on the European parliamentary programme. This item was raised by the Parliamentary Bureau, the Scottish Parliamentary Corporate Body and the conveners liaison group, which believe that it would be useful for members of all committees to have a better idea of how the remit of their committee fits into the European parliamentary context.

The European Parliament has agreed to fund a short familiarisation programme for a group of Scottish Parliament committee conveners and other members. The programme is likely to take place in spring 2001. Do we wish to send a member of the Health and Community Care Committee to take part in that visit? Although the visit is mainly for committee conveners, it is open to other members to put forward their names.

Mary Scanlon: In principle, the answer must be yes, given the number of statutory instruments that come to the committee relating to European legislation. The visit would help us to understand how the European Parliament operates.

Ben Wallace: A number of members will have been to the European Parliament on other occasions—I have been both with my party and with the European Committee. I recommend that whoever goes on the visit should not have been before. The visit will open up the committee's European remit, which is important. It does not matter from which angle one sees the European Parliament as, once one has seen it, one can understand how it works.

The Convener: Are there any other comments? Can we have a nomination? I am not going to nominate myself.

Mary Scanlon: I propose that you attend, as the committee convener.

The Convener: I am happy to accept. Would any other members wish to attend?

Dr Simpson: I nominate Margaret Jamieson, in case we can get a second place.

Ben Wallace: I second the nomination of Margaret Jamieson.

The Convener: I will put forward my name and that of Margaret Jamieson. A number of places were available for members, rather than for conveners, so that more cross-cutting consideration of the European Parliament can take place and members can feed back to their committees.

Organisations (Contacts)

The Convener: Agenda item 6 is on contacts from outside organisations. A lot of organisations continue to approach the committee and I know that members also have meetings with organisations in the area of health and community care.

The clerks' paper lists formal contacts that we have had from outside organisations. Some of them have come in fairly late in the day, so members may not have had much time, if any, to think about the organisations' comments. However, I would like to take care of all the contacts on the list this side of Christmas so, if members will bear with me, we will work our way through them.

First, we have four organisations that wish to make presentations to the committee. Lothian Primary Care NHS Trust wishes to talk to us about alcohol misuse, its impact on health and the cost to the NHS. Parliament has spent a fair amount of time over the past week or two on this issue. I am happy to make a visit as convener to the substance misuse directorate at the Royal Edinburgh hospital, if that would be acceptable to the committee. Is that agreed?

Members *indicated agreement.*

10:00

The Convener: The Multiple Sclerosis Society of Great Britain and Northern Ireland has requested to make a presentation on multiple sclerosis.

Mary Scanlon: I suggest that we revisit that, because I believe that the Health Technology Board for Scotland is examining care and treatment. Also, a Scottish needs assessment programme report is due. Can we look at what those people recommend, and talk to the MS Society after that?

The Convener: We will defer the matter into the new year for further development. We can flag it up to our researchers in SPICe that we will probably come back to the issue in the first half of next year, and they should pick up any research or work that they can on it.

Next are Macmillan Cancer Relief and the Cancer Research Campaign. Members will see from their papers that I had a meeting with representatives of the CRC, who were keen to make a formal presentation to committee members. I suggested to them that on-going briefings for members on what the CRC viewed as the key issues for cancer in Scotland would be useful to members. The cancer agenda is high

profile in the run-up to the cancer plan. Obviously, it is one of the priority areas, and as a committee, we have not done any specific work on cancer. Are there any comments?

Margaret Jamieson: Two weeks ago, the first meeting took place to set up a cross-party group on cancer. Richard Simpson may wish to say something about that, because he organised the meeting. There are other cross-party groups, such as the cross-party group in the Scottish Parliament on palliative care, so we could get information from the cross-party groups.

Dr Simpson: I was going to say that, and add that I imagine that when the health plan is published, we will want to consider how it interacts with national priorities for the delivery of health care. If we put that on our programme, we might want organisations to make presentations to us. It depends on how we consider the health plan, if indeed we decide to do it.

Shona Robison (North-East Scotland) (SNP): I take the point about the cross-party group, but the roles of cross-party groups and of parliamentary committees are different. The letter from Macmillan Cancer Relief makes a couple of good points. One is a reiteration of the fact that cancer is one of the key priorities, and that there is an opportunity to discuss issues of concern before the cancer plan is published in March. The committee must look at the issues of concern, and take a view. The question is, do we do that before the plan, or after? The committee has a clear role to play.

Mary Scanlon: That was my point. The first that I heard of a cancer plan was when I read the letter from Macmillan Cancer Relief. I presume that it is separate from the health plan. Is it a new initiative? The question is whether we gather information and then feed our points into the cancer plan or simply respond to it. I did not know anything about the cancer plan until I read the letter that I have in front of me.

Dorothy-Grace Elder: We should have a presentation from both groups, and that should be given before the cancer plan is published. We could do something ourselves later. We could also gather evidence from the four or so cross-party groups whose remits concern cancer in some way or another—including chronic pain. I would recommend that we act before the plan comes out. It is a huge issue.

Mary Scanlon: Is there a consultation process before the plan comes out? Can we suggest that we have an input into it?

The Convener: We would need clarification on that. I pointed out to the Cancer Research Campaign that periodically the committee has had informal briefings, and has pulled together a number of practitioners and organisations from various fields. Such briefings have always been very useful to members, and have given the organisations and practitioners concerned an opportunity to speak bluntly and plainly to committee members.

There is also the question whether the committee feels that it would be more useful either to have a formal presentation from the two organisations that have requested it or an informal presentation, and whether it would be worth having informal discussions and presentations similar to those which we have had in the past. That might allow us to bring in a couple of other people, such as Harry Burns. By that time, we would be able to find out more about developments on the cancer plan and about any planned consultation period. We could circulate that information to members. We could do that right away, and as a result members might be able to decide whether to act before or after the publication of the plan.

Nicola Sturgeon (Glasgow) (SNP): As a matter of principle, we should be trying wherever possible to influence Government initiatives before the relevant publications come out, rather than waiting to respond to them. I was aware that the cancer plan was scheduled to come out before March, but given that the timetable for the health plan slipped, it is possible that the cancer plan's timetable has also slipped.

We should find out immediately what that timetable is, but we should also take a decision today to get a briefing from the cancer organisations, in order to have something to say before the publication of the health plan, in the hope that we might influence it, drawing on the expert evidence and the opinions of the various cancer organisations. Part of our role is to try to influence these things when we can. Subject to our finding out the timetable, we should decide today to see the people whom we have mentioned, so that we can make a submission to the Scottish Executive, thereby trying to influence what the cancer plan says.

Mary Scanlon: Following on from the point about hearing from the cancer charities, of which there are about four, I think that the breakthrough scientific research carried out at the Roslin Institute would be worth hearing about.

The Convener: That relates to the point that I was making. If we chose to have an informal briefing, as we have occasionally done in the past, we could open that up to a larger number of organisations and practitioners than we would if we took formal evidence in committee. Our committee time will be quite precious in the early part of the year, because of our consideration of the forthcoming regulation of care bill. If members

felt that an informal briefing was the best option, we could open that up to other organisations, which members could suggest.

Shona Robison: Such a session should be held as formal evidence taking, rather than an informal briefing. That is not to diminish the importance of informal briefings but, given the importance of the plan, I would like evidence to be heard in a more formal setting.

Dorothy-Grace Elder: On purely practical lines, I agree that evidence should be taken formally, given the vastness of the subject. Perhaps we could suggest to the major bodies concerned that they get together first, to simplify things and to save time. That would avoid duplication and ensure that major, separate points were made. The organisations would benefit from co-operating before coming before us as witnesses. That would save their time and ours—we have had some rather repetitive evidence in the past.

