HEALTH COMMITTEE

Thursday 9 September 2004

Session 2

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HEALTH COMMITTEE
19th Meeting 2004, Session 2

CONVENER

*Christine Grahame (South of Scotland) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*Mr David Davidson (North East Scotland) (Con)
*Helen Eadie (Dunfermline East) (Lab)
*Kate Maclean (Dundee West) (Lab)
*Mr Duncan McNeil (Greenock and Inverclyde) (Lab)
*Shona Robison (Dundee East) (SNP)
Mike Rumbles (West Aberdeenshire and Kincardine) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Robert Brown (Glasgow) (LD)
Paul Martin (Glasgow Springburn) (Lab)
Mrs Nanette Milne (North East Scotland) (Con)
Ms Sandra White (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO ATTENDED:

Carolyn Leckie (Central Scotland) (SSP)

THE FOLLOWING GAVE EVIDENCE:

Mike Baxter (Scottish Executive Health Department)
Dr Robin Cairncross (Scottish Executive Health Department)
Derek Feeley (Scottish Executive Health Department)
David Hastie (Scottish Executive Health Department)
Professor David Kerr (Advisory Group on the National Framework for Service Change)
Jan Marshall (Scottish Executive Legal and Parliamentary Services)
Professor Sir John Temple (Short Life Working Group on Securing Future Practice: Shaping the New Medical Workforce for Scotland)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Thursday 9 September 2004

[THE CONVENER *opened the meeting at 14:01*]

The Convener (Christine Grahame): Welcome to the 19th meeting this year of the Health Committee, which is being held in this rather smart committee room. I believe that there are even smarter ones and perhaps we will graduate to them in time. I am not sure whether the decision about whether you get one of the smarter committee rooms is based on performance, but if it is, I am sure that the Health Committee will soon be in one. This is a lovely room, though.

Subordinate Legislation

National Health Service (Transfer of Property between Health Boards) (Scotland) (No 2) Regulations 2004 (SSI 2004/285)

14:02

The Convener: Item 1 on the agenda is subordinate legislation. The matter that we are dealing with is continued from our meeting on 29 June and concerns the consideration of the Subordinate Legislation Committee's report, which members have before them. No comments have been received from members and no motion to annul has been lodged.

From the Scottish Executive we have before us Jan Marshall from Legal and Parliamentary Services, Mike Baxter, the director of performance management at the Health Department, and David Hastie from the directorate of performance management and finance at the Health Department. They will clarify any points that members are unclear about.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): A question that is frequently asked of me relates to what happens to bequests that are given to specific hospitals and specific hospital departments. When any shuffling happens in the national health service, people ask what happens to that money. That question always crops up but I cannot answer it.

Mike Baxter (Scottish Executive Health Department): When bequests are made to NHS hospitals, they are usually extremely specific. When there is a restructuring of the health service, the expectation is that the bequests will be used for the purposes for which they were given. In respect of the Scottish Hospital Trust, there were specific provisions in the Public Appointments and Public Bodies etc (Scotland) Act 2003 to ensure that the functions for which the bequests were originally made are continued after they transfer to a different body.

Mr David Davidson (North East Scotland) (Con): What was our panel's view of the abridged version of the Subordinate Legislation Committee's report? I would like an opinion on its contents.

Jan Marshall (Office of the Solicitor to the Scottish Executive): The Executive has a view and, with the permission of the committee, I would like to read out a statement on behalf of the Executive.

The Subordinate Legislation Committee has drawn the Health Committee's attention to the regulations on the ground that it considers that there are doubts as to whether regulation 2(c) is intra vires. Although the Scottish Executive understands why the Subordinate Legislation Committee takes that view, it cannot agree with it.

Section 5(4) of the Public Appointments and Public Bodies etc (Scotland) Act 2003 permits any trust property formerly belonging to the Scottish Hospital Trust that has been transferred to a health board to be transferred to another health board,

"subject to such conditions … as the Scottish Ministers may by regulations provide for."

The Subordinate Legislation Committee considers that that power does not enable a condition to be imposed, as in regulation 2(c), that requires such property to be transferred back on a date that is agreed between the boards. The committee takes that view because section 5(5) of the 2003 act makes provision for the property to be transferred back when the transfer or health board so requires.

The Subordinate Legislation Committee considers that the effect of that condition is to modify the effect of section 5(5) of the 2003 act. In the Executive's view, there might have been some justification for the Subordinate Legislation Committee's view. That is to say that the effect of section 5(5) is modified if, in fact, regulation 2(c) had purported to nullify the effect of section 5(5) by preventing the transferring health board from requiring the property to be transferred back before the agreed date. However, in our view, that is not what regulation 2(c) does. It does not do that because it expressly provides that its provisions are without prejudice to section 5(5).

The Subordinate Legislation Committee goes on to say that it does not consider that that is

sufficient. It considers that the effect of section 5(5) of the 2003 act is to preclude not only any condition that contradicts its provisions, but any condition that makes any other additional provision regarding the transfer back of the property. The Subordinate Legislation Committee states at paragraph 10 of its report:

"Where an Act makes provision for a certain event, it is not open to Ministers to make provision by subordinate legislation in respect of that event unless the enabling power specifically so allows."

In the Executive's view, although there might in community law be a doctrine that is called occupying the field, the Scottish Executive is not aware of any case law that indicates that a similar doctrine is to be applied when interpreting statutes as a matter of domestic law. It seems to the Executive that the Subordinate Legislation Committee's view on the matter is not supported by domestic case law.

The Scottish Executive's view is that section 5(4) of the 2003 act enables the regulations to impose such conditions as the Scottish ministers may provide. The Scottish Executive accepts that that power is impliedly restricted by section 5(5), but only to the limited extent of preventing those regulations from imposing conditions that would prevent the transferring health board from requiring the property to be transferred back on demand. However, subject to that qualification, it is the Executive's view that there is nothing in sections 5(4) and 5(5) that would prevent the regulations from imposing other conditions regarding the transfer back of the property.

The Executive notes at paragraph 12 of the Subordinate Legislation Committee's report that that committee appears to consider that, although it would be doubtful vires for the regulations to require the property to be transferred back on such date as might be agreed between the health boards,

"there is nothing to prevent the parties from reaching such an agreement"

outwith the regulations. The Scottish Executive is surprised by that suggestion and we have doubts about whether the suggestion would be intra vires because it appears to undermine the effect of sections 5(4) and 5(5) of the 2003 act as well as the role of this committee in scrutinising the regulations.

The Convener: I am stunned. I am grateful that that response is now on the record. Are we to have in-depth supplementaries from David Davidson?

Mr Davidson: I was simply going to say, what does it actually mean? If the Executive has one view and the committee has another, who is the outside arbitrator? It is certainly not this committee.

Jan Marshall: It is the courts.

The Convener: Yes, it would be the courts. That is why I am grateful that the response is on the record. Is the *Official Report* the only record of that full response?

Jan Marshall: The purpose of making the statement was to have the response on the record. I am prepared to write to the committee in exactly those terms if that would be of assistance and to take any supplementary questions at a later stage if necessary.

Mr Davidson: The advice is that any conflict should be settled by the courts.

The Convener: That is my understanding. If there were a conflict, the courts would rely on what Jan Marshall has said as part of the legal argument. I am grateful for that, although I suspect that some of us got lost—but that is neither here nor there. Is it the case that the committee does not wish to make any recommendation in relation to the National Health Service (Transfer of Property between Health Boards) (Scotland) (No 2) Regulations 2004 (SSI 2004/285)?

Members *indicated agreement.*

The Convener: I welcome Carolyn Leckie to the committee as a guest member, as it were. I can also pass on to the committee Mike Rumbles's apologies, which I omitted to do earlier.

Work Force Planning Inquiry

14:10

The Convener: I welcome Professor Sir John Temple, chair of the short-life working group on securing future practice: shaping the new medical work force for Scotland; and Dr Robin Cairncross, senior medical officer in the Scottish Executive Health Department. I refer members to paper HC/S2/04/19/2.

Shona Robison (Dundee East) (SNP): Are you satisfied with the progress that has been made by the Executive to date in working towards the recommendations of your 2002 report, "Future Practice: A Review of the Scottish Medical Workforce"?

Professor Sir John Temple (Short Life Working Group on Securing Future Practice: Shaping the New Medical Workforce for Scotland): I thank the committee for this opportunity. "Future Practice" was accepted virtually in full by the Executive when it came out. The on-going work from that was part of the reason why the short-life working group, which I chaired, was set up. The first group was not an Executive working group; it was my own working group, which I convened. We took a year and a bit to accrue all our opinion—much of it was indeed opinion rather than evidence—which we put into the form of a report. That was accepted by the Executive. Now is the time when I would expect the Executive to start to take forward the recommendations that we made. I am not sure that the Executive had much opportunity to do so before, as further work was required to clarify some issues.

Shona Robison: I understand what you are saying about timescales and about the other work that was required. Are there any areas where you feel more progress could have been made by now?

Professor Sir John Temple: I am not sure that I am qualified to say that, as I am not a member of the Executive. Whatever needs to happen now needs to start happening quite quickly. We have given what I hope are clear messages and recommendations. I hope that we have posted the necessary traffic lights to say what needs to happen in Scotland for health care delivery. It is up to the Executive to make the right decisions to take that forward. That will not be resource negative, of course.

Shona Robison: So you are saying that we are starting the process of determining where the priorities should be.

Professor Sir John Temple: We have laid the priorities out. Our second report sets the scene carefully and clearly—at least I believe it does. We went back and considered the fundamentals for health care delivery in Scotland against the background of ill health in Scotland. It is clear from my accent that I am not originally from Scotland, but I spent three years here. I learned an awful lot about the health care system in Scotland, and I could compare issues here to those that arise south of the border. There is no doubt that there are some real challenges here in relation to the health of the nation. Once we have accepted those, we need to examine the health care system.

In both our reports, our view is clear. The health care system that we have will not be suitable for delivering health care here in future. We have to change it. That requires a fundamental culture shift. What we think should happen is in our second report and, in my view, it needs to start happening now. There is an awful lot of work to do. We have to convince you and the public, and we have to get the public onside. That is not easy, because change brings with it many difficulties.

