HEALTH AND SPORT COMMITTEE

Wednesday 27 June 2007

Session 3

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by RR Donnelley.

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HEALTH AND SPORT COMMITTEE
2nd Meeting 2007, Session 3

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Ross Finnie (West of Scotland) (LD)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Karen Gillon (Clydesdale) (Lab)
*Lewis Macdonald (Aberdeen Central) (Lab)
*Michael Matheson (Falkirk West) (SNP)
*Ian McKee (Lothians) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE SUBSTITUTES

Joe FitzPatrick (Dundee West) (SNP)
Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

*attended

THE FOLLOWING GAVE EVIDENCE:

Nicola Sturgeon (Deputy First Minister and Cabinet Secretary for Health and Wellbeing)
Dr Kevin Woods (Scottish Executive)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

SENIOR ASSISTANT CLERK

Douglas Wands

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Wednesday 27 June 2007

[THE CONVENER *opened the meeting at 10:16*]

Interests

The Convener (Christine Grahame): Good morning, and welcome to the Health and Sport Committee's second meeting in session 3. No apologies have been received.

For agenda item 1, in accordance with section 3 of the code of conduct for members of the Scottish Parliament, I invite Karen Gillon and Michael Matheson to declare any interests that are relevant to the committee's remit.

Karen Gillon (Clydesdale) (Lab): I refer members to my entry in the "Register of Interests of Members of the Scottish Parliament", which shows that I am a member of Unison, patron of Clydesdale Autism Support Group and an honorary member of Clydesdale arthritis support group.

Michael Matheson (Falkirk West) (SNP): I refer members to my entry in the register of members' interests. I continue to hold my state registration with the Health Professions Council as an occupational therapist.

The Convener: I welcome Michael Matheson back after his paternity leave.

Decision on Taking Business in Private

10:17

The Convener: Item 2 is a decision on whether to take in private item 7, which relates to the committee's away day. Do members agree to take that in private?

Members *indicated agreement*.

Scottish Executive Priorities

10:17

The Convener: For agenda item 3, I welcome to the committee for the first time Nicola Sturgeon, the Cabinet Secretary for Health and Wellbeing, and her official, Dr Kevin Woods, who is the Scottish Executive's director-general of health and the chief executive of NHS Scotland. I invite the cabinet secretary to make a short opening statement.

The Deputy First Minister and Cabinet Secretary for Health and Wellbeing (Nicola Sturgeon): I apologise if my voice starts to go—it is beginning to feel the strain. I admit to slight trepidation at appearing before two former health ministers, but I am sure that they will be gentle with me.

I thank the committee for the opportunity to appear before it. This is my first appearance here as the Cabinet Secretary for Health and Wellbeing and I hope that it will not be the last, because I look forward to a constructive relationship with the committee as we face up to some of the challenges that lie ahead.

I will outline my initial priorities for the health and well-being of Scotland. The whole Government and I are committed to taking serious and sustained action to improve Scotland's health. We all know that we face significant health challenges and I will not take up too much of the committee's time by reiterating the dire statistics on our poor health—I dare say that we are all uncomfortably familiar with them. However, I will briefly mention key matters that I see as early priorities to improve Scotland's health in the short term and—possibly more important—in the longer term.

As a new Government, we will do more to tackle mental health issues and we will make dementia a national priority. We will refocus our actions on and our approach to tackling poverty and the growing health inequalities in Scotland. We will look afresh at the issues that face us in delivering health services to our remote and rural areas, where one fifth of our population lives. We will encourage increased participation in sport and physical activity to improve health. We will work in partnership with stakeholders to improve the position of the thousands of carers in Scotland. We will look to deal more effectively with the growing twin problems of alcohol and drug misuse.

I will speak briefly about the actions that we will take to ensure that the national health service, which is Scotland's biggest public service, continues to deliver first-class publicly funded services. Those services are of crucial importance to people in Scotland, who rightly expect

standards to be maintained and improved. I am particularly keen to foster a culture of continuous improvement in the health service. In that aspect of my portfolio, the early priorities will be to continue to drive down waiting times and to continue to ensure that services are provided as locally as possible—I have already spoken about the new presumption against centralisation of hospital services.

We will ensure that dentistry, in particular NHS dentistry, receives the attention that it deserves. We want to ensure that patients are at the centre of the NHS and, in particular, at the centre of NHS change. We believe that patients are not barriers to change, but are the drivers of it. We are determined to develop community health partnerships. I believe passionately that they are crucial in helping to bridge the divide between primary, secondary and social care. We will look to focus the health service on the delivery of key targets. Given the rise in the number of people in Scotland who live with long-term conditions, we will work hard to improve services for those people.

As members know, I will make a speech to Parliament tomorrow to kick off the debate on the healthier Scotland agenda. In that debate and, I hope, in answering questions this morning, I am happy to set out in more detail my early programme as cabinet secretary. However, big though my portfolio is, if we are to be really successful in improving health and our health services, there is still a need to work across portfolios and to work hard with our partners. I think of that work as one of the building blocks of my approach. I will seek opportunities to build consensus, both in the Parliament and outwith it, so that we can together meet our objectives for a healthier Scotland. As I said at the outset, I look forward to working with the committee to achieve those objectives.

I am more than happy to answer detailed questions on the points that I have raised about my early priorities but, with your permission, convener, I will first give members some fresh and up-to-date information on junior doctors. Several members, including members of the committee, have written to me on the issue, so I know that what I have to say will be of interest. It is appropriate that the committee hears the information first.