Dr Simpson: I have some concerns. The regulation of care bill will be the committee's major preoccupation in January and February. If we are to tackle cancer and repeat what the Executive is doing in taking evidence from all those groups, we cannot do it in a half-hearted way; it must be done properly. That will require us to take evidence over several weeks, otherwise we will produce a half-baked report.

Members or parties might want to produce detailed work on cancer, but I do not think that the committee has the capacity to examine it in the detail that is needed between now and March.

The Convener: Committee members have the paper on the timetable for the regulation of care bill; it is very tight.

Nicola Sturgeon: I have seen a paper on the forward work plan of the committee. It might be useful to have a discussion on it at some point.

The regulation of care bill will preoccupy the committee for the first few months of next year. However, I have been on a committee that has dealt with a major piece of legislation; the rest of the world does not have to stop turning because we are examining major legislation. It might be an idea for us to turn our minds to the other work that we want to take on at the same time. It is possible to do other work.

I do not know what the plans are for the schedule of meetings next year. We are moving into a period when meeting once a fortnight will not be enough. We must have more meetings than that. When will we have an opportunity to discuss that?

The Convener: We intend to have weekly meetings in the early part of next year, as we will be examining legislation. If we also want to consider other matters, that precludes fortnightly meetings.

The other point about the work load will come up later on today's agenda, when we consider petitions—work is continuing on a number of them. When we get to that agenda item, several reporters who are working behind the scenes might tell us that they will be able to produce a report for the committee on a certain time scale. That will lead to the committee acting on those petitions.

Work is on-going on some issues. If we were to examine cancer formally, that would introduce new work. If we were to go down the informal briefing route, it would enable us to hear from a larger number of people. It would attune the committee to the parts of the cancer agenda on which we might want to take formal evidence. We can put on a future agenda a discussion about any points that we want to have put into the cancer plan. We can decide whether we want to take formal evidence when we have had the informal briefing.

If we were to say that we would take formal evidence, we would have to hear from a whole range of people, to do it properly. That would take up a lot of time, which at the moment we do not have. That is not to say that we would not include it in our work load in the future. The informal briefing route would enable the committee to consider the issue and put it on the agenda for future meetings so that we can have input into the cancer plan. Following the informal briefing, we could take formal oral evidence on a time scale that we could achieve. I do not want the committee to take on a work load that it cannot achieve.

Nicola Sturgeon: This issue might have been discussed before I was on the committee. What are the committee's plans for considering the health plan when it is published on Thursday?

Cancer will come up as part of that plan. I would accept what you are proposing if, in a more structured way, we were going to feed into what is essentially the blueprint for the health service over the next few years. We must have a role in the health plan and the cancer plan. We must clarify our role.

Dr Simpson: We need to start by clarifying the precise nature of the plans: are they finalised, or will the cancer plan, for example, be a draft set of proposals for further consultation? If the latter is true, we should take evidence on that plan when it is published. It is crucial that we examine the first Scottish health plan. We must set aside time in the spring to do that and to hear the reactions to it—the newspapers are talking about it already. Some huge changes will be proposed, and we need to debate the subject.

10:15

The Convener: I am sorry if I did not make myself clear. I assumed that the committee would examine the health plan at some point. That will be a significant document in regard to what we want to happen in the Scottish health service, and we will have to comment on it. The question is where the cancer plan fits in. We need clarification on that, which the clerks will provide.

The committee's work programme is an on-going item. Periodically, we have raised it in the committee, and can do so again in January. One area of work is current petitions. If we deal with those today, we will have a clearer idea of where we are with them, and can feed them into our work plan, with the background knowledge that we have to cover the health plan and the regulation of care bill. Those matters will be our substantive work for the beginning of next year.

Mary Scanlon: Some time ago—in September, I think—when we were considering the joint future group and the ministerial statement on personal care, we asked for an idea of when the Executive intended to issue the plans, so that we could co-ordinate our work and not be bounced into them. Parliament is often presented with things that we have not even heard of. We are constantly reacting rather than being proactive. I thought that one of the features of the Scottish Parliament was that committees worked together, fed into plans, had a say in the consultation process, and then scrutinised the outcome. In fact, we are being kept almost in the dark. The debate then becomes very confrontational. Committee members seek to be stakeholders and to make an input into the plans. Rather than being bounced into being reactive, we should be able to feed into the plans in a positive, helpful manner.

Someone has to determine the role of the committee. Are we part of the process, or do we exist to react to it? Nicola Sturgeon has made a good point. Cancer is one of the top three clinical priorities. Either we wait for the cancer plan to be published, and then yell at one another in the chamber, or we do something positive, by listening to people and making an input into the plan. I prefer the latter option.

The Convener: I suggest that we write to the minister to reiterate the points that Mary Scanlon and Nicola Sturgeon have made, which echo the points that we made previously to the minister. As a result of those protestations, some months ago, we received forward work plans from the Executive. However, the clerk informs me that in reply to our most recent request for information, we received a bland paragraph about modernising the NHS, which gave no dates. We will pursue that matter.

Members will know that there have been difficulties in liaison between the committee and the Executive, which culminated in six or seven letters on hepatitis C going unanswered by the Executive, until the matter was raised with the minister personally. We will make the point again to the minister that it is impossible for a committee to feed into the process properly if it does not know what the Executive's plans are. We will ask for that information. In our first year, we were given a year-long work programme by the Executive, which was useful. However, for the committee's second year, that has not been forthcoming, despite our requests.

Nicola Sturgeon: Can we discuss our own work plan at the next meeting?

The Convener: Yes. We discuss the work plan periodically, and I will bring it forward to the January meeting.

Dorothy-Grace Elder: When you write to the Executive, would you care to add that committee membership will be cut in the new year, unless there is some intervention to change that? Today's discussion on our heavy work load makes a good case for committee membership not to be cut, so that we have enough people to continue, for instance, with our reporter system.

The Convener: Shall we arrange for an informal briefing from Macmillan Cancer Relief and the Cancer Research Campaign, which we could open up to other organisations as well? Members should e-mail me or the clerk with other individuals or organisations that they think it would benefit us to hear from. We will have that briefing as early in the new year as we can. After the briefing, we will decide whether to take any further oral evidence. By that time, we will have information on the timing and remit of the cancer plan, and we will able to feed into that, if time allows. Do members agree to all that?

Members *indicated agreement.*

The Convener: We move now to possible inquiry topics. We have received a letter from Professor John Fabre of Guy's, King's and St Thomas' School of Medicine on the subject of elective ventilation for organ donation. Richard Simpson is our organ donation reporter.

Dr Simpson: I continue to have discussions with a number of organisations. I have been in communication with Professor John Fabre and Mr Engeset in Aberdeen, who is especially keen on this subject. I suggest that we do not have a specific inquiry on it. I have another two meetings arranged. I hope to meet Lord Hunt to discuss the UK's approach, which has yet to be settled. As members know, the minister has announced the intention of beefing up the opt-in system, and we will see what happens with that.

I hope to have a report for the committee some time in February, around the time when we are scheduled to report on the regulation of care bill—28 February, I believe. After we discuss that bill, I hope that we will have an evidence-taking meeting. We can then decide whether we wish to proceed with that as a committee bill. I am not asking the committee to comment on that at the moment; I am just letting members know my thinking.

The Convener: A range of options in that area could benefit from a committee-style approach.

Dr Simpson: I have met people from the Scottish renal group—physicians, nurses and technicians. I have met the transplant co-ordinators, who have been extremely helpful. I will meet intensive care unit nurses early in January. There will be a national meeting of ITU nurses at the beginning of March, but that will be after the report is out. Things are moving forward quite well.

The Convener: We shall pass this particular letter to Richard Simpson as part of his continuing inquiry.

Diabetes UK has raised points about local provision in the Glasgow area and about a lack of data on the number of people suffering from diabetes. Does the committee agree that I should extract some questions from the letter from Diabetes UK and pass them on to the Executive on behalf of the committee?