Shona Robison: Does it concern you that changes are happening piecemeal and at a local level, without any reference to the bigger picture and the national plan for where we want health care services to be delivered?

14:15

Professor Sir John Temple: That is something that I feel strongly about, and I have said so. To deliver these sorts of changes, one needs a macro system that can look down from the top and say what needs to happen, and it needs to have a big enough critical mass to allow that. I do not think that that can be delivered when there are 13 or 15 bodies pitching in the same pool. I compare that, because I must, with the situation down south: England has 30 strategic health authorities for 60 million people, whereas Scotland has 15 health boards for 5 million people. That demonstrates two fundamentally different ways of approaching the problem. Of course, not everything has to be top down, but in my view the initial strategy has to come from the top down because one has to have a big enough macro-economy to be able to do something about changing it. That is why we say quite clearly that health care planning and delivery need to be co-ordinated into much bigger units. Of course, that is a huge problem, because people have just got into the present system after a lot of change and upset and if we say that they will have to change again that will bring a huge reaction, but I believe that that is what needs to happen. The message is: 30 strategic health authorities for 60

million people versus 15 boards for 5 million people—that says it all.

The Convener: Before I bring in Duncan McNeil, does Dr Cairncross want to respond?

Dr Robin Cairncross (Scottish Executive Health Department): Thank you. I am fine at the moment.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): On the same theme, the 10 key messages that you laid out in the 2002 review stressed the need for public involvement. At the end of the 10 key points, you stated:

"Political, professional, public and service leadership is needed to create a … realistic public awareness of the issues and priorities."

In your 2004 report, recommendation 1 stressed:

"The public … must be fully informed about the sustainability of … emergency services".

You do not want to be drawn on some of the other recommendations, but will you make an observation about whether the public involvement and engagement that you describe is necessary in the process of change? Are we anywhere near achieving the recommendations that you laid out?

Professor Sir John Temple: We have not achieved the recommendations yet. From reading the popular press, which is one way to judge public involvement and knowledge, I perceive that there is a heightened awareness of some of the issues, but we have to go further than that. The political willingness to take the matter forward is equally important—that is why we included it in the report. In fairness, I must say that when I presented the report to the minister, it was as a result of that willingness that he allowed me to go on and do the second review, which considers certain issues in much more detail. There was a genuine realisation that political involvement and complicity is essential. In the past, the problem in so many places has been that because we cannot get professional, public and political consensus we go nowhere. We need all three for change to take place—that is not easy, but it has to happen.

Mr McNeil: You felt the need to make the same recommendations in the 2004 report.

Professor Sir John Temple: Of course.

Mr McNeil: Have we achieved the level of public and professional debate that is necessary to allow a realistic look at the challenges? Do we need a national debate?

Professor Sir John Temple: Yes. There has been quite a lot of local debate, and in the intervening period several further reviews have been carried out and inquiries have been set up on the same issue. You must have noticed, as I have, that the same messages recur regularly. A national debate would be another approach, but I am not politically astute to the level of knowing how that would be undertaken.

Mr McNeil: You agree that how the message is being carried does no favours to the people who oppose cuts in their localities and drowns out the voice of professionals and people like you, who are trying to manage expectations about future health services.

Professor Sir John Temple: I agree that we do not yet have the right forum to put the message across properly to the public.

Helen Eadie (Dunfermline East) (Lab): I want you to clarify a point that you made a moment ago. You said that bigger units were needed. Do you mean bigger planning units, health authority units or hospital centres for delivery?

Professor Sir John Temple: I probably mean all three. We must start with strategic planning and the organisation and implementation of service delivery. My view and my group's view, this time and previously, has been that that needs to be organised on a larger scale than at present. There are several ways to do that. Number one is through arranging liaison between existing health boards, but that would have to be real liaison through which people gave and took and did not plant territorial flags and hang on. However, when we go beyond that, we need service redesign, as the second report says. Both my reports were about medicine, but that is not to the exclusion of the rest of health care. [*Interruption.*]

The Convener: I am sorry to interrupt you, but the noise had started again. We will deal with it and continue for now, but if it starts again, we will have to settle it, because the situation cannot continue.

Professor Sir John Temple: My reports dealt with medical care because that was the subject of their specific remit. I deliberately kept them focused on medicine, because that was our brief. However, that is not to the exclusion of the rest of the health-care provision system. The parts must work together, because the system is multifactorial.

Having said that, we do not have enough doctors, nurses, paramedics or others to run the present system, especially given the pressures that are being brought on us by matters that are part of the law—the mandate—such as the working time directive. As a result, along with the macro units for organising and delivering, we need to think about the facilities that we have—the units and the hospitals—and ask whether they should all continue to do what they do today. The answer is no, but I have not said anywhere, ever, that

anything needs to be closed. What we do is redefine how we use facilities to best advantage.

Helen Eadie: You said that we do not have enough clinicians, consultants, general practitioners, doctors and house registrars, but according to statistics from the Scottish Executive, 10,000 extra people have entered the system since 1993. I know that the European Union working time directive causes pressures, but I have difficulty in understanding why we continue not to have enough people.

Professor Sir John Temple: If I may answer that—[*Interruption.*]

The Convener: Excuse me—I am sorry to interrupt again. Do members feel that I should suspend the meeting briefly to deal with the noise?

Mr McNeil: It is not bothering me.

The Convener: You want to continue. Is it not bothering you?

Dr Cairncross: No.

The Convener: So it is just me who is becoming very angry. [*Interruption.*]

I am advised that the noise is not being picked up by the broadcast for the purposes of the official report. I am sorry that the noise is making me cross, but everybody else is happy.

Professor Sir John Temple: As long as it is not something that I have done, I do not mind.

The Convener: I am sorry. Please proceed.

Professor Sir John Temple: Where were we? We can ask whether, 10 years ago or now—let us take now—we have enough doctors and nurses and enough of everybody else to run the health care that we deserve. The answer is no. It is clear that Scotland is slightly better off than any other UK country, but it is still below the average for most of Europe.

Scotland has particular issues that may be more labour intensive and involve a raft of measures that the report does not deal with in detail. I return to point number one: the health of the people with whom we are dealing. It is no secret—indeed it is well publicised—that the health of the Scottish nation is the worst in the United Kingdom. That is irrefutable, for a variety of reasons that will perhaps be considered in detail. If that is the starting point, we need more medical support, because we have sicker people. That is the first point.

Helen Eadie: Is that a short-term or a long-term problem?

Professor Sir John Temple: It has been and remains a long-term problem, for a raft of socioeconomic reasons.

Secondly, we have a dispersed health care system in Scotland because of the country's geography—we cannot change that, but it brings its own pressures.

Thirdly, in many areas we have difficulty in recruiting and retaining staff. There are reasons for that and there are ways of trying to sort it out, but there are no quick fixes. For all those reasons—whichever you pick—the system would start to improve if there were more doctors and nurses.

The education and training reforms that are dealt with in the report bring their own set of pressures. None of those is negotiable; they are part of raising the standard of medicine in order to secure better patient care and safety. When we put all those factors together, we have a number of problems that are quite difficult to fix.

Mr McNeil: Short-term or long-term problems?

Professor Sir John Temple: They are all predominantly medium to long-term problems.

The Convener: I would rather that questions were asked through the chair, because I have a list of people who want to ask questions and I want them to have a chance to do so.

Mr Davidson: Professor Temple, you talked about structures and strategic overviews and you more or less laid out a plan for the amalgamation of health boards into regional strategic authorities. However, the concerns that we are currently hearing from the public are less about how the system is organised than about how long it takes to access that system in an emergency—in other words, taking medicine to the people. I would like to hear your views on that. Schemes were tried in which consultants were sent to cottage and community hospitals, to take clinics closer to patients, but that approach seems to have been abandoned, partly because of the lack of bodies on the park, which means that people cannot afford the travel time if the patch is to be properly covered. How can a balance be struck between the structural overview—the accountants' guide to the best management of hard facilities—and the fact that although the public has bought into the idea that they might have to travel further for specialised care, as you mentioned, they want immediate problems to be dealt with in their locality? How does that fit with your model?

Professor Sir John Temple: It does fit in with the model, but we must carefully consider the two different issues that you raise: emergency provision; and the more elective, planned process of provision. The latter is relatively easy, because most people understand—if it is properly explained to them—that in the case of a major or once-in-a-lifetime event, it is better to go where the best care can be delivered. That might mean that people

have to travel for specific care and come back to access step-down facilities, but if the process is explained and care is taken the public can be won over on that issue.

We are in much more difficulty in relation to emergency care—what we call the 24/7/52. That means the around-the-clock coverage for you or me if we fall acutely ill. There is a trade-off, which was highlighted in both reports, between providing that coverage right down at local—almost cottage hospital—level and having the right critical mass that ensures that when someone is acutely ill they receive the right primary treatment. A situation in which that critical mass is tenuous because the floor cannot be covered if someone is off sick, or because the doctors, nurses or whoever staff the unit are not really equipped and skilled to deal with cases at a certain level, is worse than a system in which people are assessed and then moved quickly to a unit where they will receive the right treatment.

The public want to know, "What will happen if I fall ill?" They need to understand what the process will be, so the process must be explained.

If someone is in one of the bigger conurbations, that process may involve being seen at a big hospital with all-singing, all-dancing facilities, but if someone in a more remote place falls ill, they will be seen by a person who will realise whether their condition is serious or not. If their condition is not serious, some treatment will be arranged, but if it is serious, it will not be possible to deal with it. The patient will be stabilised and then moved as quickly as possible.

We have highlighted that it is that process of moving the patient as quickly as possible that needs some serious attention. The ambulance service does a brilliant job, but the roads are pretty terrible in many places and there are other ways of transporting patients. We have highlighted that helicopters can be used. There is a huge seaboard around Scotland. I am not talking about using the lifeboats, as someone once thought; moving patients is not a lifeboat service job. In many places, however, patients can be moved very quickly by water. We need to consider that, as it could improve the situation.

The patient will understand what is going to happen. It will not be possible for them to get their emergency –ectomy—whatever it is—dealt with in a small cottage hospital; they will certainly not be able to get it done safely. Patients need to know that. We need to get the two issues of the more elective work and the emergency work clearly understood.

We—the group that produced the report; these are not just my ideas—do not think that it will be satisfactory to continue to try to deliver everything that we do now everywhere. That is not on; we do not have enough staff to do that, given the restrictions that have been placed on what staff are supposed to do.

