HEALTH COMMITTEE

Tuesday 21 September 2004

Session 2

£5.00

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

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HEALTH COMMITTEE
20th Meeting 2004, Session 2

CONVENER

*Roseanna Cunningham (Perth) (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:

Rob Gibson (Highlands and Islands) (SNP)
Carolyn Leckie (Central Scotland) (SSP)
Mrs Nanette Milne (North East Scotland) (Con)
Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD)

THE FOLLOWING GAVE EVIDENCE:

Malcolm Chisholm (Minister for Health and Community Care)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 21 September 2004

[THE DEPUTY CONVENER *opened the meeting at 14:04*]

Interests

The Deputy Convener (Janis Hughes): Good afternoon and welcome to the 20th meeting in 2004 of the Scottish Parliament's Health Committee. I introduce Roseanna Cunningham, who is a new member of the committee, and invite her to declare any interests that she may have.

Roseanna Cunningham (Perth) (SNP): I have no relevant interests to declare.

Convener

14:05

The Deputy Convener: Under agenda item 2, we will choose a new convener of the Health Committee. I invite nominations for the position.

Shona Robison (Dundee East) (SNP): I nominate Roseanna Cunningham.

Roseanna Cunningham was chosen as convener.

The Deputy Convener: I congratulate Roseanna Cunningham and pass the chair to her.

Items in Private

14:06

The Convener (Roseanna Cunningham): Thank you and good afternoon, everybody.

The first agenda item with which I must deal is agenda item 3, which is consideration of whether to take agenda items 7 and 8 in private. Agenda item 7 is consideration of possible witnesses for the work force planning inquiry and agenda item 8 is consideration of a draft stage 1 report. I invite comments from members.

Shona Robison: Unlike some members of the committee, I will certainly not make a habit of making suggestions such as this, but I think that item 8, the consideration of our draft stage 1 report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill, should be taken in public so that the public can know what was said in the debate lying behind the committee's conclusions in its stage 1 report. We know that the public are interested in the matter from the number of e-mails and letters that we have all received. The discussion should be held in public for the sake of transparency and because of the public interest.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): That is a rather remarkable suggestion. On almost every occasion when we have discussed whether to consider a stage 1 report in private or in public session and I have proposed that we should discuss it in public so that people can see the reasoning behind our arguments and how we have reached decisions, the committee—apart from me—has unanimously decided to take the item in private. That can be checked in the *Official Report*. I welcome Shona Robison's conversion to the idea that we should consider stage 1 reports in public session and I see no reason why we should not do so. I hope that Shona Robison will not make such a proposal only for this one item.

Carolyn Leckie (Central Scotland) (SSP): Obviously, it is up to the committee to decide what to do. I would normally support the principle of everything being considered in public, but there are a couple of suggestions that I want to make about the selection of witnesses in the work force planning inquiry and I would like an opportunity to make those suggestions, however the committee decides to conduct the agenda item.

The Convener: You will be able to contribute only if the committee decides to take the item in public, not if the item is taken in private. Whether the committee wants to discuss the item in public or in private is a matter for the committee.

Carolyn Leckie: I can write to you.

Kate Maclean (Dundee West) (Lab): I am interested in Shona Robison's proposal to discuss item 8 in public. Mike Rumbles said that he welcomed the proposal and that he hoped that the item would be discussed in public. I do not think that Shona Robison will propose that we discuss such things in public in future.

The committee should decide either to discuss every stage 1 report in private or to discuss every such report in public. Members should not pick and choose specific reports. We have discussed issues and reports in which there has been as much interest as there is in the report on the Prohibition of Smoking in Regulated Areas (Scotland) Bill. I have certainly had as big a mailbag—if not a bigger one—for other matters that we have discussed in private and I do not understand why, on this occasion, the committee should change the practices that it has followed in the past.

Helen Eadie (Dunfermline East) (Lab): I am against the item being held in public, on the ground that standing orders presume that such items will be held in private. That presumption came about as a consequence of long deliberations by all the political parties in the Parliament. This is about a particular party wanting to gain political capital, which is why Shona Robison has moved that we take the item in public. Mike Rumbles is absolutely right to say that, on every occasion in the past, Shona Robison has contested taking such items in public. I do not see why today we should accede to the proposal. If it goes to a vote, I will oppose it.

Mr David Davidson (North East Scotland) (Con): I have consistently supported the Parliament's procedure over the past five years that committee reports are thrashed out fully and go public at the final stage, when we give all the reasons why recommendations were or were not made and say whether members dissented, which has always been clearly stated. I have no particular objection to the proposal, but it would break precedent. We cannot pick and choose. We have to be consistent.

Mike Rumbles: I have a small point. I do not wish to contradict fellow committee members, but if they read standing orders—as I do, heaven forfend—they will see that they are clear that there is a presumption that agenda items will be taken in public, not the other way round.