Members *indicated agreement.*

The Convener: Previously, the committee has taken the view that questions of local provision, of acute services reviews and so on, should not be dealt with at this committee, unless they were relevant to national strategic issues that we felt could benefit from committee work. Are there any comments on the Glasgow royal infirmary request? Are members happy to follow the same line as before?

Members *indicated agreement.*

The Convener: Iain Smith asked about exemption from prescription charges.

Mary Scanlon: I understood that the list of medicines that were exempt was decided by Westminster. Is Iain Smith saying that that is a devolved matter?

The Convener: Richard Simpson may be able to clarify that.

Dr Simpson: Prescription charges fall within the remit of the Scottish Parliament; they are not a reserved matter.

Mary Scanlon: Did you say prescription charges?

Dr Simpson: Yes. Prescription charges relate to exemption and, as I understand it, we can determine our own exemptions. I raised the matter with the minister in August 1999 and indicated that in due course I would want to discuss in committee and in the Parliament the whole area of prescription exemption and charges. Members may know that the matter was also raised in the Finance Committee during discussions on the budget, as the sums involved are netted off within the health budget and are not specified. That lack of clarity was disturbing.

It is an issue that we should return to. It is long overdue for consideration. The Executive itself may propose a study of that area, but I would like us to begin by raising the matter privately with the minister to see what her intentions are. Only if she says that it is not a priority for the Executive should we proceed to discuss what we might be able to do in that area.

Mary Scanlon: I would support that.

The Convener: I am happy to support that, but I would prefer to raise the matter with the minister formally. I do not see why we cannot write to her about it. We have received a formal request about the issue and I think that we should treat it formally by writing to the minister and asking whether the Executive has any plans in that area. We should also flag up the issue with the researchers, saying that we would appreciate any background research that is available.

At the same time, we can ask the Executive for a rundown of the present situation and for clarification that the issue is actually within the Scottish Parliament's remit. I certainly agree that it is likely that that is the case; that is the situation in Wales, so I do not see why it should not also be the case in Scotland. We shall ask for clarification on those points and ask what the Executive plans to do.

We have received a letter from Cathy Jamieson about optician practice. I suggest that we simply note that letter. At some point in the future, we may want to come back and discuss opticians.

Margaret Jamieson: I think that you are missing the point. What Cathy Jamieson is concerned about is the whole issue of somebody challenging the system whereby opticians are able to make any recommendation without there being any recourse for the individual other than through their MSP. That takes us back to our previous discussions about the ombudsman. This is another issue that falls in that area.

The Convener: We can link that into our previous points about the ombudsman. We shall ask for clarification of what recourse people have if they have a complaint against a high-street optician.

Margaret Jamieson: Cathy Jamieson's letter also raises the question of how some supermarket opticians are operating and how they are governed. The individual in question raises the valid point that they were given the cheaper option, but that might not always be the option that is required.

The Convener: We shall include that issue in our on-going work on the ombudsman and get some clarification on the matter.

We also had a request—it should have come in in writing by now—from Andrew Welsh to discuss hospital-acquired infections. He drew my attention to the fact that the Public Accounts Committee of the House of Commons has just completed an inquiry into the management and control of hospital-acquired infection in acute NHS trusts in England. Andrew wondered whether we were interested in examining hospital-acquired infection in Scotland. He intimated that he would like the issue to be investigated by either the Health and Community Care Committee or the Audit Committee. Do members have suggestions?

Margaret Jamieson: I think that we have missed the boat. Audit Scotland produced a report on domestic services in the health service and their effect on hospital-acquired infections. That was published well in advance of the report from Westminster. The Audit Committee could deal with the issue, because Audit Scotland undertook that report.

10:30

Ben Wallace: I read Audit Scotland's report. There are several failings in how we prevent and treat new infections. Audit Scotland spotted the problem and said that something has to be done about it. One of its key recommendations is that it is down to local health boards to produce a plan to combat infection. I am sure that inconsistency in treating infections will not lead to their extinction; indeed, it will probably encourage them. Treating a patient one way in Perth and then moving them to Falkirk and treating them differently there will do no good.

Drugs are coming on to the market to treat the infection—I think that they are available in America already. Audit Scotland failed to hone down the number of people who are dying of these infections or who are entering hospital and acquiring them. I thought that the report was quite loose. It said simply, "Here it is." The onus should be on the Executive to produce a better and more co-ordinated plan and a long-term strategy. The issue is real and should not be swept under the carpet.

Mary Scanlon: Hospital-acquired infection seriously damages not only the patient, but the health services. I have heard of people whose stay in hospital has been prolonged by three months because of hospital-acquired infections. The issue is serious—many people are more worried about methicillin-resistant staphylococcus aureus than about surgery.

I am pleased that we are now auditing hospital-acquired infections, but I would still like the number of people infected in each hospital to be published—my concern for that has persisted through written questions. The approach is different in each hospital and some infection teams do not meet the recommended standards. I feel strongly that it is time to name and shame hospitals, to give patients trust and confidence when they go into hospital and to encourage hospitals to get their act together.

Nicola Sturgeon: I agree with Mary Scanlon. This is a big issue. The briefest of conversations with any hospital risk manager will give a horrifying insight into some of the decisions that are taken daily in hospitals and that are impacting on the incidence of hospital-acquired illness. We could examine the issue.

Margaret Jamieson is right to mention the Audit Scotland report. I read it as well. It does a reasonable job of assessing the scale of the problem, but it is arguable that Audit Scotland's remit does not include examining why the infections are occurring and what can be done to cut their incidence. That would be where we come in. Perhaps the issue is not our top priority, but we could consider it, because it costs the NHS horrendous amounts of money and it prolongs people's stays in hospital. I have spoken to risk managers about decisions that are taken in hospitals as a matter of course. Far from cutting the incidence of hospital-acquired infections, those decisions are probably increasing it and building infections into the risk management process. The subject is ripe for our scrutiny.

Dorothy-Grace Elder: We know that there is concern in some areas, particularly about operating theatres. However, it is not just a question of name and shame—it is not necessarily that people are doing something wrong. The lack of a consultant microbacteriologist—there are not enough of them in Scotland—the distance that samples have to be sent for testing or the frequency of lab tests, might be the problem. I go back to the point about who is at the top of the tree. Many consultant places have been cut, including in microbacteriology, which is essential to the health of patients.

Ben Wallace: The onus is on the Executive. It is unfair to name and shame a hospital. That would cause panic, particularly if people have only one hospital that they can go to. I would not like to be the GP who is told that a certain hospital is the

death hospital and that the patient wants to go somewhere else. The Executive must address the problem nationally, rather than leave it up to health boards that might be strapped for cash and do not have the consultants.

Margaret Jamieson: I do not think that it is as sophisticated as Dorothy-Grace Elder is making out. It is not as if MRSA would disappear if we had plenty of microbacteriologists. The Audit Scotland report mentions domestics on wards, their training and so on. We need to start at that level. If we have clean hospitals, the incidence of hospital-acquired infection will reduce dramatically. That is an area where health boards and trusts must actively recruit people. That would give us the opportunity to eradicate hospital-acquired infections and only in certain areas—particular types of surgery, for example—would MRSA be prevalent. We can take a broad brush approach.

What actions have the Executive taken to implement the recommendations made by Robert Black? Once we know that, we can make a judgment.

The Convener: I suggest that that is the appropriate course of action. We should find out what the Executive has been doing. We can revisit the issue when we consider our work plan in January. The committee recognises that this is an important issue. In the future, we might want to consider it further. We can impress on the Executive the need for a swift response.

It is clear that the House of Commons report and others have said that handwashing regimes are very poor. It comes down to a very basic level of hygiene on the part of domestics and individual clinicians. There are also wider issues, as Dorothy-Grace has mentioned.