Mr Davidson: Thank you. That is quite clear.

14:30

Dr Turner: There are many things going through my head. My first thought is that when we plan ahead, we must take account not just of the illnesses that are suffered now, but also of those that are coming people's way. We have an aging population with multisystem problems. A large number of people have smoking-related diseases and even if we banned smoking tomorrow, all the diseases associated with smoking, as well as those to do with obesity, would still come our way. Our capacity is diminishing; as well as having half the number of beds that we had in the mid-1970s, we have fewer people to treat patients, as Professor Temple said.

If we are aware of the enormity of the problem, it might be possible to work ourselves out of the situation that we are in, but I am not sure that Government appreciates the extent of unmet need. The doctors and the nurses in the system are working very hard, but they are still not getting to a large number of people and, as our system shrinks, we will not be able to deal with those people. I am thinking, for example, of type 2 diabetics.

Excellent reports have been produced; for example, the obesity forum has highlighted the importance of the simple idea of diagnosing how bad people's kidneys are before they become so bad that they need dialysis. There are many ways in which we could divert resources within the system to prevent people from becoming worse. We could also devise quicker and more efficient diagnostic methods: instead of creatinine clearance, perhaps we could use glomerular filtration rate, or something like that. We could ensure that people get those tests faster.

Professor Sir John Temple: In fairness, much of that will happen if and when we get more people on the ground, because that will provide greater opportunity for devoting attention to such issues. It will also allow us to expand community services. Many of the things that Dr Turner has just mentioned ought to be dealt with at community level. I am not an expert on community services—I am a general surgeon; that is where I come from—but such work is increasingly being carried out by community services. However, at the moment we just do not have enough people. That is why Sir Kenneth Calman's report, which is complementary to mine, talks about increasing the number of medical students. We highlighted that in

2002. That is good, because it means that we will get more graduates in Scotland and that we will have a chance of retaining more doctors. That will start us on the right path.

On the argument about the health of the nation, it is true that even if we banned smoking and did something about people's diet today, a cohort would still come through who were ill, but at least we would not have a next cohort coming through. A stand has to be taken sometime on particular issues in parts of Scotland, compared to other parts of the United Kingdom. When I came here semi-permanently in October 2000 to live for three years, I noticed—certainly in the central belt—some striking things that one does not see in other parts of the UK. Smoking is the most obvious example.

It is all a question of starting and then of agreeing to consider what service we provide and changing it to make it more fit for purpose. That underlies my work—that is what we are trying to say.

The Convener: You said that certain problems strike you as being more prevalent here than they are elsewhere in the UK. Smoking was one of them; what are the others?

Professor Sir John Temple: Obesity is also a big problem in certain parts of Scotland. We see from the papers that it is a huge problem throughout the UK, but the problems are particularly striking here.

Carolyn Leckie (Central Scotland) (SSP): I have a couple of questions. First, how confident are you in the robustness of the available evidence on morbidity and mortality rates in relation to the trade-off between access and specialism? What effect does the trade-off of moving from local services to specialisation and centralisation have on morbidity and mortality rates? How confident are you about the evidence that the trade-off is worth it in terms of morbidity and mortality?

My second question relates to the first. You talked about there not being enough doctors and nurses, but I assume that you mean other health professionals and health workers as well.

Professor Sir John Temple: I said that.

Carolyn Leckie: Have you calculated how many workers would be necessary to avoid the trade-offs that are being made?

Professor Sir John Temple: Let us deal with the trade-off between keeping everything as it is and trying to change it—that is what we are really saying.

Carolyn Leckie: I am not saying that we should keep everything as it is. I am asking what staff numbers would be necessary to maintain or improve services.

Professor Sir John Temple: To maintain the present services and comply with the working time directive and the work-life patterns that young people now expect, we would need an awful lot more people on the ground than we have now. In many localities, if we put an awful lot more people on the ground, they would not have much to do for a lot of the time—they would just be sitting around waiting for emergencies. Therefore, the trade-off is acceptable.

Carolyn Leckie: Have you worked that out statistically?

Professor Sir John Temple: I have not, but we provided some statistics in the 2002 report, "Future Practice: A Review of the Scottish Medical Workforce". There are units in the Executive that would give you chapter and verse on what that means.

Carolyn Leckie: Have you calculated the number of workers that would be necessary?

Professor Sir John Temple: We now need a minimum of five and probably eight people on any shift at any time to comply with the working time directive. If there are eight people in a locality with a small throughput, they cannot keep their skills up to date and they do not see enough work to keep them interested. A trade-off must be made and the only way to do that is to alter the way in which we deal with the work in that locality. A lot of the work is therefore referred or taken elsewhere if there is an emergency.

An awful lot of minor surgery and investigative work can still be done locally in order to continue the use of facilities. The example that I have always given comes from another locality in the UK where there was a large district general hospital, a small hospital, a very small hospital and the surrounding facilities. The services were reorganised so that there was one unit that could do everything, one that did a lot of elective work and one that did a lot of ambulatory work and which, in effect, closed at 5 o'clock. However, 90 per cent plus of the patients still went to where they would have gone for investigations and treatment before the reorganisation, while 5 to 10 per cent had to travel for treatment. They did so for the reasons that I gave earlier: patient safety and high-class quality care. That is the trade-off that we have to make. There is no one-size-fits-all solution; we have to consider in every locality what can be done to alter the situation.

You wanted numbers. The Executive has suggested that we should have another 600 consultants by 2006. That is not a figure that has any scientific background, but if we could get another 600 consultants by 2006 I would say, "Yes

please, and let's have more as well", because whatever we are considering at the moment, we have not got enough. You will know we have enough when we start to see some medical unemployment, but we do not see any medical unemployment.

Carolyn Leckie: I understand those arguments, but they do not answer my question. I am trying to put the issue in a global context to make a political judgment about where we are going. You are making the argument, which we all hear in our areas, about why such change is necessary, but nowhere are we able to get evidence on centralisations that have had a positive impact on morbidity or mortality. I ask you to pitch the numbers that are necessary, so that we can get a handle on the global gap, because the examples that you quote are all locally based, are about particular shifts and about how you cannot get enough consultants and what is not practical. That is an argument; it is not providing a global picture and a global figure.

Professor Sir John Temple: If I may say so, it is fact as well.

Carolyn Leckie: Yes, but it is an argument about why something is necessary, in the context of the status quo. I am coming at the issue from a political perspective, and trying to picture our vision of the NHS if we were not restricted by some of the problems. On the basis of Scotland's health situation, health needs and the geographical and other variations that need to be addressed, what would an NHS that was not restricted by finance or resources look like? How many doctors, nurses and other health professionals would be in that NHS? In order to judge other reports and your submission, it is necessary to understand that, but to my knowledge that kind of work has not been done.

Professor Sir John Temple: I do not think that there are any factual bases for that argument at present. The work has not been done. However, there is enough evidence to tell you that the status quo cannot continue, therefore if everybody just sits back and waits for the status quo, you will end up with hospitals not being staffed for certain parts of the day, and when people present at the front door nobody will be available to treat them. That is not acceptable to the public or anybody else, and it has to be changed. I am telling you that we have looked at some of the things that might have to be done to change that situation, but I have not said that we will close anything. I want to keep that on the table. Absolute numbers would have to be examined in every locality, but you are not denying, are you, that there is a great shortage of doctors in Scotland?

Carolyn Leckie: I am not denying that at all, which is why I am trying to tease out what is necessary. The other question is, where there have been centralisations and measurements have been taken of morbidity and mortality and the effects of centralisation, have health boards' claims about improving safety actually been achieved? I am not aware that they have.

Professor Sir John Temple: There are examples of centralisation where health care in major disease specialties has improved. We would not want cardiac surgery in six centres in Scotland for 5 million people. We would not want neurosurgery in eight or nine centres, neither would we want that for oesophageal surgery. If you examine resection for cancer of the oesophagus, which is an increasingly common disease in the UK, the results are best in centres that do a lot of that work and worst in centres that deal only with the occasional case. We know that centralising that sort of specialisation definitely works. That is accepted, and that is what happens now. We are talking about extending that further and we are considering in particular some aspects of emergency medicine that cannot be dealt with because we do not have enough people on the ground to deal with them. That is where we are coming from.

Dr Cairncross: It might be helpful to say that as the report was being written, what is in Carolyn Leckie's mind was in a lot of our minds: how do we get the evidence that she is looking for? In Scotland, that evidence did not exist a year or so ago—it was difficult for us. Sir John has set out how we thought through the processes. Since the report, we have entered into a major change, with the Scottish Executive implementing a Scottish national work force strategy. It is a wide and embracing strategy that will encompass the kind of arguments that you want to be thought through, because it will not work unless we can answer some of those questions. That is prospective, if you like. It is a consequence of this work.

Carolyn Leckie: I think, sorry—

The Convener: I would like to move on. I have a list of members who want to ask questions and we have only another quarter of an hour.

14:45

Janis Hughes (Glasgow Rutherglen) (Lab): We are told that there are a number of drivers of change and that there is a need to reconfigure or centralise services—however you wish to phrase it. Some of those could be understood as relating to longer-term solutions, such as the working time directive, which will be with us for the foreseeable future, but some might be shorter term, such as those related to recruitment and retention issues, particularly in respect of medical staff but also across the board in the health service. You said

earlier that there are staff shortages, and the Academy of Medical Royal Colleges says that little progress has been made in medical recruitment and retention. What are the reasons for the shortages that are leading to the need for reconfiguration? Why is nothing in place to address that and what do you think should be in place?

Professor Sir John Temple: I need to think carefully about that for a minute.

There are shortages in some specialties here and throughout the United Kingdom, and other specialties are oversubscribed because they are glamorous and sexy. We have in place reforms in medical education to try to widen exposure of young doctors to many disciplines to encourage them to enter disciplines that they might not otherwise have considered. The strategy for that is called modernising medical careers and is now in train. I hope that it will widen the opportunity for young people to consider a broader range of medicine as doctors as opposed to as students—things are quite different once they qualify.