The Convener: I suggest that we do not address the principle of the debate. We have a specific suggestion about a specific item on today's agenda. This is not a broad debate about the issue in general. Does anybody else wish to come in on the specifics?

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): It might be clearer if we knew exactly why the proposal has been made. Members have made presumptions about Shona Robison's motives, so perhaps she could clarify them. Mainly, I do not have a difficulty with taking items in private or public. The issue that the bill deals with has been prominent for weeks and it affects the public. I have no objection to taking the item in public or in private, as long as the deliberations eventually find their way into the public domain.

The Convener: I do not propose to go on with this much longer. Shona, do you have a final statement? Your reasons have been challenged.

Shona Robison: My reasons are straightforward. For the record, I have voted for items to be taken in public for specific reasons. Because of the overwhelming public interest in the Prohibition of Smoking in Regulated Areas (Scotland) Bill—which is greater than for any other bill with which I have been involved—I believe that the public should hear our deliberations. That is the simple reason for proposing that we take the item in public.

The Convener: We should make a decision on items 7 and 8. Item 7 is the selection of witnesses for the work force planning inquiry. Nobody has proposed that it be held in public. Can I assume that the committee is content that it be held in private?

Members *indicated agreement.*

The Convener: Item 8 is consideration of the draft report, which it is proposed we hold in public rather than in private. The question is, that we hold item 8 in public. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Robison, Shona (Dundee East) (SNP)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)

The Convener: The result of the division is: For 3, Against 4, Abstentions 0. Item 8 will be held in private.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No 2) (Scotland) Order 2004 (SSI 2004/322)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 5) (Scotland) Order 2004 (SSI 2004/323)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 6) (Scotland) Order 2004 (SSI 2004/330)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 7) (Scotland) Order 2004 (SSI 2004/341)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Irish Sea) (Scotland) Order 2004 (SSI 2004/340)

Food Protection (Emergency Prohibitions) (Diarrhetic Shellfish Poisoning) (East Coast) (No 2) (Scotland) Order 2004 (SSI 2004/378)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No 3) (Scotland) Order 2004 (SSI 2004/352)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 9) (Scotland) Order 2004 (SSI 2004/359)

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 8) (Scotland) Order 2004 (SSI 2004/344)

14:13

The Convener: Item 4 is on subordinate legislation. The committee is being asked to consider nine instruments subject to the affirmative procedure regarding amnesic and diarrhetic shellfish poisoning. The Minister for Health and Community Care, Malcolm Chisholm, is here with his official, Martin Reid, from the Food Standards Agency Scotland. The Subordinate Legislation Committee made no comments on the

nine instruments. Does any member wish to seek clarification from the minister and his official on any instrument?

Mr Davidson: I do not need clarification, but I will give the reasons why I oppose the instruments if you wish.

The Convener: You have no questions at this stage. Are you content to have an exchange now with the minister, or would you rather engage in a formal debate?

Mr Davidson: We do not need a formal debate on a position that I have held and declared openly in the Parliament. We have debated the subject in the past. The position is simple: I do not understand why the minister will not consider end-product testing. The evidence for its efficacy exists and the process is acceptable in Europe. Using it would do less damage to our communities and maintain public health and safety. I stand by that. If the minister wishes to challenge that, it is up to him.

The Minister for Health and Community Care (Malcolm Chisholm): The industry performs end-product testing. End-product testing and the statutory controls that we must exercise are being confused. This is not an either/or situation: both must be done.

The Convener: Does David Davidson have any further comments?

Mr Davidson: No. The situation is just a variation on the past.

The Convener: Does any member wish to debate the instruments?

Members: No.

The Convener: Does any member object to a single question being put on the motions?

Members: No.

The Convener: I invite the minister to move motions S2M-1603 to S2M-1607 and S2M-1668 to S2M-1671 en bloc.

Malcolm Chisholm: Will I do that formally or do you want a speech?

The Convener: You can move the motions formally if you wish. If you want to make a speech, make it short.

Motions moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No.2) (Scotland) Order 2004 (SSI 2004/322) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.5) (Scotland) Order 2004 (SSI 2004/323) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.6) (Scotland) Order 2004 (SSI 2004/330) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.7) (Scotland) Order 2004 (SSI 2004/341) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Irish Sea) (Scotland) Order 2004 (SSI 2004/340) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Diarrhetic Shellfish Poisoning) (East Coast) (No.2) (Scotland) Order 2004 (SSI 2004/378) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (Orkney) (No.3) (Scotland) Order 2004 (SSI 2004/352) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.9) (Scotland) Order 2004 (SSI 2004/359) be approved.

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.8) (Scotland) Order 2004 (SSI 2004/344) be approved.—[*Malcolm Chisholm*.]