Dr Simpson: The Accounts Commission has produced several reports over the past few years, one of which was on the matter in hand. We should write to the Accounts Commission and ask at what point it thought it reasonable to reconsider the extent to which a report had been implemented. What role does the Accounts Commission take in following up its reports? The Executive has a role, as does the Accounts Commission. I am thinking of operating theatre time, which is crucial to waiting times and lists.

When Robert Black gave evidence, we asked him to indicate at what point it would be reasonable to go back and reconsider the issues. However, we have not heard back from the Accounts Commission on that.

The Convener: There have been other reports. We considered an excellent report on prescribing and an Accounts Commission report into bank and agency nursing. If both those reports were followed through, the health service would make considerable savings and possibly provide a better service.

We have been contacted by the Haemophilia Society, which is concerned about the Executive's report into haemophilia sufferers who have contracted hepatitis C. The issue comes up again later in our agenda, under petitions. Would members prefer to deal with it when we come to that item, so that we can discuss both items together?

Members *indicated agreement.*

The Convener: The next two contacts are from the General Dental Council and the Scottish Dermatolological Society—I seem to have my teeth in the wrong way. The SDS asks us simply to note its role. I think that we should note both of those contacts.

Mary Scanlon: We discussed, once, whether we should ask someone from the British Dental Association to meet us. I suggest that we tie that in with the dental action plan and the work force planning review, both of which are excellent documents. As dentistry is so important to Scotland, could we come back to this issue in the spring, in order to tie in—

The Convener: That is a specific request. For clarification, the clerks are still trying to organise an informal briefing, to which we agreed, from the BDA. The best solution would be for the committee to get that briefing from the BDA, which we envisage will be an umbrella briefing on dentistry. Dentistry and the dental action plan have been raised in Parliament on a couple of occasions in the past few weeks and I suggest that we simply note these contacts. Are members agreed?

Members *indicated agreement.*

Joint Future Group Report

The Convener: Item 7 is the joint future group report, which has now been published. It makes a number of recommendations on joint working, rebalancing the care of older people, charging for home care and the collection and sharing of good practice.

With the report, the Executive is building on the statement that was made on 5 October. There is quite a lot of common ground between the joint future group report and our committee report on community care. The deadline for a committee response is tight. The Executive has said that the tight time scale has been imposed because it is due to respond to the committee's community care report by 23 January. It would quite like to see what we will say about the joint future group report, as that will form an important element of its response to our report. The committee and the Executive are going both ways at the same time on this occasion.

If members agree that we should accept the Executive's time scale as a possibility and that we should respond to the joint future group report by 12 January, the best way forward might be for us to appoint a reporter to report on behalf of the committee. We can consider the reporter's report on a suggested response to the Executive at our meeting on 10 January.

Mary Scanlon: When I read through the joint future group report, I found that many of its recommendations are in our report on community care. I also found that some of its recommendations, such as reducing inconsistency in charging, the best practice centre, the single assessment and training, to name but a few, have been implemented from 5 October. I found that much of our report had been addressed.

Perhaps we could ask Alison Petch or Gordon Marnoch, who are steeped in the issues, to cross-reference points that they suggested and that were not included in our report, although we need the Executive's response to our report before we can commit ourselves to making new suggestions. I found little in the joint future group report that was new, that the minister did not address or that was not addressed in our report.

The Convener: They have formally come to the end of their contract with us, so we would have to ask for an extension, but I would not expect that to be a difficulty; the only difficulty might be the timing in getting it done. We could always make an approach to ask whether they are happy to do that. Are there any other points?

Dr Simpson: Chapter 3 refers to the historical position of closures and increases—essentially the switch from long-stay geriatric beds to nursing home beds between 1994 and 1999. There is nothing in here about the forward plans. We know what they are in respect of learning disability, because they are in "The Same as You?"—the probable closure of 2,500 beds.

We have political debates about the closure of beds in the health service. It is important that we distinguish between acute beds, which are important, and other beds. We should at least ask the Minister for Health and Community Care to clarify the plans for the closure of long-stay geriatric and psychogeriatric beds, and other long-stay beds. There are 17,700 of them, as we know. How many of them is it proposed to close, and over what time period? The response may be, "These plans are not held centrally," but we can at least try.

The Convener: Any other comments, cynical or otherwise?

Nicola Sturgeon: I do not think that we have a huge job to do. Like Mary Scanlon, reading through this report I get the impression that it is some way behind where the debate is just now.

Mary Scanlon: Yes, it is.

Nicola Sturgeon: One of our comments will be that some of it is redundant, because the debate has moved on. The report of this committee goes a lot further in a lot of areas. A cross-referencing exercise would be useful, although I am not sure that we need to get the advisers to do it; we could appoint somebody from the committee.

10:45

Mary Scanlon: Are you proposing yourself Nicola?

Nicola Sturgeon: No, I am not. Someone could do that job and come back with a report.

Mary Scanlon: It would be a lengthy report.

Nicola Sturgeon: It would be lengthy, but quite insubstantial.

Mary Scanlon: It would be repetitive.

Nicola Sturgeon: But it would not be a big exercise.

The Convener: Are there any other comments?

Ben Wallace: Are we appointing a reporter? If so, I nominate Margaret Smith, which is the last thing I can do before I go.

The Convener: I am happy to act as a reporter, and as a liaison between Alison Petch and Gordon Marnoch. Even if I do the cross-referencing work myself, I will ask them to cast an eye over it to check that it is okay. I am happy to do that work over the Christmas period, and we can address

this matter again on 10 January. If colleagues have any comments, along the lines of those made by Richard Simpson or anything else, they should give them to me during the coming week, and I can come back with something for the 10 January meeting. Is that agreed?

Dorothy-Grace Elder: That is what I was going to suggest. It is exceedingly noble of you, convener, because the time scale is short.

The Convener: You know me, Dorothy-Grace.

Dorothy-Grace Elder: I was going to suggest that whoever was appointed reporter, we should put our comments on paper so that we have the controversies and nuggets that come out of the exercise.

The Convener: I do not know whether I am noble or plain sad.

Petitions

The Convener: Agenda item 8 is petitions. As I said earlier, this forms a significant part of the work load of the committee. We are always seen as a good target for petitions. As members know, we circulate petitions as they arrive and committee members can comment on them if they wish to take any further action.

The first petition is from the Epilepsy Association of Scotland. The only comments that have been received are from Richard Simpson, who proposed that we await the outcome of the acute services review but ask SPICe to gather information and review this matter in the future.

Are there any other comments?

Ben Wallace: I agree. Especially as that review moves into its implementation stages, we need to monitor how epilepsy will be catered for.

The Convener: So will we maintain a holding position on the issue for the time being, on the basis of what Richard Simpson has suggested?

Members *indicated agreement.*

The Convener: The next petition, PE223, is from Mr and Mrs McQuire and calls for the Scottish Parliament to ensure that multiple sclerosis sufferers in Lothian are not denied the opportunity to be prescribed beta interferon. We covered the issue of multiple sclerosis earlier and are awaiting reports on the matter. We have asked our researchers to do some background work for us. We can return to the issue in due course.

Dr Simpson: Both the Health Technology Board for Scotland and the National Institute for Clinical Excellence are producing reports. The NICE report has been set back. It was to have come out on 3 December, but it has been postponed. Clearly, the HTBS is in communication with NICE to ensure that they do not duplicate work. A subgroup of the HTBS is examining the area and the Multiple Sclerosis Society in Scotland is represented on that working party. A comprehensive set of arrangements is in place and it would be inappropriate for us to get involved until the groups have reported.

The Convener: We might want to comment on the issue on the back of those reports. I suggest that we adopt a holding position in relation to this petition as well. Is that agreed?

Members *indicated agreement.*

The Convener: On the petition about rapeseed crushing, the committee has no comment to make other than to suggest that no action be taken. Is that agreed?