There are other reasons why some specialties do not attract people as well here as they do further south, which relate to opportunities and lifestyle. Not much can be done to change that at present. Scotland has always had a pretty efficient health service with little private practice. England has had a health service in which the further south one goes the more private practice is available in certain disciplines. That is neither a good thing nor a bad thing; it happens and a number of people are attracted by it.

Another issue is the fact that only half the doctors whom we qualify in Scotland are Scots; the rest are from England and elsewhere and many do not intend to stay here. Some do, but many do not and often take the first opportunity to go back. We can help to deal with that by providing attractive training packages and programmes. Scotland is ahead of the game in modernising medical careers, which will be launched next August. We will have two-year programmes for doctors as they qualify, which were not in place previously. Those will be well publicised and will probably be ahead of what is happening in England. That will help a little bit.

There is a need to publicise living in Scotland and the advantages of doing so—I said two years ago that I thought that we should be considering ways of doing that. However, we should not ask doctors to do that; we need professionals to go out and sell that sort of thing.

Those are some of the issues around recruitment and retention. It is no secret that there has been a huge recruitment drive by the Department of Health in London to try to get more doctors into the English health-care system. That drive has been worldwide, but it has not been a huge success. I do not know any country in the world that has quality doctors that it wants to send elsewhere for good. The drive was based on a false premise from the word go.

In Scotland we have not so far engaged in multinational recruitment. Perhaps that will have to be considered in order that we can keep up with the game—I do not know. We need to do more to encourage our doctors to stay here and I believe that the Executive is working on that, which is positive. However, that is not a quick fix; it is a continuing fix that needs to be carried on year on year. People must want to come and work here and to stay here.

Janis Hughes: You mentioned the difference between specialties. I accept that some specialties are perhaps more popular than are others. Those of us who visited the Western Isles as part of our initial investigation found that one of the problems there was the need for generalists. There has, in today's medicine, been a move away from general practice to specialties. As you said earlier, one size does not fit all and every locality has different needs. Obviously, localities such as the Western Isles have a need for generalist physicians. What can we do to attract more people to do that, bearing in mind the clinical need to update skills and so on?

Professor Sir John Temple: I looked into that two years ago, three years ago and even five years ago. There is almost a separate problem, which is that there are some great attractions to going to work in such areas, but to work there one does—whoever one is—need to be very much a generalist, because one might be faced with a variety of issues that one would be expected to deal with, certainly in the first instance. One of the difficulties of the present system is that it tends to train people who become increasingly specialised the further on they go, which increasingly takes them away from being generalised.

We have written training packages, which have been approved by all the necessary authorities, which will allow people to train for that more general type of work. That is not difficult. The trouble is, few people want to go into that type of practice; therefore, we have very few recruits. In surgery, only one person—that I know of—has signed up to that package in the past two years. That person wants to go to a remote area to continue working once they have finished their training. The difficulty is that we do not have people who want to go to such areas and—as I am sure you realise—even if a person does want to go there, we must think about the whole family package, which often makes matters more difficult.

There is another issue. Let us suppose that we

fix it for people to go to a place such as the Western Isles for a limited period so that they can see how they like it. If they are there for a while very much as a generalist, how would we get them back into the mainstream system, which is rather different? That is why the Highlands and Islands pose particular problems for us at the moment. Recruitment at consultant level there is very difficult and recruiting at junior—or trainee—level is even more difficult, because the exposure is limited. In a given period, therefore, although recruits learn a lot about the more holistic part of medicine—treating the whole patient and so on—which is very laudable, they do not get much genuine hands-on experience in A, B or C, which is what they need for their other training. If a lot of people really wanted to go to remote areas, we would solve the problem overnight, because we have the training packages.

The Convener: What is the practice in countries that have similar topography to Scotland, for example the Scandinavian countries? How do they resolve the problem of delivering services to rural and remote areas?

Professor Sir John Temple: Scandinavia has similar problems, but it has a slightly different lifestyle approach to them, in that it is quite in order for people to want to go back to such areas to live and work. Australia has the same issue as we do with its outback—it is now running into real recruiting difficulties for services there.

Dr Cairncross: I have two points to add. First, on recruitment and retention of staff in Scotland, the complementary report by Sir Kenneth Calman—which the committee may not have seen—about basic medical education, identified the need to increase the number of Scots who enter our medical schools. The number is low, yet we understand that a Scotland-domiciled entrant is more than twice as likely to remain and work in Scotland as one who is not. There is therefore a yield from getting more Scots in. The policy is not meant to be in any way discriminatory; it merely recognises that the balance is too low at the moment and that we would like more Scots in our medical schools.

Secondly, the thing about other countries is that there is a wide range of options. In Denmark and Norway, one can be directed to go to certain areas. In developing countries, one is mandated to go to rural parts. What we may do in Scotland is look much more carefully at enabling rotation of the experience of trainees so that they are not stuck only in Edinburgh, but instead see the whole of Scotland. The whole of Scotland would therefore get a chance to be exposed to them.

The Convener: On the business of there being too few Scots entering medical schools, how is that reflected in applications, and in applications that are successful? Are we making it too difficult for people to get in? It is anecdotal that one must have only A grades to get into medical school, but that does not mean that we will get the best doctors at the end of the course.

Dr Cairncross: There are many anecdotes about that and we have yet to sort it out, but most medical schools are, in effect, prisoners of the profiles of their applicants at the moment. In Scotland, we get many applicants from south of the border. Scots, even with that disadvantage ratio, have a better selection level than non-Scots, but it is nowhere near enough. As to whether they are being asked to perform at a higher level, there are different views on that. That is an area that we will want to look at carefully in the near future.

The Convener: I might ask the General Medical Council about that as well.

Mr McNeil: It seems to have been a long time since Sir John said this, but I drag you back to your comments about people's experience of a major event and what services should be delivered locally. My perception is that you have won the argument about the major event—people are used to going into the major cities to receive treatment for a head injury and for cancer services and heart services. However, we have no agreement on what happens in communities and emergency services. I am concerned about the idea that one cannot go along to their local hospital with wee Johnny or wee Josephine to get their broken arm fixed, but instead have to travel for that treatment. We are a mile away from allowing that to happen.

Apart from the recruitment and retention issues, there is the debate about what can be delivered locally and nationally. What confidence do you have that we can create the flexibility among medical professionals—the people who deliver the services—to meet the will of the communities that they serve, to make them their focus, to work effectively together across hospitals and seriously to consider intermediate care, which you said was an urgent matter in 2002?

There is no agreement among the professionals in my community about what "intermediate" means two or three years after your report was published. There are big issues about the profession and I do not know how we can convince communities that there is a problem when there is a terrific sense of denial among the professionals that there is one. They believe that they can continue as they have always done. How can we achieve flexibility? How can we encourage professionals to change their practices and meet the needs of patients?

Professor Sir John Temple: That is a fair criticism of my profession at present. The profession has to change its views on the matter simply because of the way in which contracts are

working out. I keep returning to the working time directive from which we cannot get away—it is mandated and it has to be observed.

There are good exemplars of changes where high-quality practice is delivered before people need to be moved. I am thinking of some of the general practices that have got together to deliver effective intermediate care. There are only a small number at the moment and I do not think that we have publicised enough the superb work that is going on.

I went to a practice in Lochgilphead; what they are doing is magnificent, but it is just one practice of about six doctors. If they can do it, surely we can find ways of getting others to do it. I am sorry to put it in this order of importance, but if I cannot get professional consensus first, my colleagues will not go out and sell the changes to you and they will not sell them to the public. Therefore, we will not get them through. The profession has to realise what it has to do first, which is where I think Duncan McNeil is coming from. The profession needs to change and be more flexible.

Issues are arising that mean we have to change and we can do that only by being more flexible. Change will not happen overnight and we need to start now by publicising some of the good practices that are showing the way forward. A lot of this is still about people—if a person just breaks his or her arm, cuts a finger or whatever, they will be treated locally. If, however, they need a major operation, they might have to be transferred, which is what much of the debate is about. The matter comes back to defining the situation and telling the public what is going to happen so that they understand; at the moment, they do not.

15:00

Dr Turner: Earlier, Carolyn Leckie talked about large hospitals and outcomes. I have been led to believe that the centre for health economics in the University of York undertook in 1997 the most comprehensive study of the relationship between, on one hand, hospital size and the number of patients treated and, on the other, clinical outcomes. I do not want to have to read the relevant paragraph out, but, basically, the study did not prove one way or the other whether bigger centres had better outcomes.

I am worried about the fact that, even in a big centre such as Glasgow, we are transferring efficient and safe services into other buildings in other parts of the city and, in doing so, we are giving the patient a worse service. If a change is made in a service that is given to a patient, the new form of service should be at least as good as, if not better than, the previous form. No doctor would disagree with that but that is not what is happening in Glasgow. Surgical units, such as gynaecology or oncology units, are being transferred without the provision of extra high-dependency beds, which nobody would think was a good idea. We have a rheumatology one-stop shop, which allows all patients to get blood tests, X-rays and access to professional physiotherapists, podiatrists and so on. It is proposed that that unit be shifted to save money, which will mean that the service will be broken up and will not be as efficient for the patient. We also have centralisation of pharmacy services, which concerns patients who are receiving chemotherapy—you can imagine that people who are receiving such therapy do not want to waste their day hanging around in a ward waiting for a prescription to arrive so that they can get their treatment. The so-called improvements have meant that patients who used to go to a hospital, get their treatment and get back home relatively quickly now have to hang around and wait. Our attempt to improve the service by centralising it is not working for the patient.

Coronary care is another point. In one of the hospitals in which I am particularly interested, patients can go straight into coronary care, which saves lives. The transfer of that unit down to the major hospital with an acute accident and emergency and trauma centre might not be good for the patients, who might do better under the old model rather than have to take on a new model.

On the number of doctors, I found out the other day that, in the new payment arrangements under the working time directive, young doctors who do a bit of overtime in order to learn a little more because they are keen put themselves in a bracket that might cause the department to have to make overtime payments—which everybody gets—that would come to about £10,000. Looking at the sums, it strikes me that, if we got more people working and learning and worked out their wages as opposed to their overtime payments, which could hold the system to ransom, the situation would be a little bit better.

Medics are all in favour of change because we want to do what is best for our patients—we have been used to it all our working lives. However, I am basically saying that change is not happening.

When we visited the outer Hebrides, there was a problem with patients receiving chemotherapy in the islands. Is that not right?