The Convener: The question is, that motions S2M-1603 to S2M-1607 and S2M-1668 to S2M-1671 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Eadie, Helen (Dunfermline East) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Maclean, Kate (Dundee West) (Lab)
McNeil, Mr Duncan (Greenock and Inverclyde) (Lab)
Rumbles, Mike (West Aberdeenshire and Kincardine) (LD)
Turner, Dr Jean (Strathkelvin and Bearsden) (Ind)

AGAINST

Davidson, Mr David (North East Scotland) (Con)

ABSTENTIONS

Robison, Shona (Dundee East) (SNP)

The Convener: The result of the division is: For 6, Against 1, Abstentions 1.

Motions agreed to.

National Health Service (National Framework)

14:17

The Convener: Item 5 is discussion of the national framework for the national health service in Scotland, for which the Minister for Health and Community Care is here. I welcome him to the committee and thank him for the letter that was sent to us. It arrived before I became a member of the committee, much less its convener, but I think that I can say on the committee's behalf that we are grateful for the response and for the concession that the minister is assumed on the face of it to be making on this important issue. A copy of the letter has been circulated to everybody. Does the minister wish to say something to start the question-and-answer proceedings?

Malcolm Chisholm: The first thing that I want to do is to welcome you to the chair, convener.

I am here to answer questions. Some confusion remains about moratoriums and I will start by repeating what I said in the letter, which is not inconsistent with what I have said previously, although I accept that it spells out the situation more clearly—I wanted to do that for the committee.

The point is that I do not support a moratorium. The First Minister repeated that last week. I suppose that the key sentence in the letter is where I confirm that I

"do not intend to respond to any new proposals that come to me over the winter until the Framework Group has reported, unless there are issues of clinical safety."

The main reasons why I did not support a moratorium as such were, first, to do with the exemption that I thought was required for clinical safety, and secondly, to do with the fact that I did not want boards to shut up shop over the winter, as it were. Just because I am not going to give a final view on proposals, that does not mean that boards should stop engaging with the public or stop planning. The third reason relates to maternity services in Glasgow, about which I want to say something soon.

Shona Robison: Thank you, minister, for your letter, whose contents I welcome. I wish to explore the scope of your letter and to try to clear up some of the confusion that you have indicated exists. There is a lot of it about. Your letter refers to

"any new proposals that come to me over the winter".

If we go through some examples, could you tell me whether the scope of your letter covers them? For example, is the casualty unit at Stobhill, which is set to be axed next year, covered under the scope of your letter?

Malcolm Chisholm: As I have made clear, decisions about Stobhill and about Glasgow more generally were made two years ago and went through the Parliament at that time. They were fully debated. I gave an undertaking that named services would remain at Stobhill. If there is an issue about named services, that would have to come before me for approval. The more general point about the implementation of the acute services review in Glasgow is that it was approved by the Parliament two years ago. In general terms, the review can proceed. If there is an issue of named services, however, I would have to give approval.

Shona Robison: So you are saying that, where decisions have been taken but not implemented, they could still go ahead between now and March.

Malcolm Chisholm: Absolutely.

Shona Robison: What about the emergency general surgery at St John's hospital, which is being closed? Would your letter cover that?

Malcolm Chisholm: The situation is complex. The bottom line is that the postgraduate dean has said that training approval for junior doctors will be withdrawn this month. There has been some misrepresentation about what I have said about the control that I have. The correct way to put it would be to say that, although I have control over many things, I do not have control over everything. Indeed, I do not think that it would be appropriate if I had control over everything. I do not think that it is appropriate that I, as a non-clinician, should be the judge of what is suitable training supervision for junior doctors. It would be highly inappropriate were politicians to overrule a postgraduate dean who had said that inadequate training opportunities were being provided. I do not regard that as something that I could overrule. That is also the attitude that Lothian NHS Board has taken, although it has tried to respond to the situation in the best way that it can.

Shona Robison: In short, your letter does not cover any of the services at St John's.

Malcolm Chisholm: I would put the question back to you: how could it?

Shona Robison: That is what I wish to clarify. There has been confusion, as you have rightly said, and I am trying to clear up some of that confusion.

Malcolm Chisholm: No, there has been no confusion whatever about St John's.

Shona Robison: What about the overnight beds at the homeopathic hospital in Glasgow, which are currently under threat?

Malcolm Chisholm: That is obviously covered under not making a decision during the period

when the advisory group on service change in NHS Scotland is reporting. I take this opportunity to say that I have already visited the homeopathic hospital and that I have already said very supportive things about it in Parliament. My point is that people should not assume that every proposal that health boards have made has my approval. One of the main things that I have been saying, which I repeat now, is that I can say no as well as yes. On your particular question, that issue would of course be covered by my general point about not making a decision during the period of the advisory group's work.