Dorothy-Grace Elder: The issue affects a number of people, but I do not know how the Health and Community Care Committee can deal with it. Perhaps the Transport and the Environment Committee—

The Convener: As you will see from your note, Dorothy-Grace, the Transport and the Environment Committee is leading on the matter. I suggest that this committee should say that we do not want to take any further action. The lead committee referred the petition to us for comment. If we say that we will take no action, it is up to that committee to decide what it wants to do. Is that agreed?

Members *indicated agreement.*

The Convener: The next petition, PE148, is from William Brian Anderson on behalf of the Organophosphate Information Network and calls for the Scottish Parliament to investigate various issues relating to specialist referral and diagnosis of exposure to organophosphates.

Dr Simpson: I believe that this matter is being considered by a Westminster committee. Duplicating that work would not be the best use of our time. It might be better to wait for that report to come out to see whether it has any implications for Scotland.

The Convener: Is that agreed?

Members *indicated agreement.*

The Convener: The next petition, PE192, is from Alex Doherty and calls for the Scottish Parliament to order the Mental Welfare Commission to regard all of its records as health records and to comply with access requirements.

The response from the commission says that, since Mr Doherty's brother committed suicide, the Mental Welfare Commission has changed its approach. However, it will not make the records available to Mr Doherty as some have a degree of confidentiality attached to them.

Shall we simply note the response from the Mental Welfare Commission and forward it to Mr Doherty?

Dr Simpson: It may be that, under the functions of the Mental Welfare Commission, the item should be reviewed. I suggest referring the correspondence to the Millan commission.

The Convener: Is that agreed?

Members *indicated agreement.*

The Convener: The next petition, PE214, calls on the Scottish Parliament to investigate the current recruitment crisis in the cardiac transplant unit at Glasgow royal infirmary. We have a response from the Executive. Some of the information in it is heartening, as it shows that there have been developments since we received that petition.

Nicola Sturgeon: I think that we should keep a watching brief on the matter. Perhaps in February, we should ask the Executive for a progress report, as there are a number of concerns about progress towards the reopening of the unit. I have doubts about whether it will reopen on schedule. We should reassure the petitioner that we are keeping abreast of the matter and reassure ourselves that progress is being made.

The Convener: Our interest is in the unit as a national service. If the intention is that it should reopen in the spring of 2001, it would seem reasonable for us to reconsider the matter. February would seem to be a reasonable time to do that. Are we agreed?

Ben Wallace: Has the standard that a patient who is waiting for a heart transplant can expect of transplant services declined as a result of the suspension of the unit?

Nicola Sturgeon: It is impossible to say. The number of transplants has declined, but it is impossible to say categorically that that is because the unit has closed; it may be due to a lack of donors.

The Convener: At the moment, the Executive's response is that a certain amount of people's pre- and post-operative treatment and care can be taken care of in Glasgow, but the operation itself involves patients going to Newcastle. The level of service is therefore not the same as it was, but it is impossible to say exactly what changes have taken place—the need to travel to Newcastle is one obvious change for Scottish patients.

We should reconsider the matter in due course.

Dorothy-Grace Elder: The anxiety being felt by some patients and their families is focused not only on when the unit will reopen, but on check-up operations at Glasgow royal infirmary. The concern since the unit closed is that patients have claimed that operations are being cancelled at the last minute. One person claimed that he had turned up from Wick to be told that he could not be seen until the next day.

It might be helpful if the convener could write to the trust at Glasgow royal to inquire officially into the delays. We do not want people who have had their operations and who are still being checked at Glasgow royal to undergo extra stress due to cancellations. The concern is not just recruitment for the future, but the current situation in the limbo period before the unit officially reopens.

Margaret Jamieson: There is no limbo period for pre- and post-operative care. The situation is as it was before. Only the operations have been

transferred. Post-operative care is still available to all patients at the GRI.

Dorothy-Grace Elder: That is the point. The situation may have improved in the past month or two, but the patients group claims that over the months too many post-operative appointments have been cancelled. Could the convener write a letter to check up on that?

Hugh Henry (Paisley South) (Lab): We are beginning to stray from the matter before us. We are being asked to do something specific. That is now turning into a trawl of every complaint and concern that exists about the wider issue. If we did that with every petition, we would never finish—we would be administrative postbags.

The Convener: I feel uneasy about the fact that we are going more into the day-to-day operation of the service than into the question raised in the petition. It would be reasonable for us between now and February to ask whether the current service is being run effectively, but we can deal with that through the Executive. We will also ask the Executive further questions raised by its response, which was quite good, about the on-going running of pre- and post-operative services. We will return to the reopening of the unit in February.

Mary Scanlon: I understand from the Sunday papers that interviews were held yesterday for a new consultant and that two of the existing consultants are being trained at the Freeman hospital. When you ask the minister for an update, convener, will you also ask for an update on lung transplants at the unit, which she also promised to consider?

The Convener: That is a fair point. Is that agreed?

Members *indicated agreement.*

The Convener: We have received a number of petitions on car parking charges. Clarification on the matter was sought from the Executive, which has responded by saying that it is unaware of any breach of policy. Although car parking charges should not be introduced to subsidise health care provision, they have been introduced for several other reasons, such as the better organisation of car parking. Do members have any further comments on the issue?

Margaret Jamieson: I understand that the health board in that area is reviewing car parking charges in light of the Executive's clarification. I think that we should simply note that situation.

The Convener: We should note both that and the committee's support of the Executive's position that there should be no cross-subsidy of health services.

The next two petitions under consideration are PE45 from the West of Scotland Haemophilia Society and PE185 from Thomas McKissock. We have also been contacted by the Haemophilia Society, which feels that the Government's response to a haemophilia inquiry was lacking. The society wishes to give a presentation on the matter to the committee. The report was published by the Executive on 22 October and considered by the committee on 25 October, when we questioned the Minister for Health and Community Care on the matter. The question for the committee is how we progress the issue.

11:00

Members will be aware of recent press reports about the screening of blood donations prior to transfusion. Although that is a slightly different matter, I was certainly concerned by a report in *The Scotsman*. The minister told us that it was impossible to check whether hepatitis C—non-A, non-B hepatitis, as it used to be known—had been heat-treated out of a blood donation, because the disease had not been classified with that name. The article in *The Scotsman*—backed up by extracts from minutes that were provided by regional managers of the Scottish National Blood Transfusion Service—claimed that during the 1980s, the service had a series of discussions about the presence of a non-A, non-B hepatitis, which was having an impact on people and was being screened for in other countries. At that time, the Scottish National Blood Transfusion Service wrote a letter to *The Lancet* on the issue.

At the tail end of last week, I asked the Scottish Parliament information centre to provide a research note on the matter, which members should have. Researchers have had a chance to review the documents that were supplied to *The Scotsman*, and I hope that members will find the briefing note useful when the committee comes to make a decision about petitions PE45 and PE185. Although the note refers to an earlier stage in the process from that which the committee discussed, it raises serious questions about whether it is a justifiable defence to claim that hepatitis C could not be screened out of donations because it was not called hepatitis C at the time. If it was known that a disease called non-A, non-B hepatitis was having a serious impact, surely the name of the disease is irrelevant; the point is that that impact existed.

I would like guidance from committee members on whether we wish to hear from the Haemophilia Society, which has asked to come and give evidence on the matter. We have taken oral evidence from the minister—if we ask the Haemophilia Society, we may consider asking the Scottish National Blood Transfusion Service and

others, so that we can finalise our response to the petitions.

Nicola Sturgeon: A few unanswered questions surround the matter. Since the meeting at which we discussed hepatitis C with the minister, substantial new evidence has been produced. It is incumbent on the committee to deal with that. The first step should be to take evidence from the Haemophilia Society. We can decide what to do next after we have asked the society questions on its evidence. We should talk to the blood transfusion service, and perhaps take evidence again from the minister.