I hope that the members of the committee who were involved in the previous Administration agree that the principles that underpin modernising medical careers—MMC—are sound and are the right ones. However, we cannot escape the fact that serious issues have been raised about the implementation of the new system. Two key concerns have been raised, one relating to service delivery and the other to the prospect of unemployed junior doctors. I will deal first with service delivery. In Scotland, we opted to recruit trainees in one round, rather than the two rounds in England. That means that we have currently filled about 98 per cent of all run-through training posts and about 65 per cent of the shorter fixed-term specialty training appointments. The process is not yet complete, but that level of recruitment will already ensure continuity of patient services throughout the NHS from 1 August, which is important.

I know that many members will have heavy mailbags on the issue of junior doctors without training posts. I will make three preliminary points before I give an update on the numbers that are involved and the action that I propose to take.

First, in a highly competitive profession such as medicine, not every applicant will be—or ever has been—able to secure a training post in the specialty or in the location of their choice. Secondly—this is an important point, which I think has been missed in some of the headlines—the absence of an offer of a training post does not always translate into an unemployed doctor, because some applications will have been made by doctors who are already employed in non-training posts, such as staff grade posts, who will continue in those positions after 1 August. Thirdly, the committee will be interested and, I hope, pleased to learn that of all the applicants who have secured specialty training posts in Scotland, 80 per cent are Scottish graduates.

However, NHS Education for Scotland's latest estimates suggest that there are approximately 450 junior doctors currently in Scottish training programmes who have yet to secure an offer of continued training under MMC. Some 240 training posts remain to be filled in Scotland, so I expect that figure to reduce over the next few weeks, but I accept that there will be some junior doctors who, at the end of the Scottish process, will be without posts and who would therefore, in the absence of intervention, face unemployment on 1 August. To ensure that those doctors have continuity of employment during round 2 of the recruitment process in England, when they will have the opportunity to apply for one of the 2,700 posts that will be available, I have decided that their contracts will be extended until 31 October or until they secure a training post, whichever is the earlier. That is consistent with the position in England and it represents fairness for our junior doctors.

I am committed to reviewing the situation again towards the end of round 2 in England, when, in conjunction with NES, the British Medical Association and the service, I will consider what further measures might be needed to support

doctors in Scottish training programmes who have still not been offered a training post.

Finally, I will say a brief word about the future of MMC. As I said, I think that the principles behind it are sound but, despite sterling efforts on the part of officials here, the implementation has left a lot to be desired. I am determined to do what is right for Scotland, so I will look to adapt the selection and recruitment process so that in future it better serves Scottish interests and ensures that we continue to attract the best possible candidates for the health service.

Thank you for your indulgence, convener; I thought that the committee would be interested to know the up-to-date position on junior doctors.

The Convener: I thank the cabinet secretary for providing that part of her statement in advance, which will now be distributed for scrutiny by the committee. I realise that that is not usual practice, but I thought that it would be helpful. Karen Gillon will ask the first question.

Karen Gillon: Cabinet secretary, I want to probe your legislative priorities for the coming year in a bit more detail. The committee will hold an away day in August and it would be helpful for us to know the timeframe and likely content of the legislation that you propose to introduce in the year ahead.

Nicola Sturgeon: I will try to be as helpful as I can be, but the Government's programme, including legislation and other action, will be published after the summer recess, so I am not able to be precise about specific bills or the timescale.

However, I can mention three bills that I hope to be in a position to introduce in the first year. First, as I say in an answer to a parliamentary question today, tomorrow I will launch the consultation on the Commonwealth games bill, which will be introduced on 9 November. If—hopefully, when—Glasgow wins the bid for the Commonwealth games, that bill will be required to progress the games bid.

Secondly, I hope to introduce a public health bill, which will be designed to update our public health legislation, much of which is contained in very old statutes. There is a need to consolidate and update that legislation to ensure that we are properly equipped and that there are clear lines of accountability when it comes to dealing with public health issues.

Thirdly, I hope to be in a position to introduce a local health care bill, which would deal with, among other things, our proposals for advancing our commitment to elected health boards.

Karen Gillon: Are the public health bill and the local health care bill likely to come to the committee early in the new parliamentary session?

10:30

Nicola Sturgeon: Because the legislative programme has not yet been published, I cannot give a precise timescale, but I undertake to give the committee as much information as I can, as early as possible. I was a member of the Health and Community Care Committee in the first session of the Parliament and I know how important it is for the committee to have a proper understanding of its likely legislative burden, so that it can plan other work that it wants to do. I apologise for not being able to be more precise.

Karen Gillon: Shona Robison, the Minister for Public Health, said that she wants to raise the legal age for buying tobacco products to 18. How will that happen and what is the timeframe for that work?

Nicola Sturgeon: That will be done through secondary legislation, and we have already made the draft order. The change was in train when we took office—I give credit to the previous Administration for that. We wanted to continue the policy and to take action early on it.

The Convener: We will probably deal with the instrument at our first meeting after the recess, subject to our discussions later.

Lewis Macdonald (Aberdeen Central) (Lab): Welcome, cabinet secretary. As you said, one or two members of the committee have been in the position that you are in. I understand how the committee looks from your point of view. We will be as gentle and constructive as circumstances permit.

I welcome a number of your comments, in particular your announcement on MMC. On Friday evening I attended a meeting in my constituency with some 60 junior doctors and a number of senior doctors and representatives of NHS Grampian. It was clear that an extension of contracts on a temporary basis would help trainees who are anxious to remain in Scotland but have not yet been offered a post. Your announcement will be welcomed by those trainees.

I am interested in your views on one or two other matters, which came up during the meeting. I intended to bring those matters to your attention, and I can do so a little earlier than I had planned. Partly because of the efficiency with which the system was introduced in Scotland, many posts in Scotland were filled earlier than posts south of the border, as you said. Greater flexibility might be helpful to junior doctors who have been offered a

trainee position. I would welcome your comments on a couple of specific points, either today or in response to today's discussion.

