HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 27 June 2001
(*Morning*)

Session 1

£5.00

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

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HEALTH AND COMMUNITY CARE COMMITTEE
18th Meeting 2001, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Dorothy-Grace Elder (Glasgow) (SNP)
Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
*Dr Richard Simpson (Ochil) (Lab)
Nicola Sturgeon (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Mr Jamie McGrigor (Highlands and Islands) (Con)

WITNESSES

Malcolm Chisholm (Deputy Minister for Health and Community Care)
Martin Reid (Food Standards Agency Scotland)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERKS

Irene Fleming
Peter McGrath

ASSISTANT CLERK

Joanna Hardy

LOCATION

Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 27 June 2001

(*Morning*)

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

Items in Private

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

Agenda item 1 is to ask the committee whether it agrees to discuss agenda items 6 to 9 in private. Item 6 is a draft report on petition PE123 from the Scottish warm homes campaign. It is usual for the committee to consider draft reports in private, before we finalise them. The same applies to item 7, on petitions PE185 and PE45 on haemophilia and hepatitis C, and to item 8, on petition PE217. Item 9 is on witnesses for legislation; it is our normal practice to allow full discussion on possible witnesses and it is suggested that we discuss that item in private. Is the committee happy to discuss those items in private?

Members *indicated agreement*.

Debates (Time Limits)

The Convener: Members were asked to indicate whether they wished to have emergency affirmative instruments debated. No comments have been lodged, and it is suggested that the affirmative instruments not be debated. If that is not acceptable to the committee it is suggested that the time limit for such debates be limited to 15 minutes. Is that agreed?

Members *indicated agreement.*

Subordinate Legislation

The Convener: The first instrument is the Sweeteners in Food Amendment (Scotland) Regulations 2001 (SSI 2001/212). No comments have been received from members on this negative instrument. The Subordinate Legislation Committee has no comment to make and no motion to annul has been lodged. It is therefore suggested that the committee make no recommendations on the instrument. Is that agreed?

Members *indicated agreement*.

The Convener: We move to the emergency affirmative instruments, the first of which is the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (West Coast) (Scotland) Order 2001 (SSI 2001/237). The Subordinate Legislation Committee has nothing to report. We are joined by Malcolm Chisholm, who seems to be an awfully long way away over there. Does anybody have any comments or questions on the instrument?

Mr Jamie McGrigor (Highlands and Islands) (Con): Is any research into the possible causes of the outbreak of paralytic shellfish poisoning under way? The disease seems to have been around the Stornoway area for a year or two, and has been there before. Is there any evidence of what has caused the outbreak? [*Interruption.*]

The Convener: The microphones are not working. Will the minister and Martin Reid please move to another set of microphones?

Mr McGrigor: I apologise for causing all this trouble.

The Convener: It is not your fault.

Can we now return to Martin Reid's answer to Jamie McGrigor's question?

Martin Reid (Food Standards Agency Scotland): I think that I can remember the question.

There has been quite a lot of research on toxins in general, not only on paralytic shellfish poisoning, but on amnesic shellfish poisoning and diarrhetic shellfish poisoning. The Food Standards Agency Scotland is spending about £1 million over the next three years on research into the causes of toxins and the ways in which we deal with them. So the answer is that there has been a fair commitment to deal with the problem.

Because PSP is particularly dangerous when compared with ASP at the moment, it is quite high on our list of priorities. However, the agency is being quite careful about the issue and we do not want to make too many commitments on changing

what we are currently doing. That is different from the situation with ASP, on which we have just issued a consultation document. However, as I said, large-scale research on the matter is on-going.

The Convener: As the Subordinate Legislation Committee has nothing to report on this particular order, I ask Malcolm Chisholm to move it.

Motion moved,

That the Health and Community Care Committee recommends that the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (West Coast) (Scotland) Order 2001 be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

The Convener: We come to the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (No 2) (Scotland) Order 2001. As the Subordinate Legislation Committee has nothing to report, I ask the deputy minister to move it.