Shona Robison: Helen Eadie has previously made some good general points and some particular points about her own patch in Fife. Would Fife NHS Board's proposal to reduce the number of accident and emergency units from two to one be covered under the scope of your letter?

Malcolm Chisholm: I have given general approval to Fife NHS Board's right to proceed with that. However, if there are particular things that NHS Fife can do in the meantime, they can be done, as long as they are within the general framework that I have already approved.

Shona Robison: So, out of the examples that I have given, the only one that would be covered by your letter would be the homeopathic beds.

Malcolm Chisholm: Yes, but you have not included the other examples that you could have included, such as the generality of better acute care in Lothian and anything that comes in from Argyll and Clyde, the Borders or anywhere else that I might have omitted.

Mr Davidson: My question is about your thinking when you set up the national framework advisory group, but first I will pick up on a point that you have just made. You said that you are not a clinician and do not feel that you should be in control. You inherited legal competence to intervene in health boards when the Scottish Parliament was set up, because those powers had rested with the Scottish Office for a long time. Was there any reason why, during the passage of the National Health Service Reform (Scotland) Bill, you did not raise your wish to be removed from political decision making in the health service?

Malcolm Chisholm: I completely fail to understand the point that you are making. I imagine that you must be wilfully misrepresenting what I have said. I will repeat my words, as I am trying to get across an important message that totally contradicts what you are saying. I am in control of a very great deal in the health service but I am not in control of everything. The particular exception that I referred to was the training requirements of junior doctors. I do not think that the public will expect me to be the arbiter of what is the appropriate training supervision for junior doctors. That was the only exception that I made and you wilfully misinterpreted that in a way that would suggest that I had no control.

For the third time, I say: I have control over a great deal in the health service but it is not appropriate that I should have control of the training requirements of junior doctors. The vast majority of patients and members of the public would agree that that should not be controlled by politicians. Once again, I repeat: apart from that exception, I have great control over everything in the health service.

Mr Davidson: I fully agree with what you say about qualifications, standards and training in the health service and I thank you for bringing clarity to the other aspect of the control issue.

When you decided to set up the national framework advisory group, did you envisage that in the period that it would take to do its work—perhaps up to a year—difficult choices would have to be made and that you would have to account for those or were you quite prepared to allow the status quo to continue to the extent that a moratorium was placed on general reform in the health service until the framework advisory group had reported?

Malcolm Chisholm: Again, the word "moratorium" has slipped into the proceedings. I have been absolutely clear that there is no moratorium. We have to be careful about how we use language.

When the group was set up, the issue arose of what should happen in the interim period. As stated in the letter, my judgment is that we have to allow changes to take place, particularly where there are issues of clinical safety. Apart from those circumstances, however, it makes sense not to rush into major decisions until the group has reported. That was a difficult balance to achieve, but I think that we have established the right balance. We have created a space for the national framework advisory group to do its work; the public can engage meaningfully with the group because they know that the controversial decisions that are pending will not be ruled on until the group's work is completed.

This winter, we have a great opportunity to have a discussion on the issues that have been raised today. Incidentally, that opportunity coincides with the work that the Health Committee is doing on the work force issue. I welcome that piece of work, because I think that the conclusions of your inquiry should feed into the deliberations.

I look forward to the coming months because, although people will end up disagreeing about the issues that are involved, we need to have an informed national discussion. I hope that the

position that I am outlining in relation to changes that will happen in the meantime will help that discussion.

Mr Davidson: When the chairman of the national framework advisory group came before the committee, he said that he wanted a public debate. I think that you have just supported his position. The committee and the Parliament might not always agree with you on various issues but, for the record, can you clarify that you will not go back and review any of the decisions to change elements of the health service that have been made but not implemented?

14:30

Malcolm Chisholm: It would not make sense to revisit things that I have approved and, in that sense, that the Parliament has approved—explicitly in the case of Glasgow. How far back do people want to go? When decisions have been made, everything cannot be slowed down. One of the issues that people understandably complain about in Glasgow is that it is taking a long time to implement the decisions.

We are near the stage at which the contract for the Stobhill ambulatory care and diagnostic unit will be signed. Are you or is someone else suggesting that we do not go ahead with that when a large number of people want to see the new investment on the ground? It would not make sense to go back over however many years that you suggest and make everything grind to a halt. As with new things that are happening, we must strike a balance. We cannot use the framework advisory group as an excuse to stop everything and put things into reverse. Equally, we can be sensible and acknowledge that we do not want to make decisions that we do not have to make in the interim.

Mr Davidson: Thank you for your clarity.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): When you gave evidence to the committee about the review group some time ago, you made it clear, as I understand it, that the issue was the future reconfiguration of services. However, the submission that Professor David Kerr gave us before the previous committee meeting stated that one of the objectives of the review group was

"to provide a framework for work underway or about to get underway".