First, could applicants specify the deanery of their choice, rather than just specify Scotland as their region of choice? Perhaps the making of local appointments in the next round of MMC would provide a good opportunity to apply lessons that have been learned about the system.

Secondly, given that many posts in Scotland were filled earlier than posts elsewhere in the United Kingdom, a number of junior doctors in my constituency suggested that a mechanism might be devised whereby people who have accepted an offer in one part of the country, but have a preference for working in a different part of the country, could exchange offers. For example, an applicant who had applied for posts in East Anglia and Scotland but whose preference was to work in East Anglia might swap with a person whose preference was to remain in Scotland but who had been offered a post south of the border. The junior doctors' suggestion received support from their senior colleagues. Will you respond to such suggestions, which would improve outcomes for doctors by enabling them to take up posts in the areas in which they want to work and to train in their preferred specialties?

Nicola Sturgeon: I thank Lewis Macdonald for his questions and for welcoming the action that I have taken today. We have done extremely well in Scotland to mitigate some of the worst effects of the implementation of MMC. I pay tribute not just to the previous Administration, but particularly to the chief medical officer, who has worked incredibly hard to make it work. In spite of that, some serious issues have arisen, and we have to work through them.

We will pick up all the issues that Lewis Macdonald has raised in the review of the first year of MMC, including the ability to apply to different deaneries, increased local flexibility around appointments and the matter of job swaps, to use the shorthand. There is certainly a willingness to change those things and put them right if that proves necessary. There is a healthy cross-border flow of doctors, and we would not wish to restrict that. We must look to keep our links with UK training and to keep our timescales aligned to facilitate that flow. We must ensure that the selection and recruitment systems serve our best interests; I am not sure that that has always been the case over the past year. I am determined that we will do whatever we can to get it right in future.

Lewis Macdonald: I welcome Nicola Sturgeon's affirmation of the importance of having a cross-border flow of doctors. We would all want to protect the ability to recruit doctors across the border.

May I ask a further question on a slightly different issue?

The Convener: I would like first to ensure that other members do not wish to come in on this topic. Do you wish to do so, Mary, or do you have a new issue to raise?

Mary Scanlon (Highlands and Islands) (Con): I have a question supplementary to Karen Gillon's point, and one to Lewis Macdonald's point.

The Convener: Mary Scanlon and Ross Finnie can come in with their supplementary points on this topic. We have Ian McKee's name down, too.

Mary Scanlon: My supplementary question follows the points that Karen Gillon was making about legislation.

The Convener: We will leave that for now. I want to continue with supplementaries on MMC.

Mary Scanlon: I would be happy to continue with one of those first.

The Convener: You do that first, then. I want to keep to the topic of MMC for now.

Mary Scanlon: Like other members, I welcome the announcement about the continuity of employment. There has undoubtedly been a huge amount of uncertainty and anxiety. I have two questions, although my second one has almost been answered already. The previous Executive announced 600 consultant posts. That does not just concern junior doctors. From my mailbag and e-mails, it seems that many doctors have gone through the process and have reached this summer, having done 12 or however many years of training, yet, at the point when they might have expected to get a consultant post, the posts are just not there. There is a fear that many doctors in that position will almost be expected to do consultant work anyway, given their training, abilities and experience. This is not just from me; it is from what doctors have said. They suggest that, because of the cutback in consultant posts—which might be because of the cost of consultant contracts—the opportunities to become consultants are getting cut back. The previous Executive had a target of 600 new consultants, which I understand was dropped. Do you have a target, cabinet secretary? Are you aware that many people at that stage in their career are feeling quite demoralised?

My second question was about the review, although I think that you have already answered that point. I wanted you to assure us that this year's glitches in the system will be overcome. That is an on-going issue.

Nicola Sturgeon: That is certainly my intention. I am open to suggestions and input from the committee to help us get the review right.

I wish to clarify one issue on the matter of consultant posts. The previous Administration abandoned the target of 600 additional consultants. However, there has been no reduction in the number of consultants. In fact, that number is going up—although it did not go up enough to meet the target of 600. A further issue that we must face is the filling of consultant vacancies. We are taking a variety of steps in our department, working with health boards, to ensure that vacancies are filled as quickly as possible.

I am actively considering whether or not to have a new target for the number of consultants. We must take various factors into account, many of which members have mentioned this morning. One side of the equation is ensuring that, as we train more doctors—more students are entering medical schools and the number of training posts has increased by 150 this year and is anticipated to rise next year as well—adequate opportunities are available to doctors as they go through the system. The other side of the equation is ensuring that we get the needs of the service right. All boards need to submit workforce plans, which are being analysed at the moment. We will take a long, hard look at those before deciding on a course of action that is right in the round. The issue is under active consideration at the moment.

Mary Scanlon: Is it, therefore, possible that some of the health boards and the royal colleges were working towards a target of 600 and that they recruited and planned in order to achieve that target? If so, might that mean that many of the doctors coming through the system with expectations of becoming a consultant this year will find that the jobs are simply not available?

Nicola Sturgeon: I suspect that that is not the case, for reasons that I could go into. I am not sure that health boards were all planning to meet that target of 600. Other people around this table might be able to throw more light on that than I can, but that might be an issue in terms of meeting the target. It is important to remember that, although it is easy for a health secretary to set a target for the number of consultants, we have to ensure that that target is right for the needs of health boards and that the medical students that enter the system have appropriate opportunities later in their careers. That is not an easy balancing act but it is one that we are determined to get right.

Ross Finnie (West of Scotland) (LD): Like Lewis Macdonald, I welcome the steps that you are taking to alleviate the difficulties caused by the implementation of MMC, which will undoubtedly be beneficial in the long run. I remain concerned about certain aspects, however. You make the point that not everyone always got a consultancy post. However, the delays in the system mean that the job opportunity issue remains a real problem for people who wish to go into consultancy.