Motion moved,

That the Health and Community Care Committee recommends that the Food Protection (Emergency Prohibitions) (Paralytic Shellfish Poisoning) (Orkney) (No 2) (Scotland) Order 2001 be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

Petitions

The Convener: We move to agenda item 4, which is a report on petitions. Annexe A of the report shows that three petitions have been referred to the committee for information only. If committee members want the committee to respond in some way other than merely to note the petitions, they may say so now. The petition from the Kirkcaldy area abuse survivors project has been passed to the Social Justice Committee so that substantive work can be done on it. It might be best to let the Social Justice Committee get on with it, and if members want to contribute they can do so through that committee. Is it agreed that we will simply note the three petitions?

Members *indicated agreement.*

Mary Scanlon (Highlands and Islands) (Con): There is a petition on Stobhill. There seems to be an on-going situation about the siting there of the medium secure unit and the removal of acute medical and surgical services. Should not we return to that petition, given that it relates to an on-going concern?

The Convener: I remind members of the position that we took previously, which is that despite having received several petitions about the acute services review and specific hospitals and trusts, it is not the best course of action for us to take on every petition. When we dealt early on in the session with the Stracathro and Stobhill petitions, we were careful to ensure that we looked at strategic issues, such as consultation and the involvement of staff. We did not second-guess the people on the ground with regard to acute services reviews.

There are a number of people round this table who will be particularly interested, not only in what is going on in Glasgow, but what is going on in Dundee, Perthshire, the Highlands and so on. If we get involved in every single acute services review or every decision to close a hospital or trust, what else in our work load will we get through? I am restating the position that we have taken all along. If the message went from the committee to petitioners that we will take on board every aspect of acute services reviews, we would not get any other work done.

Dorothy-Grace Elder (Glasgow) (SNP): I agree with that view in principle, but I wish to put it on the record that, like Mary Scanlon, I would like the petition to be a live petition. An indication should be given that we will keep a watching brief on the petition. We should bear it in mind that there are more than 40,000 signatures on the petition and that the acute services review that affects Stobhill and other hospitals in Glasgow is

the largest such review in Scotland.

On Stracathro, we commissioned a report from one of our members and interviewed witnesses, which improved the consultation process. However, most members would agree that we should not fade into the woodwork entirely and that we should maintain a watching brief to see whether the process continues to be fairer than it was initially at Stobhill, because it was not fair to the public at first. I request that we regard the petition as a live petition, and that we hear more about it as the months go on.

Mr John McAllion (Dundee East) (Lab): First, we should distinguish petition PE354, which is on the acute services review, from the previous petition on the special unit. Petition PE354 has nothing to do with the decision that was taken—or rather not taken—yesterday by Greater Glasgow Health Board.

The Public Petitions Committee still views petition PE354 as a live petition, although it is satisfied with the consultative method that Greater Glasgow Health Board has set up. A reference group has been established to consider all the options in the north of Glasgow, involving local MSPs, MPs and staff who work in the NHS in that area. If the reference group is unhappy with the way in which the health board conducts that review, it can come back to the Public Petitions Committee, which would forward the matter to the Health and Community Care Committee if it thought that such action was justified at that stage.

Mary Scanlon: I am satisfied with what the convener of the Public Petitions Committee has said.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): The manner in which the Public Petitions Committee has dealt with the petition is helpful. When we considered the petition on the siting of the secure unit at Stobhill, we said to Greater Glasgow Health Board that the consultation that it had undertaken was insufficient. We also recommended to the minister that the consultation process should be strengthened. I welcome the fact that yesterday's decision was made in light of our recommendation that the Stobhill consultation should be revisited. I am happy with the action that John McAllion mentioned.

09:45

The Convener: The petition has been sent to us for information and at this stage we should simply note it. The Public Petitions Committee will give us more information in due course.

We may wish to examine or obtain information about the acute services reviews that are happening throughout Scotland. Rather than examining individual issues, we could then consider the wider context.