The Convener: Those are well illustrated points, Dr Turner. The view that you are expressing is that change is being driven by necessity—in terms of staffing and costs and the boards' overdrafts—rather than the needs of the patients.

Professor Sir John Temple: I have no detailed knowledge of the situations that Dr Turner raises

but it seems that she is describing a piecemeal process of change that is driven by a necessity and which is not directly related to patient safety.

If we are going to introduce any of the measures that we have outlined, the overriding principle is that the new measures must be as good in terms of patient safety as the previous ones were. That is the number 1 issue and will involve a trade-off between doing something locally with more risk and moving a patient to decrease the risk. That is a judgment that has to be made. We will need our bigger health economists to examine that and apportion resource appropriately. However, if change is managed in a piecemeal way, we will end up with changes that might not be of benefit to the patient.

I would go back to the first principle and say that what we are trying to do is suggest a way in which Scotland can have a safe health service and safe health care. I am sorry, but I am giving members a cover-all answer. I cannot talk about individual details, but the things that have been described do not sound like improvements for the better, although they should be.

Dr Turner: That is why people are worried about the changes. It is very difficult to carry the public with you when the people who receive the treatments are saying that things are not better. Hospitals are being closed to shove units into a different place—they are just being transferred from here to there—and people do not have easier access but are receiving a worse service. Lives may well be put at risk—I do not need to describe the details, but I have mentioned a few things—and that is extremely worrying. There are also implications for the recruitment of staff in medicine. If health professionals have built up systems to be the best but they are broken down, torn apart and thrown away, that tears the heart out of them. It also means that the health professionals cannot maintain their professional standards. Their professionalism is being compromised to the extent that they ask, "Why should I stay here?" It is all tied up together.

Professor Sir John Temple: Of course it is. A lot of change used to happen because we were chronically under-resourced. We are now constantly reassured that the amount of resource that is going into health—throughout the UK, not just in Scotland—is increasing exponentially. This may be a totally naive statement, but that should mean that, when we introduce changes now, the purely financial aspect is not the overriding factor as it often has been in the past. That is the advantage of having much more from indirect taxation going into health, and we should see the benefits of that.

The Convener: I want to move on, as I am conscious of the time. We have a final list of questions.

Shona Robison: I would like to pick up on something that Sir John just said about investment. We all acknowledge the fact that there has been increased investment in the health service, all of which is very welcome. The problem is that it is very hard to see how the patient benefits from that investment. If a patient or another member of the public sees their local health services contract while record levels of investment are going to the health service, they experience a quandary. Also, when health boards are strapped for cash because the bulk of the money has gone into consultant contracts, GP contracts, drugs budgets and so on, the patients and the public do not see a huge benefit or the revolutionary transformation of their health service.

My second point follows on from what Janis Hughes and Duncan McNeil said. If we were sitting here with a blank piece of paper trying to design what a health service for five million people would look like, I imagine that we would suggest some of the things that you have mentioned. There would be certain centres where people would go for neurosurgery, heart surgery and so on. Everyone would accept that. However, I suspect that we would also have, as far as possible, accessible local emergency services, routine emergency services and routine maternity services. Those routine services are where all the contraction is happening. I do not think that anyone would necessarily expect to have a hospital at the end of every street to provide those services; nevertheless, people would expect it to be within a reasonable travelling distance. For people who live in the Highlands and Islands, the travelling distance is not reasonable.

If we had a blank piece of paper and were planning what sort of personnel the health service for five million people would need, there would not be the same drive towards specialisation that the royal colleges have been promoting. That is what I cannot understand. If the vision of the health service is of one in which highly specialised centres exist for highly specialised procedures but in which there are also more generally accessible emergency services, why are we training so many specialists and not training generalists? Is it that the royal colleges have had far too much influence over that agenda? Should we change that approach and say that it is not what the Scottish health service needs? Are there lessons to be learned from other countries? You mentioned Denmark, which seems to take a far more interventionist approach with its health professionals and where they go. Is there room for that here? Have there been any difficulties or resistance in Denmark? We really need to get to grips with such questions because I fear that where we are going to end up with our blank piece

of paper is not where we need to be. That worries me greatly.

Professor Sir John Temple: You raised a lot of issues. In the report, we move towards a more generalist type of training. We define the types of doctor that we need and suggest that only a small number need to go to that much higher—or deeper—level of specialisation. I agree that at present we train everyone to the highest level before they finish their training programme in hospital practice and many people never need to use all those additional skills. We are suggesting ways in which we can change that across the whole country.

The royal colleges have responded to public demand that we have ever more sophisticated and better health care as a result of the focus around amazing advances in technology. If I look back over my working lifetime and see what has happened in the 30 years or so—it might be longer—since I left medical school, the bodies that have supplied the training and provided the doctors have responded to that perceived need. I think that we are now at the stage where we realise that there is a need for high-tech medicine. However, there is also a need for a more general type of medicine with a small "m". That is what we mean when we talk about the types of trained doctor and that is what we would like to see. We think that that is achievable and, in achieving it, we can reduce some of the training times for hospital practice and get more people out on the ground and providing the treatment. We can then start to produce some of the solutions.

Shona Robison: What incentives do we need to use to get people to go into that more general medicine? You said earlier that it is not an attractive proposition.

Professor Sir John Temple: I think that it will become attractive. The job will still be fulfilling, exciting and challenging. It will map more realistically what the doctors do. We will just not give them all the extra depth of training that they do not need. That will get doctors out and earning their consultant salaries earlier.

We are also doing a lot with nurses and other paramedical branches and professions to enhance their role and give them a more fulfilling job. Big change is coming but it will take some time. It is a culture shift. At the moment, we are stuck in a time warp with what I call the 1948 model, and that needs to be changed.

Helen Eadie: My question is really a follow on because Shona Robison asked the first part of the question that I was going to ask.

During the past week, I heard that 100 new consultants had been recruited to the Lothian area. However, other areas of Scotland lack consultants. That comes back to the question of diverting people to particular local areas. To what extent is that possible and practical? If we are to have consultants throughout Scotland, can we take such an interventionist approach? If it is not possible because the big hospitals are the teaching hospitals and that is where the consultants want to go, is it possible to design the service in such a way that general hospitals become satellites of the big teaching hospitals?

The people who speak to me are the same as the people about whom other members have concerns. My people say to me, "I just want to feel safe", and they will not feel safe if they see the general hospital being closed. They do not mind having to travel for the big heart operation and other services such as those that Duncan McNeil mentioned. Can we use such a satellite hospital design?

Professor Sir John Temple: We have made that suggestion, to an extent, in our views on what we might do about recruitment in some of our remote and rural hospitals. Some of those hospitals are unsustainable under the working time directive given the staff numbers that they have.

Helen Eadie: Mine is not a remote or rural area. I live in a semi-urban and urban area.

Professor Sir John Temple: In some of the semi-urban to urban areas we have suggested that there could be some linkage. Certainly, if there are two hospitals in a locality and we decide that we have to combine the functions and pool the staff of hospital X with those of hospital Y, which is of a completely different size, the staff will have to work at both units. That is quite a painful process, but it has happened and is what we need to do. There are some good examples of areas in which we might want to do that.

However, in some areas, we cannot recruit. We can recruit in the urban areas and the big teaching hospitals but we cannot recruit radiologists, anaesthetists and obstetricians, for example, in some areas of Scotland. If we cannot recruit, after trying hard, looking at the locality and considering twinning, it will be necessary to redesign the service and decide what can be run there safely. That is happening in one or two of those places. We have not closed facilities, but we have redesigned the service. We must keep coming back to this point: all that means that we have to redesign and change the service.

15:15

Mr Davidson: A concern about the modernising medical careers programme, which you hinted at, is the public perception that fast tracking people to become consultants might not give them enough

skill and might not maintain standards. Will fast tracking dilute the role, which again equals patient risk? How do you answer those queries?

Professor Sir John Temple: The answer to your question about whether the role will be diluted is no. We fast track people because we do not include the significant periods spent marking time while waiting for the next jump, which are currently built in. There is no reason on earth why we have to have the longest training programmes in the western world, but that is what we have at present.

Robin Cairncross and I have been involved in this area for the past four or five years and we are trying to ensure that we build a streamlined training programme that has the right hurdles to ensure that people acquire the right skills and competencies. That means that we should be able to get people off the training programme in their early 30s, as opposed to their late 30s, which means that they are skilled but not as experienced. Experience is something that one gains throughout a professional lifetime. I finished my career doing operations that were not even thought of when I started my consultant career. I learnt how to do those things as I went along, as part of lifelong learning. We must bring that process forward a little bit, but we have to accept that the people who come off the programme aged 32 or 33 as trained doctors in X or Y are not as experienced as they would have been had they come off at 38 or 40. However, they come off when they are still fired up, enthusiastic and have great ideas; that is when we need them. I have no truck with the idea that the position for which we are training now is what used to be a senior registrar. We are now training doctors, who do not work in isolation as consultants to whom everything was referred and who knew everything. Doctors now go out to work as part of a clinical team that will contain other consultants—younger and older—who are there to refer to, talk to and help. That is where we should be.

Mr Davidson: You feel that those people are perfectly capable of running consultant teams, which brings in various other skills within medicine.

Professor Sir John Temple: I am absolutely sure that they can do that. They do not all jump at consultant jobs when they finish, but that is for a different reason: they still try to cherry pick the job that they want. Young people use all sorts of holding strategies to hang on until they see the sort of job that they want, but they are perfectly adequately skilled. They go through a training programme that ends with their completion of specialist training. We sign documents to say that they have completed the programme and that they are competent at that level to go out into the big wide world.

Mr Davidson: Do you agree that they are not competent to provide training? They have to go over some more hurdles if they want to develop and train registrars.

Professor Sir John Temple: I do not quite understand your question. What I am saying is that when someone gets their certificate of competence that means that they are competent at that level. We define the levels as where we think they should be. There are only two levels of trained doctor. The first is the judgment-safe level, which will cover the majority who will run district general hospitals and so on. A smaller number require in-depth care skills beyond the first level: I am thinking of people who will do oesophageal surgery, for example. They will get additional competencies for such skills, but when they get their certificate, wherever they are, they are competent and confident.