In other words, although it is all very well to say that people might not necessarily have got a post, if people had been aware, at an earlier stage, of what options were available to them, that talent might not have been lost to Scotland as it could have been put to use in a different sphere of medicine.

Although I welcome what you say, I will just mention the fact that, over the weekend, I was contacted by two people who have been offered opportunities abroad—one in North America and one in Australia—and, because they are frustrated with the system here, are likely to accept them. I am sure that other members' postbags have received similar communications. That is concerning, in terms of a loss of talent. I am not suggesting that those people would have necessarily qualified for a consultant post but, as Mary Scanlon and the convener did, I point out that they have eight to 10 years' training.

In addition to extending their contracts, are you or is your department able to do something to help those people find employment? I am not aware of our having a surfeit of doctors. Can we minimise the numbers of doctors who might leave the country? How do you intend to disseminate the important announcement that you have made to the individuals who have been most affected?

Nicola Sturgeon: The announcement that I have made first, rightly, to the Health and Sport Committee, will be communicated today to BMA Scotland and information will be made available today on NES's website. It is important to put on record my thanks to NES, which has been working extremely hard to ensure that it is on top of this situation. The reason why I am able to give you such up-to-date information is down to its efforts, not mine.

Of course it is concerning if doctors are leaving this country, not because they want to go elsewhere, but because they cannot find opportunities in Scotland. That said, we should not forget that we have always been a net exporter of doctors, although I do not want any junior doctor to feel that they are being forced to leave Scotland because of a lack of opportunity. The profession is highly competitive, as are many others—there are no job guarantees in the modern world—but I want to ensure that our skilled junior doctors get the opportunity to work in our health service, because that is right for them and for the service.

10:45

Ross Finnie is right to point out the particular

problems this year, which arose not just because of the delays that we know about and the implementation problems, but because of the attempt to absorb a cohort of junior doctors into the new system. We have always been clear that that is not necessarily a one-year job and that people who have not been successful this year in their chosen specialty and location will have opportunities next year, too.

I said specifically in my opening remarks that, as well as extending contracts until the end of October, I want to review the situation again as we get closer to that date. I am confident that the figure of 450 junior doctors will come down considerably because, as I said, about 240 Scottish posts are still to be filled—not all of them will necessarily go to Scottish applicants, but a proportion will. Further, I hope and expect that many Scottish applicants for posts in England will be successful. When we are closer to the end of October, I will re-examine the situation to find out how many junior doctors who are in training programmes have not secured a training post. In consultation with NES, the BMA and—importantly—the people who have to deliver the service, I will then consider what else we can do to give them the support that they will no doubt want at that stage.

Ian McKee (Lothians) (SNP): I, too, welcome the cabinet secretary and thank her for coming to the committee so early in the session, which I believe is unprecedented. I welcome her statement, which will alleviate the worries of the great many junior doctors for whom the prospect of becoming unemployed suddenly loomed on the horizon. We should congratulate her on dealing so speedily with the situation that she inherited and on doing so in such a forthright way. There will now be a pool of doctors whose contracts are guaranteed until 31 October who otherwise would have been unemployed. By the nature of things, those doctors will be distributed fairly haphazardly throughout the country. Does anyone have ideas about how that medical talent can best be utilised for the benefit of the NHS in the period for which their contracts are guaranteed, or is the period too short?

Nicola Sturgeon: It is ultimately for health boards to decide how to deploy staff to deliver the service; it is not for me to place doctors in particular posts in hospitals. I know that health boards will think about that.

Dr Kevin Woods (Scottish Executive): We need to know how many doctors we are talking about, but we will not know how many and where they are until the end of October. We must consider the matter in that context. We need a bit more detail on the numbers and the distribution.

Nicola Sturgeon: That applies to the doctors whom we will deal with after October. The 450 whom we have now will be deployed by health boards as they see fit.

Malcolm Chisholm (Edinburgh North and Leith) (Lab): I warmly welcome Nicola Sturgeon to the committee and I warmly welcome many of her comments. To latch on to one that I particularly liked, she said that community health partnerships will be crucial in bridging divides between primary, secondary and social care, which is one of the main reasons why those bodies were set up. That point illustrates the main theme that I want to pursue, which will broaden out the discussion from the issues to do with MMC. I will talk about the extent to which the cabinet secretary's comments in the past four or five weeks represent continuity or a departure from previous policy.

From where I sit, I see a great deal of continuity, which I welcome. However, there are three areas in which there might be a difference and where Nicola Sturgeon has tried to present a difference. First, she said today that there is a new presumption against the centralisation of hospital services. Is that a new presumption or was it not, in fact, central to the Kerr report, which the previous Administration accepted?

Secondly, I was interested in the cabinet secretary's speech to the NHS Confederation, which I remember speaking to three years ago. Her headline message to it was that in Scotland we are opposed to

"the use of public money to help the private sector compete with the NHS."

Is that really a change in policy? Has public money ever been used for that purpose? My understanding of the decisions of all previous health ministers is that such money was used to create extra capacity when required. Was it ever used to help the private sector compete with the NHS? What I am saying is that I have no quarrel with her remark.

My third point is on what the cabinet secretary said about general practitioner hours flexibility. Everybody welcomed that in principle, but everybody also saw the difficulties in bringing about change. I would welcome substantive comments on how she intends to pursue that objective and on whether she accepts my interpretation of the other two comments.

Nicola Sturgeon: I can probably characterise my approach in three broad categories. First, there are areas in which continuity is definitely appropriate. I have no problems putting on record the fact that we have inherited a health service that is in reasonably good shape. That is not to say that everything is fine and that change is not

necessary in some areas, but I think that the health service is in not bad shape.