Dr Richard Simpson (Ochil) (Lab): I did not receive a copy of petition PE367, which is from Mr Drummond.

The Convener: I did not receive a copy of it either.

Dr Simpson: We are lucky to have John McAllion with us. I would like to know why the petition has been referred to us for information purposes only; I am concerned about that. An increasing number of nationally important but small services fall under only one health board and are not funded appropriately. We may be required to investigate the principle of funding those services. However, I cannot tell why the petition was referred to us for information only, because we have not seen the papers.

The Convener: I seek clarification on whether committee members have received papers on the petition.

Mary Scanlon: I do not remember seeing any papers.

The Convener: I do not recall receiving any, either.

Mr McAllion: Perhaps I should say why the petition was referred in this manner. A number of committees criticised the Public Petitions Committee for referring petitions to them too readily, so it was decided that the Public Petitions Committee should do the initial spadework. In this case, we wrote to the Executive and the relevant health boards to ask for their response to the petition. When those responses are received, we will consider how to dispose of the petition. If we are not satisfied with the response, we will pass the petition on to the Health and Community Care Committee.

The Convener: We should probably deal with the petition in the same way as we dealt with the petition on the secure unit at Stobhill hospital. We will note that it is on-going and await the further information that the Public Petitions Committee has requested.

Margaret Jamieson: May I make a suggestion about future consideration of petitions? It is useful that John McAllion is a member of this committee, but other committees will not be told why they are being asked to note petitions. It would be helpful if we could receive an indication of the action taken by the Public Petitions Committee and an explanation of its recommendations.

The Convener: On a more administrative note, even though a petition has already been circulated, it would be useful if it were circulated

again with the meeting papers. We tend to misplace the odd paper now and then, given the amount of paperwork that comes to us.

Dr Simpson: Although John McAllion has heard our comments, could we communicate them formally to the Public Petitions Committee? I have been contacted by a number of organisations about small groups of people who suffer from particular diseases or conditions. Those organisations are concerned about current funding methods. Under the internal market, people could purchase treatment from a health board. However, the new system is much more cumbersome and funding has yet to be dealt with adequately. I have concerns—I put it no more strongly than that. Perhaps we could pass those points back to the Public Petitions Committee to consider and ask it to seek a response from the Executive on whether particular principles apply to the funding process.

Mr McAllion: When we raised that privately with Malcolm Chisholm, he said that, as a local constituency MSP, he, too, had written to complain about the service—to himself.

The Convener: We have had a partial success in Lothian as the funding has now been found. However, we have all received similar letters; on this occasion they seem to have borne some fruit. We will write back to the Public Petitions Committee with Richard Simpson's point that, although we are concerned about the specific problems of sleep apnoea, petition PE367 opens wider areas of concern. We will return to the petition when we have had further information.

Let us move on to annexe B, which lists on-going petitions. Petition PE320 is on the implications for health policy in Scotland of the World Trade Organisation's liberalisation of trade in services. Perhaps John McAllion can update us on that, as he is the reporter on that petition.

Mr McAllion: I have not been officially appointed as the reporter.

The Convener: Have you not?

Mr McAllion: No. However, I have been reading the papers that have been sent to me by the World Development Movement and the Health and Community Care Committee clerks.

The situation is complicated—as ever, there are two sides to the story. The concerns are not about the general agreement on tariffs and trade treaty that was negotiated with the WTO in 1994. The concerns that have arisen come from the on-going renegotiations. The supporters of the general agreement on tariffs and trade—the WTO, the UK Government, the American Government and the big multinationals across the world—are trying to allay everyone's fears by saying that there is nothing to worry about, because the GATT treaty defends the position of public services. However, opponents point out that that is not the case. The system is complicated. The GATT was created to remove trade barriers and to allow the expansion of trade and competition.

Given the recent general election and the indication from the Prime Minister that he is seeking greater involvement of the private sector in the provision of public services, it would be worth appointing a reporter to investigate the matter. I know that health is a devolved matter, but the move towards greater competition and private sector involvement could have implications for our health service.