Mr Davidson: Do you think that that will attract young graduates from other parts of the UK to come here and go through that fast-track training? Could Scotland develop that competitive edge over the rest of the UK?

Professor Sir John Temple: Although the approach will start in Scotland, it will be universal before very long. We are not promulgating the programme just for Scotland; it is something that has been discussed by various bodies in other parts of the UK. Because of the size and scale of the service here, we have the opportunity to get things moving fairly quickly. That is a plus; it is a wagon that we should try to jump on.

Mr McNeil: People had the perception that your reports have become the justification for centralisation, and they have certainly been used to justify some of the discussions that we have had, but you have dispelled that a bit today. You are arguing for centralisation of services where it can be clinically proven to improve outcomes, patients' experience and equality. We have listened to that argument. We have heard that you would support a national debate. We have heard that the number of boards in Scotland is perhaps too high, and we should perhaps be looking into that. Do you have any more thoughts on how the committee inquiry could further inform the work force planning agenda? I am sure that others will have more thoughts on what you have said today.

Professor Sir John Temple: If we could move those arguments forward, we would probably get some real progress. I said three and a half years ago—I am still saying it now—that Scotland could start to take the sort of action that Ireland is taking on smoking. That is a big jump but, although a smoking ban will not have an immediate effect, if we started to act now, the next generation to sit

round this committee table would see an effect. We need to influence young people. To me, that is the numero uno priority for health prevention in the UK, and particularly in Scotland.

I was in Ireland recently, and people no longer smoke in pubs there—there is no question about it. The landlord makes sure that people do not smoke. If he is caught with somebody smoking in his pub, the fine that he gets is horrendous. If such issues were grasped, some progress could be made. At the moment, we are reacting to a sick population that is not getting a lot better. We need to act and to move the goalposts.

The Convener: You will be aware that the committee is considering a member's bill on smoking on which we will shortly produce a report.

Professor Sir John Temple: I was not aware of that, but it is good news.

The Convener: We will produce a report based on the evidence that we have taken, some of which has come from Ireland and New York.

I thank you for your evidence and for your perseverance during the work of various labourers outside. It has been music of different kinds. We seem to resolve the tapping only to have somebody drumming on pipes.

I intend to move on—straight on—with no break. [*Interruption.*] Heaven forfend that members pay attention to the convener—I was just saying that it is my intention to move on without a break. Do members agree?

Members *indicated agreement.*

The Convener: I welcome Professor David Kerr, chair of the advisory group on the national framework for service change, and Derek Feeley, head of national planning in the Scottish Executive Health Department. I know that you were sitting through the previous evidence session. Could you update the committee on the work of the advisory group and on any progress that it has made to date?

Professor David Kerr (Advisory Group on the National Framework for Service Change): Our group has been asked to provide a vision for how the health service and health care delivery will evolve over the next two decades in Scotland, so its work is forward looking.

We will take account of a range of drivers. John Temple spoke clearly about the work force; we will also consider aging population, changing demography and changing medical technology. We will see how we can underpin this evolution with service redesign and modernisation. We have also been asked to provide a much clearer structure for national planning, picking up many points that have already been alluded to during John's evidence. I would love to engage in a national debate about how we can drive that forward.

The Convener: On your website, you say:

"The Scottish Parliament will also be kept informed"—

which you have done—

"and will be given the opportunity to input."

Apart from having a national debate, what plans have you to involve this committee or the Parliament?

Professor Kerr: Clearly, this meeting is a good chance for us to establish contact with each other. The possibility of coming back here, at your behest, would be reasonable, sensible and logical. We would also be interested in catching up with things with individual members. There are a number of clear hot spots, or areas of controversy, to do with service delivery, and I would like to find out more. If we could engage with committee members, using you as a conduit into local communities so that we could further the debate, that would be enormously useful to us. We can ensure that you are kept informed of our reports and of what steps we are taking.

The Convener: I was thinking not only of MSPs in the committee but of MSPs across the Parliament. I am not quite sure how we will move forward, but your suggestion is interesting.

Derek Feeley (Scottish Executive Health Department): We are trying to work in an open and transparent way. The minutes of advisory group meetings go on the website as soon as the minutes are agreed. The minutes of all the work streams are also on the website.

The committee may wish to consider the offer made by the Minister for Health and Community Care for the committee and anybody else who wishes to attend a presentation on the work to date. A good time to do that would be around the time when the drivers for change—to which David Kerr referred—are pulled together and available for publication.

The Convener: Can you give me some idea of the timescale?

Derek Feeley: A draft of that paper will go to the advisory group meeting on 4 October, so some time later in October would be ideal.

The Convener: We will bear that in mind.

Mr McNeil: It is a good offer, and our briefing papers today have been useful. I want to go back to some questions that were put to Professor Sir John Temple and to his recommendations on involving professionals, politicians and the public. Our papers tell us that, since 1998, the professions have dealt with the issues one way or

the other, but almost exclusively in dialogue among themselves. I am delighted that you are making this offer now, but I am tempted to say that, in some cases, it is a bit late. However, I do not want to spurn your offer, which I think is genuine. There are certainly people in my community—among the professionals and the public—who would wish to talk to you about the Argyll and Clyde review, and I would welcome that.

Professor Kerr: The offer was well meant and true. When you say "a bit late", you do not mean us really, because I have only been here for about two minutes, not since 1998.

Mr McNeil: No—I do not mean you personally. I am talking about professionals having a dialogue with other professionals about the health services delivered to our people, to whom you and I are accountable.

Professor Kerr: Your question to John was apposite and interesting, and clinical engagement is awfully important. That might be why Malcolm Chisholm got a doc to lead that engagement. Not only do we have to engage in a dialectic with the citizens of Scotland, but we have to engage—as John clearly said—with drivers for change, and so on. If we are considering service redesign, the slogan would be "Work better, not harder." We need to be able to engage with the professions, and sometimes that means doc talking to doc, but that must not be exclusive. We must open out and get that dialectic going with the public.

15:30

Janis Hughes: I was interested to hear you say that you would like to use this opportunity as a conduit into local communities. What strikes me is that your remit says that you do not intend to override or delay current service redesigns in the NHS but that you intend your work to complement future planning by boards. In the communities that I represent in south Glasgow, a lot of the changes will have taken place or will be on the point of taking place by the time you report in the early part of 2005, so people in those areas will see that as closing the stable door after the horse has bolted, because any proposals you make will be in the context of what is currently in place rather than what was in place before. How will you be able to engage with people in local communities, who may be disillusioned by boards and by what they see as their failure to engage with or listen to communities when it comes to service redesign in their areas?

Professor Kerr: That is another interesting and important question. The first point to make is that we are building for the future. There cannot be a single snapshot in time and we cannot get all of Scotland's health service delivery problems sorted out on a single map on a single day by March of next year. However, what we hope to do is to build a platform that is rational and logical, which involves citizens and which allows us to plan for the future, so that we have a framework that should obviate some of the problems that have occurred in your patch, in Greenock and elsewhere. This is about the future and about building something sane and rational that we can go back and use over and over again.

You are right to highlight the concerns of your constituents. I have been sent photocopies of *The Herald*, so I cannot help but know about what has been happening over the past couple of days. There is a wee sense of the agenda slipping away, or perhaps of the ice floes breaking up beneath our feet. We have already had semi-formal meetings with the chairmen of the various health boards to say that, if we want to get planning sorted out, it might not be a mechanistic matter of reducing numbers and we need to think very seriously indeed about what decisions should be made nationally, regionally and locally. Like Professor Sir John Temple, we are not centrist by nature. We need to get the balance right and devolve as much as we can locally. As has been said by members of the committee, we need to pull together that which requires centralisation in a properly balanced way.

We need to understand some of the local problems better. I used the term hot spots, and I did not mean that to sound odd or at all pejorative, but it appears that there is a bundle of such hot spots. Because I am something of an outsider—being based in Oxford these days—I think that it would be awfully useful for Derek Feeley and me to be able to connect with and bring back to the group what is happening in the streets out there. If we felt strongly enough that there was such a huge amount of tension or that such a lot of work was required in those areas that it would get in the way of our delivering the national plan, we would be prepared to go back to the minister at some stage and say that, although we cannot have a moratorium—we cannot paralyse the whole of the Scottish health service until we produce our report in March—there might be some key issues that we need to hang on to and bring back centrally. Otherwise, as you say, it might seem like too little, too late.

Let me finish by saying that our work is something that we are building for the future. We are building a set of tools that will allow us to make decisions time after time and which should obviate what seems to be a highly compartmentalised health system.

Shona Robison: I listened carefully to what you said. You said that, when you go out to speak to

people and get a feel for what is happening locally, you would bring those issues back to the centre and to the Minister for Health and Community Care. I presume that what you mean by that is that you may well be recommending to him that there should be a delay on a decision in a specific area until your group has had a chance to establish the parameters that the local health board should be following.

That is certainly welcome news, if that is what you mean. My only slight concern is that there are decisions pending now. For example, a decision on the Queen Mother's hospital is imminent. People would be rather upset if, by the time your group went to speak to them, such decisions had already been taken, given that you could manage the process on the basis of who happens to be up next. We need a pause so that there can be equality of treatment, rather than a process whereby you might manage to get out somewhere and report back to the minister but the decision might already have been made if you did not get there soon enough. We are calling for equality of opportunity, so that people can make the case for their local services and so that the national picture about what makes sense can be considered—I get no sense that that has been happening up to now. If you could tell us that you will argue the case for equality and common sense and that you will take that back to the minister, I—and other members of the committee, I am sure—would welcome that.

Professor Kerr: I sense the fluidity of the situation and some of the tensions, and I recognise that, even from the outside—I must use the term "outside", because clearly the advisory group was formed relatively recently and its report is not due until March, so we are giving the committee our early impressions of the work that we have been doing—there is no doubt that the geography of highly compartmentalising the decisions among 15 health boards, as John Temple said, seems a little odd. Because decisions are made in one patch and in a specific way, one might question whether such decisions are best for Scotland as a whole, or for citizens of whole regions.

I note Shona Robison's point, which is well made. I meant it when I said that we are keen to get out there—I do not mean in six months' time—and understand the situation better. We have been discussing the fact that we want to get out and engage as quickly, fully and equitably as possible. I am not sure how pending decisions are, but we might say that there are five key things that we must do during the next four to six weeks—we are thinking about that sort of timetable, not about delaying and delaying. We have to make sense of the situation and publish our report by March, so we must work with speed.