Why and when did the remit of the review group change?

Malcolm Chisholm: I am not aware of the remit having changed in the way that you describe. It was always the case that the group would provide a general framework. I always took that to mean a framework that would be immediately applicable. Obviously the group would look into the future, but it was never the case that the group would consider only change in the future; it would provide a framework that the service could use now.

Clearly, a related issue is the extent to which the group would examine specific service change issues that are out and about, such as the ones in your area. Professor Kerr made some helpful comments at the previous Health Committee meeting about visiting Greenock and taking an interest in the issue. However, the general intention of the group is to provide a framework for changes that happen anywhere in Scotland. That was always the remit of the group; its remit did not have reference only to the future.

Mr McNeil: I welcome the broadening of the remit and I welcome the national debate, as does the committee.

Following the discussion that we have had and given your indication that David Kerr wishes to go out to communities such as mine to speak to people, what would your response be if David Kerr came back to you and suggested that he felt strongly

"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 … delivering the national plan"?

Malcolm Chisholm: I am not picking up your point.

Mr McNeil: I am feeding David Kerr's words back to you. David Kerr said that it was his job to go out to those areas. He stated:

"We need to understand some of the local problems better … 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"—

or, as he describes them, "hot spots", such as Greenock in Argyll and Clyde—

"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".—[*Official Report*, *Health Committee*, 9 September 2004; c 1172.]

What would your response be?

Malcolm Chisholm: As far as I understand that, I do not have a problem with it. Was he referring to the possibility that a decision would be made about Argyll and Clyde before his group reported? That is what I take out of those comments, but I do not have the full context of his remarks.

Mr McNeil: He said that it was important that he went out and understood the local problems better. He said that, if the tensions were so great or the work in progress ran contradictory to his national plan, he had a role to take that issue back to you. That seems to be an extension of his role in health matters in Scotland.

Malcolm Chisholm: I very much welcome the interest that he is taking in your area and I am keen to hear his comments on what is happening there. The general role of his group is to deal with the generality of the issues, but it may be that that would have direct relevance to what is happening in your area. I would be interested to hear his comments about what is happening in your area in relation to the general approach that the group takes to those matters.

Mr McNeil: He also said that he would book a slot with you. When did you last meet David Kerr and what did you discuss?

Malcolm Chisholm: I met David Kerr when he was last in Scotland, which was on the same day as he spoke to the committee. We discussed the generality of these issues.

Mr McNeil: Are you due to meet him again?

Malcolm Chisholm: I expect to meet him again quite soon.

Janis Hughes (Glasgow Rutherglen): You mentioned the situation in Glasgow and stated that there is a call there for acceleration of the acute services review. Decisions were made two years ago and I know that the area medical committee, which covers clinicians from both the primary care and the acute sectors, is calling for acceleration of the review on the ground of clinical safety, about which you make a point in your letter. Can you say more about how you define clinical safety?

Malcolm Chisholm: I cannot be the only judge and arbiter on that. Clinical advice is highly relevant to matters of clinical safety. Obviously, clinical safety is related to the quality of care and clinicians' judgments that care is not being provided in an optimal way. The issue is subject to clinical advice. I cannot give the committee a final definition of clinical safety, because a politician cannot be the final judge of that and must take advice from clinicians in relation to it. However, in general terms it is fairly obvious what the public understand by clinical safety. People want to have a high standard of care that does not put them in danger.

Janis Hughes: I am sure that you understand that people believe that clinical safety is sometimes used by health boards as an excuse to make changes that drastically affect the provision of health care at local level. People used to believe everything that doctors said but today—quite rightly—that is not the case. People ask questions. How can you assure us—rather than our simply being told by you and by health boards that decisions must be right because they are based on clinical safety—that we will be given tangible information that will allow us to understand why such decisions are made and the evidence on which they are based? People are very sceptical about decisions that are taken on the ground of clinical safety.

Malcolm Chisholm: I understand fully and I sympathise with the member's point. I did not mean to imply that I would automatically take the advice of doctors or nurses; I was saying merely that we would listen to their advice. We would do so critically. We would not automatically assume that that advice was correct. However, we would want to listen carefully to the advice that doctors and nurses give us and we would have to be very careful before we rejected it. That is my general approach to those matters.

We would want to consider all the evidence and we would want it to be presented in detail so that it was transparent and framed in language that people could understand. Of course, we would have to make a judgment about that evidence, just as we have to make judgments about service-change issues more generally. My general point is that politicians would be wise at least to listen to the advice that doctors and nurses give them. Ultimately, they may say that they are not convinced, but politicians should listen very carefully.

Janis Hughes: Can I take it from your answer that further information on decisions will be provided from now on?