Mary Scanlon: I propose John McAllion as the reporter, as he seems to have such an interest in the topic.

The Convener: If John McAllion is happy with that suggestion, do members agree to appoint him as the reporter?

Members *indicated agreement.*

The Convener: Petition PE283 calls for the Scottish Parliament to initiate a public inquiry into the practice of organ retention at post mortem. We are still awaiting comments from the Executive on the petition, so we will have to postpone its consideration.

Mary Scanlon: Can we have an update from John McAllion? I understand that petition PE283 was discussed at the Public Petitions Committee last week and that Lydia Reid gave evidence.

Mr McAllion: That was a different petition on the same topic. The Executive inquiry has not been published yet and we are waiting to see that before we decide on our next step.

The Convener: Am I right in thinking that the other petition is also heading our way?

Mr McAllion: It will be. When petition PE370 was before the Public Petitions Committee last week, we were told that the Scottish Organisation Relating to the Retention of Organs was no longer calling for a public inquiry. However, the petitioners pointed out that, although the head of SORRO had switched her position, the majority of people involved still wanted a public inquiry. We are still lacking a lot of information. The Public Petitions Committee should do more work on the matter before we pass it on.

The Convener: We will note the petition at this time. We will consider the petitions on haemophilia and hepatitis C later.

Petition PE145 is on vaccines and autism. The committee awaits the Executive's response on the measles, mumps and rubella vaccine. We hoped to have that before the recess, but it has not arrived yet. We were anticipating that we would

have comments today on the cancer plan, on hepatitis C and on MMR, but we have not received them. We were told that we would have the comments before the summer recess, so they might arrive later in the week. That is how things stand, although it is unfortunate.

Dorothy-Grace Elder: We set a deadline, did we not?

The Convener: The deadline is Friday, so the Executive is technically allowed until then to respond.

Dorothy-Grace Elder: The Executive is perfectly aware that this is the last meeting of the Health and Community Care Committee before the recess.

The Convener: I have been informed by the committee clerk that we set an earlier deadline, but that the deadline was changed at the Executive's request. We will write to the Executive to say that, although we accept that the revised deadline was Friday, it would have been useful for us to have had some comments today so that we could deal with them before recess.

There is a wider issue about the manner in which the Executive deals with requests for information from this committee. I do not know whether other committees meet with the same treatment, but the Health and Community Care Committee is constantly kept waiting for responses until the last moment or beyond. Members will see that, later in the agenda, we are dealing with a response from the minister on haemophilia and hepatitis C. We were asked to push back our deadline in relation to that response as well. Members can decide later whether that response was worth waiting for, but I do not think that it was. It is difficult for us to do our job if the Executive constantly flouts our deadlines for the receipt of information.

Dorothy-Grace Elder: It is especially problematic in relation to issues such as hepatitis C. The delay means that the patients groups and the interest groups that have worked hard on the matter might be kept waiting for another two or three months before they get a response. I think that the Executive's conduct is unacceptable.

The Convener: The responses that we are waiting for are special cases, as we are about to enter the summer recess, but we will pursue the matter nevertheless.

Shona Robison (North-East Scotland) (SNP): We should send two letters. One should raise our concerns about the MMR response and the other, which should be more strongly worded, should deal with the general issue of the time it takes to get a response. That letter should point out that a protocol has to be developed to ensure that responses are received in good time, particularly when committees are facing deadlines such as the beginning of summer recess.

The Convener: There is already a protocol that says that the Executive should respond within eight weeks. The clerk informs me that the Executive is not responding to us within that eight-week period. However, we would have to check how often the deadline is being missed before we sent a particularly strongly worded letter. The clerks and I will do that. My anecdotal view is that we are often kept waiting for information on important issues and that that has an impact on the clerks' ability to give us information in good time rather than on the day of a meeting.

Mary Scanlon: Petition PE145 has significantly wider issues, given that the uptake in the MMR vaccination rate is down by 2 per cent. According to reports in the press this week, there is an increase in autism. Many parents are waiting for the advice that they will receive in the report. If it cannot be addressed in eight weeks, we should at least get an update and a date by which all the issues can be examined.