I will not betray the background that both John Temple and I come from, which is strongly evidence based. I want to gather the sort of evidence that we would all find compelling so, although we want to work quickly and efficiently, we must gather the data that we need to make logical, sensible decisions, rather than knee-jerk decisions on the hoof. Speed and equity are important, but the work must be carried out in a thoughtful, rational way. You want that too, of course.

Shona Robison: For clarification, will you have a role in considering Greater Glasgow NHS Board's recommendations on the Queen Mother's hospital?

Derek Feeley: We will look at them and it is important that we do so, because we can learn from the experience of local reviews. However, it is ultimately for the minister, not for us, to take a decision about such issues. We are aware of them—

Shona Robison: Will you make comments to the minister?

Derek Feeley: We are engaging with the people who are conducting reviews on the ground. That is one way to address your concerns—you seemed almost to suggest that we might be taking a haphazard approach to who we engage with. We are aware, just as you are, of areas in which decisions are pending and we are giving priority to discussions with those boards about the way forward.

The Convener: For clarity, when you leave this room, what exactly will you do about the examples of imminent decisions that we have given? How will the mechanics operate?

Professor Kerr: We have discussed the matter during the past couple of days and we hoped that we would be able to make contact with members of the committee who want to raise problems about particularly hot areas, to see whether we might be able to set up a forum that would enable us to work with you and bring together interested clinicians, citizens and whoever, so that we can understand better the arguments that are being presented. We can also be briefed by the health board and will have full access to the papers that are now coming through. However, I would be quite interested to make a local site visit to understand the matter better.

The Convener: But some of these matters are highly imminent. If we are talking about something that might happen even a month down the road, irrevocable decisions might have been taken. Perhaps you cannot tell us this at this very minute—after all, we are now into another area that I did not think we would be exploring—but what can be done just now? Given that you say

that you are not in favour of an absolute moratorium—in fact, you said that that is just not possible—will you set out the mechanics of how you might address any specific circumstances that might arise within the next two weeks? If you did not want something to happen, could you do A, B or C? I just want to know what your intentions are so that things are clear in my head and in the report.

Professor Kerr: Sure. We will take our impressions from this meeting back to the rest of our group, which will next meet on 4 October. We will carry out a piece of work before that meeting. We have also booked a slot with the minister to discuss matters with him. This is our plan. We will take the matter back to the group and find out how to drive it forward. Is that sufficiently clear or does that seem a bit soft to you?

The Convener: I will let other members come in at this point, because they might pursue exactly the same issue with you. In fact, I see their eyes glinting at the prospect.

Derek Feeley: Perhaps it might be helpful to put the matter into the wider context of our plans to engage the public in this exercise.

The Convener: I would rather pursue the issue of urgency than the wider issue, which is not of such moment. Jean Turner, David Davidson, Helen Eadie—and Carolyn Leckie, when she returns—want to ask questions.

Dr Turner: You have just talked about providing the committee with details of the contact that you made with the NHS work force during your deliberations. You might remember that I said earlier that certain things are happening at the moment that clinicians would love to speak to you about. You said that you do not want a moratorium, but you should be a patient that is affected by the changes that are happening now. For example, very good oncology and gynaecology units have been transferred to temporary accommodation with no thought given to providing extra high-dependency beds. A rheumatology unit that is doing a very good job and with which everyone is happy is about to be moved and a minor injuries unit slotted in in its place. This is all happening now.

Moreover, beds are being closed. Once they close and the wards are demolished, they cannot be put back again. Most people accept that the Queen Mother's is a specialised unit, but it is tied up with Yorkhill hospital. I cannot believe that anyone would want to split paediatric and maternity provision, but that is what is happening now.

People are also worried that homoeopathic beds might be closed. It does not matter whether we believe homoeopathy is or is not the right way to go; it serves people well. We cannot afford chronic pain clinics that would treat people and free up the general practitioners who have everything dumped on them. Everything is coming into general practice and there are no extra doctors to deal with the situation. This is all happening now. If you do not want a moratorium, somebody somewhere has to stop and think about what should be done. I would like to know whom you have spoken to up to now. Indeed, I could give you names of some people you would love to speak to so that you might get a different picture.

Sorry.

The Convener: No, it is all right. We in different parts of the country share the same feeling. It is fair to say that the matter is urgent in many parts of Scotland.

Professor Kerr, you said that your group will have its next meeting on 4 October and that you will meet the minister after that; however, that might not be soon enough to address some matters. You might need to take some interim step, which might not necessarily prejudge things.

15:45

Professor Kerr: That point is well made. Let us think about that and take it back. Although I would love to be cast in a heroic mould, we cannot deal with things instantaneously. We must remember that what we are building is for the future—it is a platform for making decisions. The group was set up to provide the report in March. Devoted though I am to Scotland, and great though it is to come back, I have a day job somewhere, too. What we are doing takes overriding importance, but we cannot instantaneously solve every single bit of what is going on, hence the sense of prioritising.

Dr Turner: I am not asking you to do that, but you have to be aware of what is happening and why we have hot spots, as you term them.

Professor Kerr: Indeed.

Dr Turner: If it were a business—any kind of business: a supermarket, or what have you—the customer would be the most important person. No one is more important than a person who is very sick, and they are on a very lonely journey in the health service.

Professor Kerr: I could not agree more.

Dr Turner: What is being eroded at the moment is faith in the system. Patients go into hospitals—big centres—and seem to be passed from pillar to post. They are not even sure who is a qualified nurse. They are in and out as fast as they possibly can be. Where do they go in general practice? Somebody has to take advice on what is happening now in order to move forward.

The Convener: Thank you. I want to keep to the issue, as other members have questions to ask.

Mr Davidson: With your permission, I will ask Professor Kerr a question that I was going to ask later on, but which I think is pertinent now.

Your group was set up by the Scottish Executive—in other words, the ministers. Does your group aim to develop an holistic framework for the future of the NHS throughout Scotland, or will you come up with a series of scenarios and plans that could be available as options for health boards, regions or whatever we end up with? I get the impression that you are talking about something for the future that is totally divorced from what is happening at the moment.

We, in the Parliament, are stuck in the jam in the sandwich—all 129 of us, including the minister. Are you producing a game plan with a series of options for the future, so that people in the future will be able to consider whatever the outcome is, or have you been set the task of going in and examining the problems that exist now, perhaps to suggest a staged system of things that need to be considered now as well as an ultimate long-term goal? It would be helpful if we knew what you are setting out to do.

Professor Kerr: Indeed. You will be glad to hear that we are doing a mixture of the two. We are setting up a national strategic review of how decisions should be made. A common theme this morning has been that decision making is confused, compartmentalised and parochial. There is no national agreement about how decisions are made, so we need a proper framework. However, if all that we were doing was some theoretical intellectual exercise of that sort, it would be much less engaging and not something that we would get involved in. To use a crude analogy, we want to undertake part of the exercise of testing the decision making by putting pins on maps—actually making some real decisions about where the services should be delivered.

Often in the past, reports of this sort have fudged that sort of issue. Reports have been made, they have gathered dust on shelves and there has been no real impact on either the health of the citizenry of Scotland or the way in which health care is delivered. That is not what we are doing. We are going to do an amalgam of the two things that you mentioned; therefore, our engagement with you, concerning decisions about what some of the priorities are, is interesting, important and timely. Clearly, we have identified themes of our own that we have started work on, which are on the website and described in detail in the papers that we have submitted to the committee. However, there has to be a fusion of the two.

Mr Davidson: When I ask about options, it seems that different health boards are coming at the same issues from different angles. Perhaps there is a shortage of consultants or perhaps there are no anaesthetists, therefore nothing happens in the surgery, and so it goes on. The health boards are coming up with those reasons. I presume that you are not looking at any of the work force issues; you are looking at general planning of services and for people to be slotted in to deliver what is appropriate to an area. That is where you are going.

Professor Kerr: Yes, but how can we describe a vision for Scotland's health service without at least being aware of, or taking account of, the drivers for change? The work force will be one of those drivers and an aging population and changing technology will be others. I hate to sound like a technocrat. We have a matrix of work to do in which we will drive forward the themes on accident and emergency facilities, elective care, care in the community and so on. Beside that, we will have different drivers for change of which we will take account, so that when we describe what the best elective care system might be, whether it is orthopaedics, colorectal surgery or whatever, we will take account of epidemiology, the work force and other matters. We will try to provide the strongest matrix structure for the future.

Mr Davidson: I understand that, but we must take from what you said that whatever you do on the minister's behalf will have no input into the current crisis of centralisation, closures and amalgamations, because you are talking about long-term stuff.

Professor Kerr: No. I reiterate that it is a 20:20 vision, but we have said that part of that will involve putting pins in maps now and part of that will involve supporting with real examples how we can make concerted decisions throughout different health boards. An interesting decision concerns whether Scotland should have a single neurosurgical centre and if so, where it should be. The set of arguments about how we should drive forward tertiary health care is interesting. We can pick up on examples for which we would provide a detailed map of service. Those are some of the work themes that we have driven forward for making sense of in that way.

I am interested in the pattern of some issues that have arisen recently, such as the balance between delivering care locally and centrally. That is another issue that we must take care of, and that is an immediate pressure for you. As I have said, I am sure that our group would want to take a view on that. That may be the more immediate low-hanging fruit.

Helen Eadie: You said that it would be March before you could deliver on some of what you

have described. We are reasonable people and we understand that the national health service could be paralysed if a moratorium were declared, which would have implications for staff morale and other matters. However, the time between now and March is not long, and it is reasonable to ask for a moratorium between now and March on some of the big issues, because by March, you will be able to put in place some of the indicators that will shape the big decisions about the way forward. Some decisions that are coming before us are about not just small general hospitals—about which I am concerned in my locality of Dunfermline East—but big strategic hospitals, such as the homoeopathic hospital and hospitals in Glasgow and elsewhere that cater for people in my constituency. It is not unreasonable to ask for a moratorium for only those six months.

Professor Kerr *indicated agreement*.

The Convener: Do you agree about a moratorium or just that it is not unreasonable to ask for one?