Malcolm Chisholm: The member is absolutely right. We should ensure that boards examine the issues rigorously and that we do the same when matters are referred to us. It is difficult to tie down the answer and to provide a clear definition of clinical safety because we cannot predict particular circumstances. However, boards and clinicians must make strong cases for their propositions. At the end of the day, judgments must be made. I accept that there is an element of subjectivity in that process, but it should at least be open and transparent so that we can make judgments based on evidence. We all know the kind of territory to which clinical safety refers. I imagine that patients are more concerned about clinical safety than they are about anything else.

The Convener: A number of members have indicated that they want to ask about safety.

Dr Turner: I thank the minister for his letter. Like the public, I am sometimes a little confused. I am not convinced that you always get information from the health boards on which to base decisions. We have accepted the acute services review, the acceleration of which seems to have come out of Greater Glasgow NHS Board's trying to clear its debt of £58 million. It must then find the money for the new building programme. I make it clear that everybody wishes the ACAD unit to go ahead.

I asked a parliamentary question about safety in connection with units that have had to be moved because of the demolition of wards. The oncology and gynaecology unit was originally going to be slotted into a floor of the new maternity building but—for some reason—the unit had to be sidestepped into temporary accommodation at extra cost. However, high-dependency beds were not put at the service of that new unit. The same number of high-dependency beds exists for the surgeons who already worked there and who work at the new unit. Therefore, there has been compromise on safety, which means that clinicians will be working with each other and trying to see whose case is the most urgent; there will be delays. I would like to think that the minister could intervene and say that the board must find more high-dependency beds. Why was that unit moved so hurriedly without ensuring that high-dependency beds were on offer?

We have been told various things about the need to close the casualty department at Stobhill, one of which was that it was done because we required accident and emergency consultants. I accept that the training of A and E consultants in the UK is different from the rest of the world—we have specialised A and E consultants and it is now accepted by the colleges that we have them in A and E departments. Stobhill had a casualty department that was covered by clinicians—a system that worked reasonably well until now, although that is not to say that it could not be improved. However, we were told that if we could get the A and E consultants, the department could be kept open. Those consultants are available to rotate in the next few months, but there is still desperation to close that department, which covers 47,000 people, and to accelerate its closure, despite the lack of capacity in the city. Capacity is a problem, and however one looks at it, those 47,000 people need to be dealt with in other ways. One of the ways—

The Convener: Jean, will you come to a conclusion and ask a question?

Dr Turner: I will come to it if you allow me to develop my point.

The Convener: I do not want it to be too long.

Dr Turner: I am coming to the point about clinical safety.

The Convener: Please get to the point.

Dr Turner: A minor injuries unit is being developed at the same hospital. In order to do that, the health board is developing a musculo-skeletal unit, which is a one-stop shop that will give everybody a share of a service that is better than what existed before. The clinicians there have worked for years to improve the system so that everybody has the best service. If that unit is shifted to another hospital to make way for a minor injuries unit, people will be disadvantaged. Safety is not necessarily being treated as if it were of prime importance. I am not sure that the minister is, to inform his decisions, hearing from people in Greater Glasgow NHS Board about all that is going on.

The Convener: I ask the minister to respond succinctly.

Malcolm Chisholm: I will try.

It is interesting that, until two weeks ago, David Davidson and others were criticising me for having too much central control of the health service. I always denied that, but he still made that charge regularly. Over the past two weeks, the accusation has been the complete opposite; I am now said to exert not nearly enough central control over the health service. The examples that Jean Turner gave highlight the dilemma. We need to get the balance right—we want a national health service, not a centralised health service. I accept that a national health service needs a strong framework and strong national steer and direction, but how centralised do we want it to be in making the kinds of decisions to which Jean Turner referred?

14:45

Some people might have disagreed with it, but two years ago Parliament approved Glasgow's overall strategy, which included the changes at Stobhill. Okay—I accept that there is a debate about the month, or even the year, in which some of those changes should take place, but although all those things were not written explicitly in the strategy, the general direction of the strategy was approved.

Should I have intervened in each of the examples that Jean Turner gave? That is a good question. It is not that I was not interested in those issues. During my visit two weeks ago—to see the impressive gynaecological cancer network, which is a superb service that allows many hospitals in the west of Scotland to link up via telemedicine to discuss every new patient that presents with a gynaecological cancer—I took the opportunity to ask specifically about the new arrangements at Glasgow royal infirmary. I heard different things but I did not, either from consultants or nurses, hear that the new arrangements were clinically unsafe. Indeed, they mentioned that the beds in the high-dependency unit had facilities for epidurals and so on, which help in some cases. The situation is complex and it is not clear-cut. However, it is not that I am not interested in those matters.