Dr Simpson: We need to be clear about whether the Executive has broken the protocol. If that has happened, a strongly worded letter is appropriate.

10:00

The Convener: The Executive has broken the protocol.

Dr Simpson: Has it?

The Convener: Yes. Our deadline was 8 June, and it had been put back to suit the Executive.

Mary Scanlon: Given the general election, does the eight-week protocol still stand?

The Convener: The general election was nothing to do with us.

Mary Scanlon: That is what they all say.

The Convener: We can absolve ourselves of all blame.

We will move on. Later in the meeting, we will consider petition PE123 from the warm homes campaign. We will also look at PE217 from the Glenorchy and Innishail community council.

We move on to petition PE247 from the Epilepsy Association of Scotland. On 12 December, the committee agreed to await the acute services review before looking at services for the 30,000 people in Scotland who have epilepsy. However, the petitioner has asked us to look at the petition again on its own merits rather than in terms of the implementation of the acute services review.

Margaret Jamieson: Does that relate to the Scottish health plan?

The Convener: We have no further information on that.

Margaret Jamieson: We should have that information. We need to know whether we are talking about the Scottish health plan.

The Convener: Do members want to reverse the decision that we took on 12 December? If we want further information or notes to be provided by the Scottish Parliament information centre, we should make a decision today.

Dr Simpson: The problems are similar to the geographical question that was discussed earlier in relation to Stobhill. If we look at a particular disease group, we will have to look at every disease group. Are there any general principles that the committee wishes to look at in respect of a petition of this sort?

The general principle is that a minimum standard of service should be available across Scotland to all epilepsy sufferers. That principle applies to any disease group. In the light of the new performance assessment framework that was reported to us in the budget debates, I suggest that we write to the Executive asking what minimum standards it intends to set for the provision of services to epilepsy sufferers. That would at least allow us to establish a starting point for future decisions about investigations of the kind that are raised by PE247.

The Convener: That suggestion would tie in with some of the comments that we made in our budget report. We raised concerns that some services across Scotland vary in certain postcode areas. The example that we used was the availability of multiple sclerosis nurses—that example was symptomatic of the committee's wider concerns.

Are members happy with the suggestion that was made by Richard Simpson?

Members *indicated agreement*.

The Convener: We await the decision from the National Institute for Clinical Excellence in relation to petition PE223. The Health Technology Board for Scotland will then look at the suggestions that are made by NICE and add to them. We await both those responses.

Dr Simpson: I apologise if I am taking up time, but our timetable showed that NICE's second lot of economic investigations would be completed in August. The HTBS would then take six to eight weeks to comment on those investigations. I suggest that we write to the Executive to ask for confirmation of that timetable. We owe it to MS sufferers to be certain that there has been no further slippage in what is an already significantly delayed timetable.

Dorothy-Grace Elder: Could we write direct to NICE and ask it?

The Convener: At this stage, all we need is the information on the timetable. It is probably best to get that from the Executive because the issue involves not only NICE, but the HTBS, as it will do work following the NICE judgment. Writing to the Executive would be the most effective course of action. Are we agreed?

Members *indicated agreement*.

Contacts

The Convener: From time to time, people contact us with proposals to brief or give evidence to the committee on their work. We have a number of requests and we can approach them in a number of different ways.

The Scottish Executive physical activity task force and John Beattie, who heads up the task force, would like to brief the committee on the task force's work. I am sure that members think that the amount of physical activity in which children are engaged—certainly at school level—is important.

Margaret Jamieson: Would it be of benefit if we invite the Education, Culture and Sport Committee to a briefing if we agree to one? Could we have a joint briefing, given that it would cover both areas?

Mary Scanlon: If we are considering public health, could we include the briefing? We have a busy agenda for the forthcoming year, but I hope that we do not lose sight of public health. Perhaps we could include the briefing in a day with Phil Hanlon or others to get an update on public health.