In light of the evidence that is in the public domain, it is totally unsatisfactory that the matter should rest on an internal report—a report by the Executive on an Executive agency. While questions remain on that, it is incumbent on the committee to try to get some answers.

It is not for the committee to tell the Minister for Health and Community Care who she should see, but I would like this point to be noted. At the meeting that she attended, she said in answer to a question from an MSP that she would be happy to meet the Haemophilia Society again to discuss continuing concerns and new evidence. The society has since received a letter from her, in response to a request for a meeting, which said that she would not meet the society. That is unsatisfactory, and the committee should take note of that.

The Convener: That is a serious issue. As Nicola Sturgeon said, the minister told us that she would be willing to meet the Haemophilia Society again. As convener of this committee, I feel that that would be a reasonable thing for the minister to do in the circumstances. Committee members may have opinions on that—especially when we consider that the minister raised the point in evidence to us. What she said was welcomed by committee members.

Margaret Jamieson: To follow on from what Nicola Sturgeon said, I agree that we should take evidence from the Haemophilia Society. We should hear from the blood transfusion service too. To hear from one but not the other would serve no purpose.

Cathy Jamieson represented Mr McKissock, who was unable to attend to discuss his petition. His situation was different and has not been considered in the inquiry by the Scottish Executive. If I recollect correctly, Mr McKissock contracted hepatitis C through routine surgery. Cases such as his have been excluded from the inquiry. We should look into that, because a great number of individuals find themselves with hepatitis C through no fault of their own. Some have contracted it during the course of emergency treatment, not through the normal course of their treatment, which is the way that haemophiliacs have contracted it. We must consider sufferers of hepatitis C who are not haemophiliacs.

The Convener: Initially, we asked the Executive to include such people. The Executive ruled that out, but members seem to be suggesting that we should continue on that tack and ask the researchers to give us information on the acquisition of hepatitis C by non-haemophiliacs, so that we can get an idea of the extent of the problem and how it comes about. That might lead us on to consider the screening of blood products and other questions of hygiene.

Mary Scanlon: It is crucial that we take evidence. This issue has been with us for more than a decade and is not going to go away. We must listen to all the available evidence. I support asking the Haemophilia Society and the Scottish National Blood Transfusion Service to give evidence.

Dr Simpson: Can I be clear that we are confining our evidence taking to the question of screening? I assume that we are not going to go back over the old ground about heat treatments and so on. That has been covered adequately in the report. In relation to the new evidence about whether the blood should have been screened, we must decide whether the information was available and whether the screening test was appropriate and focused—in other words, that it did not produce too many false positives and false negatives. I would not support the committee broadening the inquiry to consider heat treatment.

The Convener: The Executive report examined heat treatment. If we have witnesses from the Haemophilia Society who do not believe that that report is adequate, I do not know how we can get the information from them without going back to the Executive's response on heat treatment.

Having said that, I believe that the Haemophilia Society will make some points to us about why it does not believe that that report is adequate and why it questions the reports findings. If the Scottish National Blood Transfusion Service is coming to give evidence, it would not be reasonable for members to feel that they were unable to ask questions about heat treatment, which is central to the Executive's report. We got at least one of the petitions because of that report.

Nicola Sturgeon and I have made the point that new evidence has come to us on screening. We will consider that issue afresh because it is a new development. How could we conduct an oral investigation effectively without asking questions about the main point of the Executive's report?

Dorothy-Grace Elder: We will find that a deal more evidence is produced.

It is surprising that the letter from *The Lancet* has not come to our attention earlier. The files of *The Scotsman* and other newspapers will produce information from the early 1980s. We have been told that hepatitis C was not identified until the early 1990s. That is the terminology that was used. However, we know now that it was called non-A, non-B hepatitis. I refer to comments that I made in the Health and Community Care Committee from October onwards. I remember clearly that in the early 1980s haematologists and the blood transfusion service were pleading for a few hundred thousand pounds to set up a heat treatment unit in Scotland. We must look back and examine the issue as rigorously as possible. We should call in the authors of the letter in *The Lancet* and haematologists who were serving at the time.

The Convener: I do not want to keep on interjecting on every comment made by committee members, but I think that the point that was raised earlier—that when we have heard evidence from the Haemophilia Society and the Scottish National Blood Transfusion Service, we must decide whether we believe that the report published by the Executive is adequate—covers all the issues. The question for the committee is how we proceed if we feel that it is not an adequate response. That leads us into whether the matter requires further work by the committee, the Executive or somebody else.

At this stage, it is not for the committee to redo all the work that has been done. Members are well aware of committees' limitations. It might be that other people are better placed to get answers. When we have heard evidence from the Haemophilia Society and the Scottish National Blood Transfusion Service, we will be better placed to judge whether the Executive's report is the final work that needs to be done to investigate the history of the matter.

Shona Robison: I agree that it would be impractical and unfair to constrain the discussion, so I support the convener's view that the discussion about the issues and the evidence should be wide ranging.

11:15

Hugh Henry: I think that everybody supports the principle that there should be further investigation of the broad issues. However, we are struggling to agree on, or even to understand, the terms of reference. I think that we should agree that the matter will return to our agenda and that there will be an inquiry. We can then try to draw up terms of reference. We should have a debate, based on the evidence and the arguments that we have heard this morning. The last thing that we should do is begin an inquiry when members have different ideas about what we are discussing. We all agree on the principle, but as this is such a sensitive issue, we should take a wee bit of time to sort out the terms of reference properly.

Nicola Sturgeon: I do not think that there is so much confusion about the terms of reference—the issue is quite simple. In response to what Richard Simpson said, I say that it is inconceivable that we could invite representatives from the Haemophilia Society to give evidence and then tell them that they can only discuss certain aspects of the matter. We should take evidence from the society on the points on which it disagrees with the Executive's report, or on which it thinks that the report has not been exhaustive and has not taken into account particular pieces of evidence. It would be fair to tell the society that we expect it to be quite focused so that we do not go back over matters that are not disputed by the Executive or the society. We should also ask about any new evidence—in relation to screening, for example—that was not examined for the report. If we agree to do that, what we are trying to achieve becomes clearer.

At the end of the process, we may conclude that the Executive report is fine—we can decide that once we have taken evidence. It may be that the only aspect that we will want to address is the new evidence about screening. However, it is inconceivable that we should tell the Haemophilia Society that it should give evidence only on the part of the issue that we want to hear about.

Irene Oldfather (Cunninghame South) (Lab): If I recollect correctly, the area of contention was the chronology of what happened. That information exists. In fact, we addressed much of that when Susan Deacon attended the committee. It is important that we do not try to conduct the investigation again and that we focus on one or two clear points on which we could make some progress. We received a lot of information in the report, and accepted much of it. The chronology of events was, however, the issue. We could ask about that and the new evidence on screenings.

The Convener: The other matter about which the Haemophilia Society is unhappy is how the report addressed the manner in which people were informed of risks in advance of treatment, and the manner in which people were dealt with after they contracted hepatitis C. The society will want to raise that as well.

The Executive's report was meant to deal with that, but committee members may recall that when the minister dealt with it, questions of confidentiality were raised. I do not know whether the Haemophilia Society believes that those issues can be overcome. The society will raise questions about the report's chronology and will discuss whether people were informed and, if so,

how. We have not touched on that.

Dr Simpson: Will our clerks produce a note on the issues that members think should be raised? I remain concerned that we will try to repeat the inquiry. If we are to do that, we must appoint a special adviser, take evidence from absolutely everybody and do the task properly, but I do not think that that is our role. We should focus on our concerns. We can draw up a list, send it to the Haemophilia Society and find out whether the society agrees with it. I do not mind that. However, I do not wish us to go back into the entire inquiry again.

Nicola Sturgeon: We should take evidence from the Haemophilia Society about its concerns. Then, by all means, the clerks should draw up the note on the issues that the committee wants to progress with. We may think that some of the society's concerns are not justified. However, in fairness to the society, we must give it the opportunity to tell us about its disagreements with the report, what new evidence it has and what its concerns are. After that, we can boil down the issues.