Malcolm Chisholm mentioned last week's NHS Confederation conference. I dare say that some in the English service would look quite enviously at the position that we find ourselves in here. As the new health secretary, I am not in the business of ripping up things that the previous Administration did for the sake of it. I want, when possible, to have continuity.

My second category is policies that were introduced under the previous Administration that I want to develop. Community health partnerships fall into that category. I see them as the route for bringing about a lot of what the Kerr report said in relation to shifting services into primary and community care and making much more use of anticipatory care—which, as we face up to long-term conditions, an ageing population and the health inequalities in our country, will be increasingly important. That is where I would like to see some development.

The third category is areas in which I might do things a bit differently. Malcolm Chisholm raised three issues, which I will take in turn. On the presumption against centralisation, he is spot on. Kerr articulated a presumption against centralisation, but it has not always been applied as it should have been. I am determined to ensure that it is applied properly in future. That does not mean that there will be no change in any circumstances—I have been clear about that—but it does mean that, when any health board makes significant service change proposals, it will have to satisfy me that they are robust, that alternatives have been considered and that they are in the best interests of patients. I will set a high burden of proof.

I hope that Malcolm Chisholm takes those comments in the spirit in which they are intended. On private health care, he is perhaps better placed than I am to answer the question about how much of a departure my comments were. I was determined to give some clarity last week, as the previous Administration was rather confused on the issue: there was not always clarity in what it said and did. At times, pressure to conform to what was happening in England led ministers down a particular path, even though sometimes it did not look as though their hearts were in it.

I want to give clarity. Health boards have always been able to use existing private capacity around the margins. There are examples of that in the health services just now: positron emission tomography—PET—scanning to help us meet the cancer waiting time target is one. I am clear that the model that has been pursued in England, where public money is used to build additional private sector capacity to compete with the health service, is the wrong way forward. That is not an anti-private sector statement. I believe fundamentally that the route to improvement in the health service is not through markets and competition but through partnership and collaboration. Targets have a role to play in keeping people on their toes and in the mode of continuous improvement, but partnership and collaboration, typified by the community health partnership model, is the route to improvement. I hope that there is a fair degree of consensus on that.

Lastly, and briefly, I am keen to develop a more flexible health service. In the 21st century, people have a right to a user-friendly health service that is there when they need it. However, it is not all about GPs, and it is certainly not about GPs working more, although it might be about them working more flexibly. I look forward to having a dialogue with GPs about how we take that forward. Pharmacists and other allied health professionals also have a big part to play, and I will look to ensure that we take a broadly holistic view as we go forward. I am personally very committed to that agenda.

The Convener: I have a supplementary question but I will let Michael Matheson come in. Is your question on the same topic?

Michael Matheson: To some degree.

Nicola Sturgeon: Do you want to ask me about robots in Larbert?

Michael Matheson: Not as long as they are not replacing the nursing staff.

I welcome the cabinet secretary's statement. Some of her comments about the Government's priorities have been helpful. The good news is that I do not want to ask a question about doctors, but I have some questions about other professional groups in our health service. It is a matter of concern that there is the continuing problem of a large number of NHS vacancies in professions that are allied to medicine—I am talking about dieticians, physiotherapists and occupational therapists—which has been going on for several years. What action do you intend to take to address that problem, given that it has persisted for several years? Is the issue a lack of funding on the health boards' side, or is it about the numbers who are being trained by the universities?

Nicola Sturgeon: It is probably a mixture of those. I am not in a position to give you specific actions yet, although we are examining the situation closely. Before the election, I was struck by the physiotherapists' lobbying and the issues that they raised. Review work is continuing on that. I am clear that allied health professionals have a big role to play in a modern health service, and it might be bigger than the role they are

playing now. If potential is to be realised, we must start to tackle some of the long-standing problems around recruitment, filling vacancies, the attractiveness of the professions and the pressure that people are working under. I give you a commitment that that is on our agenda.

Michael Matheson: That is helpful.

I want to take you on to another issue that Malcolm Chisholm raised, about community health partnerships. I am conscious that, as the former minister responsible for health, he was largely responsible for the joint futures agenda, and I am concerned about how it is being taken forward. To a large extent, its implementation has been piecemeal in how it affects patients' experiences of working with different agencies. How can we ensure that there is greater consistency throughout the country in terms of how community health partnerships are developed between the health service, education, social services and other community services, rather than partnerships being different in different health board areas?

Nicola Sturgeon: First, local flexibility is not in itself a bad thing. Different approaches will sometimes be appropriate. For example, the approach that is taken in inner-city Glasgow need not be the same as that which is taken in the Western Isles or other rural parts of Scotland. A degree of local flexibility in arrangements is necessary. However, I accept your point. I have had experience of patchy development, and we have to examine that. The community health partnership model is right, but I am not suggesting that there is no room for change or improvement in how it operates. It is not for me to dictate the committee's work plan, or even to suggest one, but I would be happy if the committee took a keen interest in that issue.

11:00

Michael Matheson: That might be an issue for our away day.

You said that increasing people's participation in sport and physical activity is a Government priority. Most of the previous Executive's sport 21 targets to increase participation in sport and physical activity were missed. Are you therefore signalling a review of sport 21? Will the present policy change significantly?

Nicola Sturgeon: Stewart Maxwell is looking into that just now. I am not trying to dodge the question, but I am sure that members will understand when I say that our overwhelming sports priority is winning the Commonwealth games bid. That is Stewart Maxwell's main focus, although he is also looking into broader issues.

To increase participation, a number of approaches will be required. Our manifesto included measures to have more physical education in schools, to improve community participation and to improve facilities, which I know Michael Matheson is interested in. The simple answer to his question is that we do not want to turn sport 21 on its head, but we do want to ensure that it is implemented better than before.