The Convener: I echo comments from colleagues, and from Mary Scanlon in particular. There might be some mileage for the committee in considering the wider public health agenda and having a briefing that would include the briefing that is proposed. Margaret Jamieson made a point about opening up the briefing. Do committee members wish to do that in open session of the committee or to have an informal, round-table discussion?

Dorothy-Grace Elder: We should have an informal discussion. Perhaps we could have an advance briefing sheet. It is always good to have something in writing.

The Convener: If the committee is thinking of an informal briefing on a range of public health issues, such a briefing might also include issues relating to public health nurses and school nurses. An update on such issues might be good. The clerks could prepare something for after the summer recess.

Clydeside Action on Asbestos is asking for the issue of clinical trials for those with mesothelioma to be included and noted within the cancer plan. At this stage, that is within the Executive's remit rather than that of the committee. I would be happy to write to the Executive on behalf of the committee to point the matter out and ask that the Executive make reference to the matter in the cancer plan. Is that acceptable?

Members *indicated agreement*.

The Convener: Greater Glasgow Health Board has offered to brief the committee on the plans to modernise Glasgow's acute hospitals.

Margaret Jamieson: I would have concerns if we were to accept the offer. We would find that every health board area would want to discuss such plans. That could compromise the committee at a future date.

Dr Simpson: I agree with Margaret Jamieson on the general issue of the acute services review in relation to Glasgow, but there is another issue on which we might want to brief ourselves. Hospitals in Glasgow, Edinburgh and Dundee provide services to a much broader group of individuals than do hospitals in other areas. Constructing services within an acute services review is a major problem when, for example, Greater Glasgow Health Board provides services to Lanarkshire Health Board, Ayrshire and Arran Health Board, Argyll and Clyde Health Board and Forth Valley Health Board. I would appreciate an opportunity to hear from Professor Hamblen, or from somebody else, on how it is proposed—within an acute services review that is based on an individual board—to undertake the strategic review that will be necessary for providing those services.

Mr McAllion: I agree with Richard Simpson. My main interest is in the acute services review in Tayside Health Board. That is of much more interest to me than the Glasgow review. However, there is a national problem. Clinical standards are being raised all the time and more expensive equipment is required. We are seeing big, mega, superhospitals—teaching hospitals. Those are currently based in health board areas that simply cannot sustain them. That is the case in Tayside and, indeed, in Glasgow, which is leading to the pressure to close Stobhill general hospital and other places. Something is happening that almost demands a shake-up in the way that we run the national health service. The problems in Glasgow and Tayside are symptomatic of that. This committee should be addressing the problem.

Dorothy-Grace Elder: Professor Hamblen has offered assistance and that is good. We may not be inundated with requests from other areas. We must bear in mind that Chris Spry, the chief executive in GGHB, is leaving, and that Professor Hamblen is chair of the board. It is good that he has taken the initiative to reach out to us. I do not think that we should turn him down. We have an opportunity.

The Convener: Richard Simpson and John McAllion's points covered issues that go wider than the acute services review. They were about how services are provided across Scotland. Because of other work, we did not take the opportunity when the national plan was published to ask the minister about it. After the summer

break, when things will have settled down a bit, we should perhaps invite the minister so that we can hear a progress report on the national plan. We would be able to ask specifically about acute services, and we would also be able to decide on other people that we might want to take evidence from. We could cover members' concerns in that way. It was unfortunate that, because of the time that was required for the legislation that we were working on, we did not have the time to focus on the national plan.

I have a certain amount of sympathy for Dorothy-Grace Elder's point, simply because we have been quite critical of the consultation carried out by Greater Glasgow Health Board, and rightly so. Other colleagues may know more than I do about the situation in Glasgow, but it seems that the health board has changed the way in which it consults and has become more open. The health board has made us aware that it has done a lot of extra work in the intervening months.

If it would be an acceptable compromise, I would be happy to meet Professor Hamblen on behalf of the committee. In that way, we could get updated information and GGHB would have an opportunity to brief the committee.