For casualty—perhaps I am not being succinct, but I am trying to be as general as possible—the issue is, as I have also highlighted in relation to

West Lothian, the role of the royal colleges. Again, much could be said about the casualty department at Stobhill. As far as I could see, Stobhill had a different model for A and E from almost every other hospital. We could go into that in detail, but the bottom line is still that I do not have complete control over what a royal college says about training requirements. I accept that I do not have complete control over that area—I hope that I am not misinterpreted and misquoted once again. To be honest, I think that that is reasonable.

That is probably as succinct as I can be.

Mike Rumbles: Like other members, I welcome the setting up of the national framework advisory committee. It is much better to be in command of the situation than it is to have to react to 15 different plans that are produced independently by 15 different health boards.

In his letter, the minister states:

"I … do not intend to respond to any new proposals that come to me over the winter until the Framework Group has reported, unless there are issues of clinical safety."

However, as far as I know, all the plans that have been produced by the 15 independent health boards appeal to "clinical safety". None of them fails to use that phrase—they keep telling us that the issue is not money or affordability but clinical safety. All the plans that have been proposed by the health boards have been based on clinical safety. Therefore, does the minister's letter mean anything? He says that he will not make decisions unless there are issues of clinical safety, but the health boards all say that, in all their plans, there are issues of clinical safety. Where are we with that?

Malcolm Chisholm: That is an important question—it relates to Janis Hughes's question, which was also absolutely central to the discussion. That is why I said that we would not just say, "Oh, well, the health board says it's clinical safety, so that's that." There will be a hard test that will involve looking at the evidence and so on.

It is not true to say that all plans have presented clinical safety as the fundamental issue. Obviously, there are issues of clinical safety everywhere in Glasgow's plan—to use the example that we have focused on today—but if Glasgow's general plan from two years ago was to be presented now, we would not say that it would have to be approved today because of clinical safety. Most of that was a long-term plan that was going to take time to implement.

The Argyll and Clyde NHS Board plan—let us be specific, since specific concerns have been raised about that plan—is another good example. Obviously there will be issues of clinical safety; there are such issues in Argyll and Clyde. However, it is a major issue—perhaps the most controversial in Scotland at the moment—and it is reasonable to reassure people that I am not going to give a final view on Argyll and Clyde before that group has reported. I give the committee that undertaking if doing so is helpful, because I think that members' line of questioning will suggest that nothing will be delayed because everything can be passed on the ground of clinical safety. I say, if it will be helpful, that the test will be strict, as I said to Janis Hughes. There will not be a final ruling on Argyll and Clyde before the national framework advisory group has reported because that is a major and controversial issue.

Mike Rumbles: I am glad that you said that because what is puzzling the committee and what has focused our deliberations is that we keep hearing that the issue is fundamental. There is the European working time directive and we do not have enough consultants or doctors; the plans that are being produced by all the health boards are reactions to those issues.

Examples of places that have been affected include the hospitals in Oban and Fort William. I am sure that Jamie Stone will talk about there not being consultants available in Wick. There is a fundamental issue about clinical safety and the working time directive. It is not an add-on. It is a fundamental point; that is what I am trying to get at.

Malcolm Chisholm: Yes, but I am distinguishing an immediate issue of clinical safety in which, if I did not make a decision before March, the problem would manifest itself in that six-month period. Of course, clinical safety is bound up with the long-term plans of Argyll and Clyde and Glasgow. I suppose that I am making a distinction between something that is going to bite in the period that we are talking about and longer-term clinical safety issues. In practical terms, people can see that distinction.

The Convener: Helen Eadie indicated that she wanted to speak. Is it on clinical safety?

Helen Eadie: Yes. I support the minister on clinical safety: there is no question but that it is paramount.

My question is about a point that was made by Dr Cairncross when he was before the committee two weeks ago. I understand the arguments of the royal colleges, which will be among the arbiters when it comes to clinical safety arguments. I understand that in the big teaching hospitals, we might have recruited 100 new consultants and other doctors.

Dr Cairncross said

"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"—[*Official Report*, *Health Committee*, 9 September 2004; c 1159.]

I have discussed Dr Cairncross's point with other professionals since then. He is saying that the professors in major teaching hospitals such as the Queen Margaret hospital in Dunfermline or the Victoria hospital could adopt general hospitals as satellite hospitals, which would help to ensure clinical safety in such hospitals because of rotation. That is the view that is coming across, so we have to be creative about how we tackle the problem. We do not have to have consultants in the hospital. We can consider cutting our cloth differently.

Have you had discussions with Dr Cairncross, Professor Temple or any of the other professionals who are involved? I make it crystal clear that I accept now that the decision is right for Fife and that we have to move on. There is no question that there will be a hospital closure in Fife, but there will be a review and reconfiguration of services. I accept that, and I want to put it on the record for the benefit of people who might misquote what I have said today.