Mary Scanlon: I have a question that supplements a point raised by Malcolm Chisholm. I was delighted to visit Stracathro regional treatment centre this week—I really had to visit it to understand it. Malcolm Chisholm mentioned last week's press release in which the cabinet secretary said that the private sector creates conflict and competition with the NHS. What I saw at Stracathro—and I commend Andy Kerr for the pilot project—was private sector money going into the NHS. The private sector is complementing the NHS and utilising theatre capacity after six o'clock at night and at weekends, when the theatres are normally free. If the pilot project drives down waiting times by more fully utilising NHS capacity, if it brings private sector money into the NHS, and if it is the success that it appears to be in its early days, are you still against rolling the model out elsewhere in Scotland, simply because a private sector company is involved?

Nicola Sturgeon: I suspect that Mary Scanlon and I will not see eye to eye on private sector involvement in delivering health services. I have not visited Stracathro yet, but I hope to do so. As I have made clear, what I said last week has no implications for the Stracathro contract. I do not intend to interfere with that contract at all, and I will be interested in an evaluation of the work that is going on there.

I would like facilities such as those at Stracathro to come within the health service. As we said in our manifesto, the Stracathro model of diagnostic centres is one that we would like to develop in the health service. That will be our priority.

Mary Scanlon: Sorry, minister, but it is in the health service—that is the whole point. I will not go into too much detail, but I asked the royal colleges why theatres could not be used in the evenings and at weekends, and was told that they could not do that within the health service. At Stracathro, we were shown round by Gerry Marr of NHS Tayside. The private sector is leasing health service buildings. The centre is within the health service.

Nicola Sturgeon: I suspect that we will debate such issues often, and that we may not see eye to eye, but I hope that we can agree on the need to make progress in driving down waiting times. I am always open to suggestions and innovative ways of doing that. Our manifesto contained an ambitious waiting time target, and we will say more about its delivery over the next few months.

My guiding principle—and I think that it is right for patients—is that public money should be invested to expand capacity in the public health service. I believe strongly in that principle, and I believe that the vast majority of people in Scotland do too.

Mary Scanlon: I have a quick supplementary question about the bill for no-fault compensation in the NHS. Is it going ahead?

Nicola Sturgeon: Shona Robison and I are keen to progress it but, as Mary Scanlon knows, the area with which it deals, in common with most legal issues, is highly complex, so it will take some time to ensure that we get our proposals right.

Lewis Macdonald: I turn to a quite different subject. I welcome what the cabinet secretary said about the importance of dental health and the emphasis that she places on NHS dentistry. Does she agree that the most important measure that can be taken to improve access to NHS dentistry is to provide rewards and incentives for high street dentists to treat all categories of patients on the NHS? Does her Administration intend to continue that approach?

Nicola Sturgeon: Yes. We do not intend to change radically the NHS commitment criteria, which I think you introduced, although we are considering improvements that can be made around the edges. We are keen to build on the work that has been done to improve dental services.

Our manifesto contained commitments on the introduction on a pilot basis of a school-based dental service and on improving access to NHS dentistry, which will be achieved partly by the measure that Lewis Macdonald mentioned. In addition, we are considering turning the Aberdeen dental institute into a third dental school, and we will have more to say on that over the next few months.

Lewis Macdonald: I welcome all those commitments. I am looking forward to the introduction in Grampian of the childsmile initiative, which is already in place in a number of other parts of Scotland. Is that compatible with the commitment on school dentistry that you mentioned?

Nicola Sturgeon: Yes. We regard the school-based dental service as primarily a preventive service. As we develop that, we will look very much to the childsmile model.

The Convener: Some of us are happy with a pensioner smile.

Nicola Sturgeon: It is a very nice smile.

Karen Gillon: I have two questions on the theme of sport. Michael Matheson and I have worked together on trying to improve co-ordination between Executive departments on sport. How do you foresee your Administration making progress on that? In particular, how will you make the link between the education department and your department work, given the resistance that sometimes exists in the civil service to doing that? Secondly, what are your intentions on sportscotland and what is the timeframe for pursuing them?

Nicola Sturgeon: I am going over old ground when I say that we have a smaller Cabinet, whose members have bigger and more strategically focused portfolios. One of the key strengths of my portfolio is that, as well as covering the traditional health responsibilities, it includes responsibility for some of the key determinants of people's health. That is what gives me the best opportunity to make the biggest difference.

However, despite the expansive nature of my portfolio, I am highly aware of the need to work across portfolios. I have no doubt that what Fiona Hyslop does on early years education will make just as big an impact on our long-term health and on closing the health inequality gap as any actions that I take over the next few years. We are acutely aware of the need for cross-portfolio working and are determined to make it work. Of course there will be challenges—I do not say that only because Dr Kevin Woods is sitting next to me. The civil service has been extremely responsive in mirroring our restructuring of Government. I am not suggesting that there have not been, or that there will not be, any problems with that approach, but the experience so far has been positive.

We have not taken any final decisions about sportscotland. Our sporting priority is bringing the Commonwealth games to Glasgow—that will be our focus over the summer. We will take care to consider what we want to do about sportscotland. I will not put a timescale on that at the moment; you know what was in our manifesto, so you know what we are minded to do, but we will take time and care to consider what action we will take, to ensure that we get it right.

Karen Gillon: Can I clarify that your intention is to abolish sportscotland?

Nicola Sturgeon: That was our manifesto commitment, so you can take it that that is how we are minded to act. However, we will take time to consider our proposal.

Before this meeting, I appeared before the Local Government and Communities Committee, at which I was pressed on some other, completely unrelated manifesto commitments. I will say the same to you as I said to members of that committee: you can take it that what was in our manifesto is our view on these matters. However, I

recognise that we are a minority Administration and that we must listen to the views of other people before deciding on a way forward. I hope that you will take that as an open invitation to give me your views and to have an open dialogue with us about sportscotland. We will take the appropriate time and make space to consider the issue properly and make the right decisions.