Members *indicated agreement.*

Dorothy-Grace Elder: Convener, could a Glasgow member of the committee be present? We have to bear it in mind that Glasgow contains one national hospital—the royal hospital for sick children at Yorkhill. Glasgow is the biggie in all acute services reviews.

The Convener: I do not know whether other members wish to comment. My suggestion is that, although when we walk through the door we bring our own experiences and views, we work as a committee. I could meet Professor Hamblen over the summer recess so that he did not have to hang around for months until we returned. The committee recognises that Greater Glasgow Health Board is continuing with work that follows from work that we did.

Shona Robison: I suggest that if you set a date, you could e-mail members about it. Members who were available could then accompany you to meet Professor Hamblen. It would also be a good idea to question the Minister for Health and Community Care about aspects of the national plan.

The Convener: I am happy with both Shona Robison's suggestions. Is everyone else happy?

Margaret Jamieson: I want to clarify a point that Dorothy-Grace Elder made. The sick kids hospital in Glasgow is not the only sick kids hospital in Scotland. There are another two. I say that so that we do not get mixed up.

Dorothy-Grace Elder: I am well aware of that, but the hospital in Glasgow is a national hospital.

Margaret Jamieson: That is the point. It is not a national hospital.

Dorothy-Grace Elder: It takes people from everywhere and especially severe cases that are passed on.

The Convener: It is like many hospitals—it has specialisms and accepts patients from throughout the country, just as the Edinburgh sick kids hospital takes patients from outside Edinburgh. We should not get into a discussion about which hospital is the most national. All the hospitals do great work. A visit next week to Yorkhill sick kids hospital was organised for me yesterday. I will do a night shift with a paediatric nurse, so I will see for myself what people get up to there.

Do members agree to the proposals?

Members *indicated agreement*.

10:15

The Convener: An update on hospital-acquired infection has been prepared by the Scottish Parliament information centre.

I am sorry; I have missed out a contact. The Health Technology Board for Scotland has offered us an informal question-and-answer session. I am open to suggestions about that—are there any views? We have had an informal briefing from HTBS, the clinical resource and audit group and all the other bodies such as the Clinical Standards Board for Scotland. I have some concerns about the way in which the HTBS is developing, which picks up on comments that a range of organisations has made to me.

It would probably be useful for us to have an update on developments. We are in a different situation from that which some of us had expected to deal with, as the HTBS will not end postcode prescribing and it is suggested that the HTBS will rubber stamp something that NICE produced. I would like to ask the HTBS for the facts on whether the suggestions that are being made are correct and I am happy to meet the HTBS. If other members are available at the same time, we can all meet its representatives, or we can have an informal briefing that is more akin to those that we have had before.

Mary Scanlon: The organisations are all new, but when I saw that the HTBS was this year examining positron emission tomography scanners, alcohol intervention and digital eye cameras for diabetic retinopathy, I thought that those were issues for the Clinical Standards Board. I am confused about why the HTBS is not considering drugs or therapies. There is some overlap. Should not the Clinical Standards Board

examine PET scanners, a protocol for alcohol intervention and which digital eye camera is best?

Dr Simpson: No. The HTBS examines the technology and finds out what it is appropriate to use PET scanners for. The Clinical Standards Board will then say that a PET scanner should be used as part of the protocol for that clinical condition. The two things are separate.

For example, there are different ways in which fundal examination of diabetics can be done; there are different types of cameras. Mobile laboratories are used in Tayside. Are they of an adequate standard? Do they meet the requirements of modern technology? That is the HTBS's role. The requirement for fundal examination of diabetics would be a matter for the Clinical Standards Board and would be part of a Scottish intercollegiate guidelines network guideline. The two roles should be complementary; they should not overlap. The point that is perhaps being hinted at is that now that the new organisations are in place, which is excellent, we must ensure that they are being co-ordinated and that the centre is overseeing them effectively. I am not convinced that that is happening yet, but it may be too soon for it to happen.