The Convener: I agree. We have heard the minister speak to her report. The Haemophilia Society has intimated that it is not happy with the report. As things stand, if the minister refuses to meet members of the society—and that appears to be the situation—natural justice demands that we should hear from the Haemophilia Society. That will allow the society to put on record its thoughts about how the report has not gone far enough, which I think will relate to how information was passed on to the people involved. The society will be able to dispute points about chronology and other matters in the report. We must hear the other side of the argument, from the Haemophilia Society.

Hearing from the Scottish National Blood Transfusion Service would allow us to clarify some of the screening questions and any other issues that we may hear about from the Haemophilia Society. After that, the committee will have all the information that it will need on which to make decisions on the following questions. First, did the Executive's report go far enough? Secondly, do we want the Executive to do further work?

The screening issue has been brought up late in the day, so we could point that out to the Executive. Further work may be required on the question of non-haemophiliacs who have contracted hepatitis C. We would have to consider whether the committee should suggest that somebody—or ourselves—should take on further work. My gut reaction is that the committee would not do such work.

The committee can decide whether further work is required from the Executive or others only on the basis of evidence from the Haemophilia Society, the SNBTS and the minister. We would decide on an inquiry only when we had covered all the issues and had a chance to ask the main players about them. At the moment, we have heard only the minister's point of view, and we have had to take account of new developments.

I suggest that the committee undertakes to speak to the Haemophilia Society and the SNBTS. After receiving information from them, the committee will be able to decide how to proceed and whether further work is needed from anyone, including the committee. Our view is broad. We have two petitions that cover the haemophilia issue with the SNBTS, the ways in which people are acquiring hepatitis C and the manner in which we have dealt with blood products. The fact that we have two petitions on the matter has already broadened the issue out. Are there any comments from members?

Margaret Jamieson: If the Haemophilia Society could list the areas that concern it following the Executive's publication of its inquiry, we could cross-reference that with the areas that we have already dealt with. That would keep our work quite narrow, rather than rehashing what we have already dealt with.

Nicola Sturgeon: We have not dealt with anything. We have heard the minister give evidence on her report. As Margaret Jamieson said, we have heard one side of the story. Natural justice would suggest that we should hear the other side and give the Haemophilia Society—

Margaret Jamieson: We heard from the Haemophilia Society.

Nicola Sturgeon: Yes, but not in response to the report. We should give the Haemophilia Society the opportunity to respond. I agree that, after that, we have to focus on what we do next and on what progress we can make. However, to try to shut the debate down before we have heard one side of it is not fair.

Hugh Henry: The minister gave a commitment to the committee. She seems to be saying something different from what the Haemophilia Society is saying. It is reasonable for the committee to write to the minister to remind her of the commitment that was given to the committee and to indicate that we expect her to fulfil that commitment. In the event that that commitment is not fulfilled, it is within the competence of the committee to ask the minister to come back before us. At that point, we can undertake some of the functions that a meeting with the Haemophilia Society would have fulfilled. It is not right that the minister should make one statement to a committee and give a completely different

message to the organisation that the commitment concerned.

On the general point that is raised in the petition, I wonder whether we are going way beyond the agenda item. On the basis of some of the evidence that has come forward, I think that there is an argument for retracing our steps on haemophilia. Perhaps we could conduct an investigation or produce a report. However, if we stick to the issue that is raised in the petition, that might not be possible. Correct me if I am wrong, but I believe that we are talking about a petition from Thomas McKissock.

The Convener: Yes, and one from the west of Scotland group of the Haemophilia Society.

Hugh Henry: The petition from Thomas McKissock deals with a specific issue. We need to determine what we will do about that. However, the other petition calls for a public inquiry. To some extent, we have been over that argument previously. If we think that it is legitimate to have a revolving inquiry in the committee and for us to rehash matters every time a decision is made, every petitioner will ask us to go over subjects again, even although we have already undertaken work. There is an argument for saying that new evidence on the issue should be examined carefully, but we need to separate what we have done from what we are trying to do. I think that the committee will create a rod for its own back on a range of issues if it starts rehashing work that it has already done.

Ben Wallace: I am not aware that we have closed our inquiry. Nicola Sturgeon is correct when she says that Susan Deacon used her time to talk about her report. We have not listened to the Haemophilia Society's opinion of the report. It would only be good manners, having heard from one side, to hear from the other. That is very important. When we have heard that, we can decide on a course of action.

11:30

Shona Robison: This is not just about the petitions—we agreed to discuss the letter from the Haemophilia Society at the same time as the petitions. The letter states that the society disagrees with the report and would like to bring its views to the committee. Anything short of allowing the Haemophilia Society to give evidence and voice its concerns would be totally inadequate. We should decide what to do after having heard the evidence. At this stage, all we need to do is to agree that we will listen to the views of the Haemophilia Society. There has been a suggestion that we listen to the views of the Scottish National Blood Transfusion Service at the same time. That seems reasonable. After we have heard that evidence, we can decide whether we should begin another inquiry.

Dorothy-Grace Elder: I do not agree with Hugh Henry that such a decision would compromise us in the future. The case is unusual. We cannot ignore the direct petitioners or the Haemophilia Society. I hope that this is a one-off, although it may not be. If necessary, we should make recommendations as to whether there should be compensation.

Dr Simpson: We have not decided what sort of evidence to take. We should ask the Haemophilia Society to detail in writing its objections to the report. All we have is a statement that the society is not happy with the people who carried out the inquiry. We need more details. The oral evidence should rest on questions that arise from the written evidence. We should also ask the society to present evidence on screening.

The Convener: I want to pull together the various suggestions for action. I did not recall—and nor did the clerk—that we had decided that, once we questioned the minister about hepatitis C, that would be the end of the matter. We asked her about several issues on that day; we took advantage of her presence to ask several questions because we had not had responses to six letters. Our final letter said that, if we did not receive a response, we would ask questions when the minister appeared before us to answer questions on other matters. That was why we took that approach.

I agree with the points made by Nicola Sturgeon, Hugh Henry and me. [*Laughter.*] I may change my mind, but not during a meeting. Given that the minister assured the committee that she would be happy to meet representatives of the Haemophilia Society, it would be perfectly reasonable for the committee to write to say that we expect her to honour that commitment. That would give the society a chance to discuss the issue with her face to face. Does the committee agree to that suggestion?

Members *indicated agreement.*

The Convener: The second point relates to the wider issue raised in the petition from Mr McKissock, on hepatitis C being contracted by non-haemophiliacs through health treatment provided by the NHS. Is the committee happy to request a research note on that issue, so that we can revisit the matter at a future meeting?

Members *indicated agreement.*

The Convener: I suggest that we invite the Haemophilia Society and the Scottish National Blood Transfusion Service to give evidence. It would be reasonable for us to ask the Haemophilia Society to outline in advance its areas of

disagreement with the report and the subjects that the society believes the report has not fully covered.

The Haemophilia Society is concerned about the secondary issue of the information available to patients not having been investigated as much as it could have been. Some of its concerns might be about not only the content of the report, but the breadth of the secondary part of the inquiry. If we ask the society to outline its concerns in writing, that would give us the opportunity to concentrate on the appropriate areas when taking oral evidence. It is important, with both the Haemophilia Society and the Scottish National Blood Transfusion Service, to use the new information that has been given to *The Scotsman* and to other parties on the screening programme. That links into the chronological aspects raised by Irene Oldfather.