Karen Gillon: Although I accept and understand that, the staff of sportscotland, who are working hard to try to support the delivery of the Commonwealth games bid and to support our athletes as they look forward to 2012, are considerably concerned about the uncertainty that is hanging over them, which may influence their decisions about their future employment. The earlier that decisions can be taken forward, the better.

Nicola Sturgeon: I take that point and I put on the record my appreciation of everything that the staff do. Stewart Maxwell has met the chief executive of sportscotland and we have made great efforts to ensure that we communicate our thinking and intentions to the staff, so that, in what I appreciate is an uncertain time for them, we deal with them fairly and in an up-front way. We will continue to take that approach.

Ross Finnie: The committee has rightly focused its attention on doctors, and Michael Matheson asked about allied health professionals and others. I want to return briefly to the physical aspects of the situation.

I do not think that anyone will argue against your presumption against centralisation in whatever manifestation. However, the delivery of that policy requires you to take forward issues around the reconfiguration and redesign of what was previously regarded as the district general hospital concept. Do you have any preliminary views on whether your Government will support the previous Executive's development of the community hospital strategy? Do you envisage there being a need to deliver that physically through investing in local health centres as well as in personnel?

Nicola Sturgeon: I have made it clear that I think that there is a need, particularly in certain health board areas, to invest in community facilities. When I took my decision on Monklands hospital, for example—we probably do not have time to get into that in any great depth—I made it clear that I thought that underdevelopment of community and primary services was a serious issue in Lanarkshire. I have no doubt that there is a link between that situation and levels of deprivation in Lanarkshire, and there is probably a link with additional demand on emergency services.

I am clear that I want to develop community facilities, but there are of course infrastructure and physical issues around that. I also support the district general hospital model. These are difficult issues, irrespective of the health minister's political colour. There will always be difficult issues around service change and reconfiguration and how we develop the service to meet future needs, given our ageing population and given that people with long-term conditions will need support in the community. Somebody will have to take difficult decisions—for the moment, that person is me.

The Convener: I thank you, cabinet secretary and Dr Woods, for the comprehensive list of your priorities, and I thank my colleagues for what I expected: vigorous questioning. No doubt we will have much more of that. I am pleased with my restrained convenership, which is not on my curriculum vitae.

I suspend the meeting for five minutes.

11:13

Meeting suspended.

11:20

On resuming—

Subordinate Legislation

Spreadable Fats (Marketing Standards) (Scotland) Amendment Regulations 2007 (SSI 2007/303)

Health Protection Agency (Scottish Health Functions) Amendment Order 2007 (SSI 2007/316)

National Health Service (Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2007 (SSI 2007/317)

Addition of Vitamins, Minerals and Other Substances (Scotland) Regulations 2007 (SSI 2007/325)

The Convener: The next item is consideration of four negative instruments. The Subordinate Legislation Committee considered them yesterday, and had no comments to make. Do members have any comments?

Is your silence an affirmation that you have no comments to make?

Karen Gillon: Indeed.

Mary Scanlon: I wanted to seek clarification from a minister on a certain matter. However, as no ministers are present, I have no comment to make.

The Convener: These are negative instruments, so a minister is not present to answer any questions. It is merely a paper exercise.

Mary Scanlon: I appreciate that. I simply wanted some clarification.

The Convener: As members have no comments and no motions to annul have been lodged, is the committee agreed that it does not wish to make any recommendation on these four instruments?

Members *indicated agreement*.

Smoking, Health and Social Care (Scotland) Act 2005 (Variation of Age Limit for Sale of Tobacco etc and Consequential Modifications) Order 2007 (draft)

The Convener: Item 5 is consideration of an affirmative instrument, which means that we can take evidence on it if we so wish. Annex A of paper HS/S3/07/02/6 sets out the responses to the Scottish Executive consultation on varying the age limit for purchasing tobacco—in other words, annex A sets out the consultation findings. Annex B contains a note of the previous Deputy Minister for Health and Community Care's meeting with members of the Scottish Youth Parliament.

I remind committee members that we are required to report to Parliament on this draft order by 17 September, which means that, if we wish, we can deal with it at our first meeting back and at our second meeting on 12 September. I am in the committee's hands.

Malcolm Chisholm: As I said last week, this committee has a potentially enormous agenda—indeed, we began to touch on that when we were questioning Nicola Sturgeon—which means that at the away day we will have to make some hard choices about what we should concentrate on. We should not feel that we have to go into great detail on every single issue that comes before us. The fact is that this piece of legislation not only has support across the Parliament but, given the various responses, is overwhelmingly supported by stakeholders throughout Scotland. Although one or two groups—I am thinking of one in particular—have reservations about it, that does not justify our taking oral evidence on the matter. I hope that we can deal with it on 17 September simply by recommending that the draft order be approved.

The Convener: It is up to the committee to decide whether to bring in a minister to comment on an affirmative instrument. We are not required to do so.

Karen Gillon: I certainly share Malcolm Chisholm's views on the matter, although I wonder whether we can seek written clarification from the minister about enforcement. A number of small shopkeepers have told me that, although they support the proposal, they are concerned that, if a nationally accepted proof-of-age card, for example, is not introduced, they will find it difficult to differentiate between customers who are below the age limit and those who are above it, and that they might then be subject to abuse. Perhaps we can move such issues forward.

The Convener: I might disagree with Malcolm Chisholm on some of the issues that are covered in our papers. It could be useful to have a short round-table discussion with some of the people who contributed responses. Enforcement issues were raised, as was the matter of funding to local authorities. Trading standards bodies will require more funding. The issues around the proof-of-age card have not really been resolved in the consultation.