The Convener: There are two options, the first of which is that the committee has an informal meeting with the HTBS. The other option is that I arrange to have a meeting with the HTBS and, as with the Greater Glasgow Health Board meeting that we have just discussed, if other members of the committee are available, they can come along.

Mr McAllion: In the letter, the HTBS suggests next spring for the meeting.

The Convener: The letter referred to this spring.

Mr McAllion: Yes. The letter is dated December 2000.

The Convener: We have sprung over them.

Shona Robison: I favour the informal question-and-answer session. It is some time since we met the HTBS, and it would be useful to have an informal meeting in that format.

The Convener: We will opt for the informal briefing. We will inform the HTBS of that decision.

The next matter for us to consider is an update on hospital-acquired infection. Andrew Welsh suggested that there should be an investigation of that issue and there may also have been a petition about it. Hospital-acquired infection is an important issue for all of us. There has been some debate about the numbers involved, but any of the numbers that have been bandied about—on the number of people infected, on potential fatalities and on the financial cost to the health service—are cause for great concern.

The committee has three options. Do we want to appoint a reporter to develop the work that has been done so far, which has been done by the researchers? Do we want to take evidence on the issue, or do we want to leave the issue in abeyance and perhaps come back to it at some point?

Dr Simpson: Going back to first principles, I recall that in one of the committee's discussions soon after the Parliament was formed, it was suggested that we should consider the timetable of Audit Scotland reports and ask that body when it would be appropriate for us to inquire whether it was reviewing the matter in question. We would also ask whether the Executive had carried out those reports' recommendations, and we could choose to carry out an investigation.

The Auditor General's report, "A clean bill of health? A review of domestic services in Scottish hospitals" is now more than a year old. We should contact Audit Scotland and ask what it is doing about the report. We should also ask the Executive what steps it has taken to implement the report's recommendations. We should do that for all the reports at the same time. The operating theatre report is important in relation to waiting times and waiting lists, and I am not convinced that it is receiving the attention that it should receive at local level.

The Convener: I had forgotten that we had written to Audit Scotland when we discussed the issue previously and asked for that information. We are still waiting for a response. We can pick up on Dr Simpson's point about the operating theatre report.

Apparently we wrote to Audit Scotland in April. We will chase up that information.

Margaret Jamieson: My understanding is that every hospital trust must provide a report on "A clean bill of health?" by this August.

The Convener: Okay. We can check that. Did that requirement follow an instruction from the Executive to all trusts?

Margaret Jamieson: Yes. As a result, when we write to the Auditor General, it might well be of benefit to ask the Executive for an update. That would give us further information to consider before we make a decision.

Mary Scanlon: I welcome that suggestion. After writing recently to all health trusts, I discovered that there is no agreed definition of hospital-acquired infection. We need an update on the working group's three recommendations.

The Convener: A working group that was set up to examine surveillance was meant to report in March, but as yet there has been no indication of when we will hear from it. Perhaps we could also

ask the Executive about that.

Mary Scanlon: There are clear figures for hospital-acquired infections in England, whereas we seem to be having difficulty in gaining those figures for Scotland. I would certainly welcome an update on that point.

The Convener: We will ask Audit Scotland and the Executive for updates on all those issues.

Dorothy-Grace Elder: Mary Scanlon is quite right. Hospital-acquired infections fall outside the current net of notifiable diseases, because a person with such an infection dies of some other disease or contracts some other severe problem. There is also a problem with death certificates. The policy must be tightened up, and any mention of suspected hospital-acquired infection must be added to death certificates. That issue would have to be dealt with by individual health boards deciding on some kind of national policy.

The Convener: Are we agreed to ask for the information that we have discussed and then, on receipt of that information, to decide how we will proceed with the matter? The various points that committee members have raised will be covered in any further work that we might undertake. For the moment, are we agreed to elicit information?

Members *indicated agreement*.

The Convener: That brings us to the end of the public part of the meeting.

10:26

Meeting continued in private until 12:28.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178