Professor Kerr: The statement is reasonable, but I disagree with it. I do not think that we should have an absolute moratorium, but I promise that we will try to be as fleet and quick-footed as we can be to sort out the situation. That is just my opinion. However, I understand the point.

Carolyn Leckie: I have found your comments illuminating. I support a moratorium—I have argued for one for more than a year, so that we can have the overall strategic debate. My questions will probably explain why. Even the Scottish Executive policy and documents that I saw when I was a member of the Public Petitions Committee provided plenty of evidence that health boards have not met their regional planning obligations, for example.

An awful lot of accusations have been made—I have seen plenty of evidence for them—about consultations that have taken place from which health boards have excluded the views of professionals or the public and have not even represented those views in their reports. You said that you would engage with health boards and have access to their documentation and I am a wee bit concerned if that is your only access to documentation on the pressing issues.

I welcome your offer to engage with members of the committee and would be happy to participate in that process. I suggest that you should have access to some of the petitions that have come to the Health Committee, because there is a strong division between health boards and the public. There is disillusionment with the Executive's attempts to hold health boards to account and with how all such processes have taken place. People do not have trust in the decision-making process and they do not believe the arguments that are being made. Health boards have gone ahead and taken decisions in spite of massive public opposition.

A moratorium is necessary just to re-establish some sort of trust and to persuade people that an overarching, strategic view of needs will be taken. Do your terms of reference include the task of examining need and unmet need or do you have to report within the constraints of current resources and policy? Will your report be visionary and offer us options that require difficult political decisions about resources and so on?

I have a point on documents that have already been published. There is a situation that explains why people have lost all trust in health boards and the decision-making process. The report of the expert group on acute maternity services exemplifies the perception that health boards pick and choose which elements of guidance and reports they use to argue for a particular change. EGAMS requires that women have one-to-one care in labour, but that does not happen everywhere; it is not regarded as a priority. On the other hand, EGAMS is used as an argument for closing consultant-led rural maternity units, so only certain bits of that report are quoted.

Professor Kerr: I understand that.

Carolyn Leckie: Such issues mean that your work is urgent. You can probably sense the committee's desperation and can perhaps understand why you are being seized on as a bit of a saviour and why the work of your group is perceived to offer a way out.

The Convener: Do not frighten him any more.

Carolyn Leckie: We do not want you to leave this room without recognising the strength of feeling that exists. I would welcome the opportunity to be able to give an even deeper explanation of the situation and I am sure that all of us would like to point you in the direction of sources of information other than just the health boards.

Professor Kerr: That is fascinating. I want to make two important points. The minister has encouraged us to be as visionary as we can, so there are no barriers. We have been told to push the envelope in thinking about how the service will evolve and reconfigure over the next two decades and how we can underpin that process with the best modernising ideas. For example, we need to consider what we can pinch from Canada, which has remote rural outreach. The committee should take comfort from the fact that we have been invited to think laterally.

I wonder whether, instead of having a moratorium, another way of satisfying your need

for us to reconnect with citizens would be through better public engagement. Although the committee has examples of where the system of public engagement in consultation has gone wrong, has been of poor quality or has been misleading, there have been some very good examples of public consultation. Tayside NHS Board has done a fantastic job, as has Forth Valley NHS Board, and Grampian NHS Board is starting to get its act together. The committee sees the bad side, but there are some good sides. There are some excellent innovative ways of involving the public through one-to-one meetings with clinical engagement nurses and other professions allied to medicine, which result in cohesive, concerted bits of action that citizens support. In fact, some of the exercises that have taken place in Scotland are better than those that have gone on in England and elsewhere—they are the best in the United Kingdom. The committee can take comfort from that.

We have had public engagement at the forefront of our minds. One of the other reasons for wanting to engage with the committee and to have local engagement is that we did not want some of the current issues to get in the way of what we want to do, which is to start a national debate. We have a communication plan for doing that, which I am sure that Derek Feeley would be able to describe in detail. That debate will be about what the future of Scotland's health service should be like and how we can make it quicker, safer, better and closer. I was worried that some of the cynicism that has been engendered by what has gone on before and the current consultatory procedures might get in the way of that debate or that it might be hijacked. We are dead big on public consultation—we absolutely agree with it. We have a plan for a big national debate, not only with the public, but with doctors, nurses and all the rest. That might be a better way of re-engaging, rather than a moratorium. An absolute block on all health care planning in Scotland sounds a wee bit extreme.

16:00

The Convener: The national debate is running ahead of you. In an ideal world, you would have your route charted out and you would have gone down that path, but people are cynical. If people hear the word "consultation" again, faces will turn away. Time is running out. Those are fine words, but, with respect, the debate is now; it is all over the newspapers and in our mail trays. You spoke about the consultation in Tayside and there are others. As Duncan McNeil mentioned, people feel that such consultations are just cosmetic exercises.

The climate is completely different now, which is why you are sensing concern in the committee. We are pushing you hard on the issue, but there is concern that by the time your report comes out, so much will have shifted that the data that have been used in it will no longer be of use in many respects. As colleagues have said, when services have gone, they have gone.

Carolyn Leckie: I will just follow through that point, because it is important. Our concern is not just about a perception, it is about material issues. Our worry is that the objectives of your report may well give us a basis for developing a strategy, but it is clear that current decision making and its outcomes may well be fatally flawed, if judged by your terms of reference. However, we cannot go back and unpick things.

Professor Kerr: The point is well made.

Dr Turner: It has been ruined now.

The Convener: Can we speak through the chair, please? Shona Robison and Duncan McNeil want to speak.

With your help, Professor Kerr, I would like us to reach a position on this important issue, if we can. The committee may take a view, although I cannot prejudge that—I would like us to discuss the matter before we finish. Obviously, it would be helpful if we had your support, if not now, then in early course.

Shona Robison: Helen Eadie is a reasonable person and I agree with everything that she said. The request for a suspension of decisions that are pending to allow a national debate and better public engagement is not unreasonable. If we do not do that, we will have a national debate with a very cynical public. If we meet members of the public in areas where services are closing to engage them in a national debate about the health service, they will just say, "But services are closing. The decision has been made to close or downgrade a hospital."

If the debate is to be taken seriously and people are to believe that it is not a cosmetic exercise to finesse decisions that will be made anyway, a signal must be sent out. That might mean that some decisions go ahead at the end of the day. We all know that that could be the case, but surely the public would be more likely to accept decisions if they felt that the pins on the maps made sense. We could be sticking pins on maps where there are no services for a pin to go in. There is a commonsense issue about credibility, trust and confidence. We need to say, "There are no guarantees for the future, but while the exercise is going on to re-engage the public and build up trust, we will suspend the decisions that are being made."

Mr McNeil: May I reflect on a moment of cross-

party unity? Shona Robison makes an important point on the credibility of the planning process and the national debate. We have broad agreement today, which is necessary, about trying to create a debate while local decisions are being made. We are reaching out to you to consider the matter. We are not saying that work should not proceed—services are monitored all the time anyway—but it would be damaging, during a national debate, for a health board to come out with a decision that the community found detrimental. The credibility of this committee, of the minister and of everybody else would be affected by that. I urge Professor Kerr to consider seriously the cross-party view that has emerged today.

Professor Kerr: I sense it intellectually and sympathetically. I understand exactly where you are coming from and the advice is good advice. May I take it back? Neither Derek Feeley nor I are empowered to impose a moratorium on anything.

The Convener: You are not, but your views are valuable.

Professor Kerr: Exactly. Your views have been strongly put. We understand them and we share the majority of them.

Mr Davidson: To back up what Duncan McNeil said, we have a date in the calendar for the implementation of the new out-of-hours services; that is set in law and it cannot be undone. The urgency on the matter is coming loud and clear from each of the many communities that I have been in touch with. Some communities are saying, "We like the proposal because we are in a town, but we have a wee concern." Others are saying, "We cannot cope with this idea." Local doctors are saying that they think they will get lynched. That is a public debate about the roll-out of a service. The health boards are in charge of the consultations and they came up with the models, but it appears that they are not doing anything other than driving a budget. There is a meeting in Grampian tomorrow. I am trying to convey the urgency—there is to be a national debate, but the issue is on the national agenda now.

Professor Kerr: I am troubled by the depth of cynicism. The point is well made and I accept all that you say. I understand it. Being bombarded with the newspaper headlines in the past few days started me thinking along the same lines as you.

The Convener: I will stop the questioning there. We have reached an important point. We do not expect you to make decisions here and now, of course, but it would be helpful if you could write to the committee, hopefully in time for next week; we will not have a meeting next week, but we will have an away day. It would be useful for the committee to have your views, following our discussion today, on the best way forward for everyone.

Professor Kerr: Indeed.

The Convener: There would be no guarantee that any community would keep its accident and emergency facilities or whatever, but if there were to be a suspension until your report was published, it would be honest to say that, pro tem, nothing would happen until we had considered the matter on a national basis and come back. We fully support that idea. That would be fair to people all round and it seems to be common sense, given that you are doing such important work.

You have walked into the maelstrom of a health service that is in rebellion throughout the country. If it is acceptable to the committee, we will have something from you for our away day, at which we will also discuss witnesses. I think it would be extremely useful to Professor Kerr and Mr Feeley for petitioners and members of the public to give evidence to the committee. We want to engage with them, and this is a forum for the public, who can engage with the Parliament here as well as at the Public Petitions Committee.

Derek Feeley: I am happy to do the second aspect of that, on engagement with the committee and petitioners, but I am not clear about what you are asking us to do in your first request. To reiterate what Professor Kerr said, neither of us is empowered to make a decision about—

The Convener: We are not asking you for a decision. We know that it is the minister's decision, but we would like your views. I do not want to write the letter for you, but we would like your views, having come to Scotland and seen what is going on—it has been going on for a long time—against the background of work that was perhaps commissioned without awareness that the issue was going to explode. We would like a rethink about the method and your recommendations about what is required in the meantime—that is all. We know that that is all that you can do.

Professor Kerr: We have heard with great clarity what you have said, and the common sense and wisdom here. We will reflect on that and we promise to bounce a letter back by whatever date you said.

The Convener: The away day is next Tuesday.

Professor Kerr: We will do it.

The Convener: That would be useful for the committee to discuss.

Meeting closed at 16:10.

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