Small shopkeepers have expressed concern about the behaviour in shops of young people who

are able to purchase cigarettes at present but who will be prevented in the future from doing so. There are some unresolved issues around that. Some responses suggest that, as psychiatrists and others have said, although the message is welcome, there is no evidence that raising the age limit actually reduces smoking. Those are just some observations. It might be worth having some people contribute their ideas on enforcement, funding and so on.

Michael Matheson: I am with Malcolm Chisholm on this issue. There is cross-party support for the proposals, and there is a danger that, in spite of the committee's potentially heavy workload, we will get drawn into issues that we do not really need to examine in detail. I do not see what difference the change in the minimum age from 16 to 18 will make as regards the number of trading standards officers who have to deal with the matter. The same people will deal with it—it is just a matter of the minimum age moving from 16 to 18.

Karen Gillon made a valid point about the national proof-of-age card. The issue goes wider, however—it also concerns the alcohol strategy and the attempts to tackle underage drinking. I suspect that the Justice Committee will have an interest in the matter, too. We might be able to deal with the issue in correspondence with the minister, but I would be reluctant to consider the matter in any further detail.

Lewis Macdonald: I take the same view. Karen Gillon's suggestion that some of the issues could be addressed in correspondence with ministers in advance of our further considerations is helpful. I have to declare an interest—I was the minister who held the meeting that is covered in annex B to our paper. It is fair to say that the Executive and the Gruer group conducted fairly extensive consultation on the proposals before they reached this stage.

However, some valid issues have been raised this morning around implementation and enforcement, and those issues will apply across the board. Given that the cabinet secretary has indicated to us today that a public health bill is being produced, I would be surprised if there was no opportunity in the context of that bill for the committee to explore enforcement issues around tobacco, alcohol and related matters.

Mary Scanlon: I confirm that the matter is not contentious from my party's point of view, although we are concerned about enforcement. Sitting on the fence like that, I feel like a Liberal, but I agree with Malcolm Chisholm, in that I do not want to create work for the sake of it. That said, I am sort of on the convener's side, too. Sometimes, the devil is in the detail, and I would like some commitment to be made on enforcement and so on. We could have a short discussion on the matter—I do not think that we will need two full meetings. I suggest that we allocate a short period to a round-table discussion on the issues that will be raised in the eight weeks between now and September, when the subject will be discussed out in the open.

The Convener: Ross Finnie is next. Try to desist from making fence-related remarks.

Ross Finnie: I will try to do that—I suggest to Mary Scanlon only that although she might be feeling some pain, she has arrived at the wrong diagnosis.

Like other members, I think that taking extensive evidence from witnesses is not appropriate in this case. I should point out that, on 14 June, I had an oral question answered by the Solicitor General for Scotland. He revealed that in relation to underage sales of tobacco, over the past year, only

"11 people were subject to court proceedings".—[*Official Report*, 14 June 2007; c 789.]

That is completely out of kilter with the other evidence that attracted our attention to the matter. The issue of enforcement remains tricky. The other parts of the Solicitor General's response, which concerned other measures, were interesting. If our whole intention is genuinely to reduce smoking among younger people, we must be a little clearer about how raising the purchasing age will affect their smoking. The answer that was given is not helpful on that, although it points to the need for further information.

11:30

Ian McKee: We will have the opportunity to resolve the small but important matters that have arisen in the discussion on other occasions with the Justice Committee and in the public health bill. We must be careful, because any time that we spend on one thing is time that we cannot spend on something else. I tend to agree with Malcolm Chisholm that, as so many important issues are ahead of us, we should move on and consider them.

The Convener: We must deal with the draft order, notwithstanding the fact that some aspects—such as delivery—may be a justice issue. I understand that the minister will have to appear at some point to move a motion and be questioned. I have no doubt that she will read in the *Official Report* of this meeting the issues that we have raised. Would having the minister along on 12 September to question her on the issues that have been openly discussed be sufficient?

Karen Gillon: As the minister must appear before the committee, it would be useful to say

that we would like information on enforcement and proof of age—

The Convener: Those are the two issues.

Karen Gillon: That will ensure that the minister has the answers to our questions when she appears and that we are not looking for answers that are not at her fingertips, which would mean having to return to the subject the following week.

The Convener: I agree. If the minister reads the *Official Report*, she will see that enforcement and proof of age are the two issues that have come to the surface.

Michael Matheson: It would be worth writing to the minister to highlight the issues that we have raised, which will be in the *Official Report*. The civil servants will bring that to her attention, but writing would ensure that, when she comes along, she is aware of the matters.

The Convener: I intend to write to the minister but not to spell everything out. I will say what the issues are and that they are developed in the *Official Report*. I do not expect the minister to listen in great detail to everything that we say—every blow, turn and corner.

Ross Finnie: Why not?

The Convener: I suspect that we may be stars yet, Ross.

Are members content that the committee's next meeting will be on 12 September and that we do not need a meeting before then?

Members *indicated agreement*.

Budget Adviser

11:32

The Convener: Item 6 is the appointment of a budget adviser. I ask members to agree in principle to appoint a budget adviser to the committee, without going into detail today.

Karen Gillon: I certainly agree with that in principle. It would be useful if the Minister for Public Health or the Cabinet Secretary for Health and Wellbeing said tomorrow what the intention is for the budget process and what its implications are for the committee's budget scrutiny role this year.

The Convener: A list of possible advisers will be compiled for the committee to scrutinise. Committees' normal practice is to discuss such business in private so that individuals' details are not in the public domain. It will be up to the committee to select the adviser. Are members content with that?

Members *indicated agreement*.

The Convener: That ends the public business.

11:33

Meeting continued in private until 11:54.

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