Frankly, I do not believe that the committee will be able to carry out a full inquiry into the haemophilia and hepatitis C situations; we do not have the research resources to take on that task, although I mean no disrespect to the research resources that we have. However, after hearing the evidence from all sides, we will be better placed to say whether we believe that the Executive's report is adequate, whether the Executive should modify the report and whether other avenues, such as a full, independent public inquiry, should be pursued. The point at which the committee can make such decisions is after we have heard from the three major players. We have heard from the Executive, but we have not heard from the Haemophilia Society or the Scottish National Blood Transfusion Service. I suggest to the committee that that is the way in which we should proceed.

Dorothy-Grace Elder: We are going to invite the Haemophilia Society, but the petitioner is from the west of Scotland group of the Haemophilia Society. How do we work that out?

The Convener: When investigating petitions in the past, we have not always questioned the petitioner. We have taken on board the tone, spirit and letter of a petition and have then taken information and evidence from other people in order to arrive at a position. We can clarify this with the Haemophilia Society, but I presume that the west of Scotland group would be happy to be represented by the society, of which the group is an offshoot. There should not be a problem with that, but we can clarify the situation.

I will let Ben Wallace in, but I would like to get to a decision on this.

Ben Wallace: Many of us—including Hugh Henry and Irene Oldfather—supported Brian Adam when he called for an independent inquiry on hepatitis C. We ought therefore to continue with that, ensuring that we hear the minister's response before proceeding.

Hugh Henry: Can I respond to that?

The Convener: Yes—I think that you have to.

Hugh Henry: I do not think that we are arguing otherwise. We have been saying that the committee should not retrace the ground that it has already covered but should try to move on. I remind Ben Wallace that I said that we should move forward on the basis of some of the new evidence that has come to light.

Other issues flow from this matter, and not just on haemophilia. Will we be opening the door to any group that wants us to question Executive reports, regardless of the issue? We should consider issues of procedure. Nothing that I have said contradicts the views that I have expressed in committee or outside it.

The Convener: Let me clarify the matter for the committee. We are dealing with petitions that came to us in the normal way. The committee's response to the petition from the west of Scotland group of the Haemophilia Society was influenced by the fact that the Executive had intimated that it was going to commission an on-going report. Had that report not been undertaken, the committee might have taken a different approach to the petition, but we decided to wait for the Executive's response before we acted on the issue.

I suggest that the committee agrees to the course of action that I outlined a few minutes ago. Are there any objections to that course of action?

Dr Simpson: My objection is that the organisations that you will invite to give evidence are the two protagonists in the case—the Haemophilia Society, with its concerns over the report and the screening, and the Scottish National Blood Transfusion Service. I recommend that you, as the convener, also invite an independent expert, so that we can receive evidence from someone who is not directly engaged in the conflict.

The Convener: Do members have any problems with that?

Nicola Sturgeon: Although Richard Simpson may have the right idea, he is perhaps a bit ahead of the process, as that is a decision that we should make after we have heard the evidence from the Haemophilia Society and the blood transfusion service. At that stage, we can determine whether we require independent advice.

The Convener: Does the committee agree to the course of action that I suggested?

Members *indicated agreement.*

The Convener: We can revisit the situation when we have taken evidence.

Petition PE145 is from Mr Bill Welsh and concerns the vaccination for mumps, measles and rubella. Mary Scanlon is working on this issue as a committee reporter. Mary, can you give us an update on the situation?

Mary Scanlon: The starting point for the petition was concern over parental choice on the MMR vaccine. In my early reading on the subject, I have found that, although some parents and medical practitioners are adamant that there is a link between the vaccination and autism, others, including public health officials, are equally adamant that there is no link.

I have attended several meetings and conferences on the subject and I have amassed lots of reading material, which I shall need two or three days to get through. Just as you will be reading up on the joint future group over the recess, convener, so I shall use the recess to read up on this issue. It is the sort of project that cannot be pursued while phones are ringing and so on. I intend to undertake all the reading over the Christmas recess. So much research is being conducted that I am slightly worried that I shall not return to the committee with the conclusive evidence that many of us are hoping for.

This is an extremely complex issue and the Dáil's Joint Committee on Health and Children is taking evidence on it at the moment. I talked to Richard Simpson about it, as I value his input, but I would like to visit the Irish Parliament by the end of January.

Ben Wallace: On your way back from Finland?

Mary Scanlon: Yes.

The Irish Parliament is taking evidence and considering all sorts of information. Moreover, I have yet to read the report of the Kenneth Calman investigation. I have a lot of information. There are genuine concerns, but I have not reached any conclusions. I would like to take advantage of the evidence that will be taken in the Irish Parliament—and have a holiday. I will report back to the committee at the end of January or the beginning of February.

11:45

The Convener: If the committee is happy with the principle, Mary Scanlon and I will investigate whether the timing of the evidence taking by the Dáil committee would make it helpful for her to go there. Like all decisions on whether a committee member can travel, the matter would then be referred to the conveners group. Is that agreed?

Members *indicated agreement.*

The Convener: Mary Scanlon will then report back to the committee on her visit at the beginning of the year.

Malcolm Chisholm was working on a report on fuel poverty, which I believe is incomplete. He has not made up his mind what he thinks, but we have some of the evidence that he took. It would not be a major piece of work to complete the report and I am looking for a volunteer to do that.

Dorothy-Grace Elder: I will do it. Such things as allowances have changed in the past few weeks. Should I contact Malcolm Chisholm directly?

The Convener: Yes.

Dorothy-Grace Elder: Is there a deadline?

The Convener: You should look at the material first and then tell me when you think you can finish the report. Is the proposal that Dorothy-Grace Elder act as reporter on fuel poverty agreed?

Members *indicated agreement.*

The Convener: The final petition is from Glenorchy and Innishail community council general practitioners who have to run a practice single-handedly. Margaret Jamieson was appointed as our reporter on this matter.

Margaret Jamieson: I have met the Scottish Medical Practices Committee, the British Medical Association, the Scottish Executive and the medical director of the primary care trust in my area. However, I have put the matter on the back burner while we await the health plan. I will reassess the situation on Friday and speak to Jennifer Smart. I did not want to do much work on this before we had learned whether the health plan addresses the issue.

The Convener: That is the end of this agenda item. I understand that Ben Wallace wishes to say something on the record before we move into private session.

Ben Wallace: As some of us will no longer be members of the committee in January, I place on record my thanks to the clerks, Jennifer Smart, Joanna Hardy and Irene Fleming, who keep the committee going and without whom we could not work. I also thank the convener and those members who are staying for putting up with me.

I will speak briefly on the changes that are being made to the committee. This has been one of the best committees of the Parliament. I know that because I sit on another committee, the European Committee—although that is no slight to its convener, Hugh Henry. The Health and Community Care Committee deals with a difficult and sensitive issue, and I am proud of what I have achieved with other members.

I think that the restructuring of the committees is wrong and will probably say so in the chamber. It did not result from a recommendation from the Procedures Committee, but was cobbled up by business managers over the past year, who have approached us with different forms of arm twisting, bribes and threats.

The Convener: I am glad that I let you put this on the record.

Ben Wallace: I do not think that the restructuring has been born out of a desire to seek better accountability or the better operation of the committee. It has been the result of the views of certain MSPs from different groups who have their own reasons. I do not think that that is a good basis on which the Parliament should proceed. Changes to the structure of committees are not best handled by a coterie of MSPs, but should be decided by the Procedures Committee, for which Parliament is bigger than the parties. That would lead to a procedure that befits a Parliament rather than a procedure that merely suits the way in which our groups work.

Most important, I would like to say thank you. I have learned much and will miss being a member of the committee. I will certainly try to turn up sometimes to annoy members. I wish members all the best for the future.

The Convener: Thank you, Ben—mild to the end. Some members will be leaving the committee and we will begin the new year with a clean sheet and new personnel in place. I thank all members for their hard work and support. I wish everybody a happy Christmas and a good new year. Those of us who have reading to do will be kept out of mischief for part—not all, I hope—of the time. I will see you all in the new year.

11:50

Meeting continued in private until 12:27.

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