Malcolm Chisholm: What Helen Eadie described is of fundamental importance and can work in different ways. Sometimes it can work through managed clinical networks. What I described a moment ago when talking about gynaecological cancer is a managed clinical network in which the clinicians in the Beatson centre are talking via telemedicine to the clinicians in Inverclyde at Crosshouse hospital and everywhere else. They are all sharing their knowledge, which is one manifestation of the idea.

The other idea that Helen Eadie seems to be thinking about is rotation—junior doctors can rotate among different hospitals. That can and is being done, although it could be increased. However, consultants can move between different hospitals. They can network to communicate, but they can also do their work in different hospitals.

Shona Robison mentioned West Lothian and what has been highlighted as the loss of emergency surgery there—which is four people a day, or whatever. However, what has not been highlighted is the massive increase in elective surgery at St John's hospital. The regius professor of surgery from Edinburgh is doing elective surgery in St John's and boosting the training of junior doctors there. That part of the story has not been told. Basically, all surgical training in St John's was under threat, but the new arrangements have boosted surgical training for everything except for the small number of people who require emergency surgery. That training boost is one of the potential advantages of having a single system in Scotland, rather than a fragmented system based on trusts. I know that some members do not like the single NHS system, but one of the opportunities that arises from having such a system is that consultants can work across different hospitals in an NHS board area.

Some boards do that more and better than others. For example, Tayside NHS Board, to which I have referred, does it well and Lothian NHS Board is beginning to do it well. However, I have no doubt that some members think that that kind of arrangement could happen more in their areas. We have discussed Argyll and Clyde NHS Board; I have no doubt that it might want to consider a single system.

The Convener: I want to stay on this subject because several members have indicated that they want to speak specifically on clinical safety—that includes repeat requests. Jamie Stone wants to say something specific about clinical safety.

Mr Jamie Stone (Caithness, Sutherland and Easter Ross) (LD): The minister is aware of what is happening in Wick; I do not need to remind him of it. There is an increasing sense of anger and despair in the north, which is why Rob Gibson and I—and other MSPs from the Highlands—have signed up to Jean Turner's moratorium motion. We feel that we have no alternative but to do so. As the minister does, Highland NHS Board continues to talk about clinical safety, often within a rather cosy Inverness-based room. However, when I talk about safety, I am talking about the distances involved.

You referred to the fact that we are about to go into winter. We know that helicopters sometimes cannot fly in winter, that trains do not run and that roads are blocked. If we say to a citizen—for example, a pregnant mum in Bettyhill, Canisbay or Reay—that they will have a return trip of more than 200 miles to Inverness, there is a real safety issue; it is possible for someone to die in an ambulance or in a snowdrift. We must therefore stop talking about what is a rather medic-centred view of safety and we must consider the wider context. Otherwise, we will have a tragedy on our hands.

When you consider the safety issue, will you please consider more than just medics talking to each other about good practice and what is right? Highland NHS Board seemed to leap on the safety issue again, based on paediatric cover. So far we have not had paediatric problems in the north, but if we downgrade from 24-hour consultant cover to a lesser service, that will mean that more mums will have to travel down to Raigmore hospital. Frankly, I just cannot have it.

Malcolm Chisholm: Obviously, access must be taken account of. In certain situations—I am not talking particularly about Caithness, but in general

and theoretical terms—there might be a balance of risk and we must weigh up the advantages. The discussions that are going on all over Scotland are partly about weighing up the balance of risk between having a higher quality service, perhaps in a specialist centre, and the access issues around that. There is no simple rule of thumb that contains a general truth about that. That is just part of what people must consider in respect of all these issues. Certainly, distance is a factor—somebody might decide that it is all right to travel a certain distance, but if that distance is multiplied by five or 10, that might change the argument.

In general terms, I agree with Jamie Stone. We must consider the full range of factors, and clinical safety must obviously take account of access. There is no simple answer.

Mr Stone: I thank you for your partial agreement. However, I remind you that when Professor Andrew Calder examined the problem in the far north he did not address distance or inclement weather. He said that they were issues, but he did not propose solutions. When I pushed him, he said that it was for Highland NHS Board to do that. I have two questions. First, do you accept that a mother and her child in the far north of Caithness have the same rights as a mother and child anywhere else in Scotland? Secondly, will you take the safety issue, if necessary, to the Cabinet?

Malcolm Chisholm: Will I take—?

Mr Stone: If Highland NHS Board proposes a downgrading, will you please take that to the Cabinet and prevent it from happening?

Malcolm Chisholm: I am sure that that and a range of health issues are likely to be discussed in the Cabinet. As I said, I agree generally with your point about access. What was your first point—before the one about the Cabinet?

Mr Stone: Do you accept that a mum in Canisbay has the same rights as a mum in Airdrie?

Malcolm Chisholm: Of course I accept that, but without prejudging the issue, we must consider the rest of the Highlands as well. I agree with you on that point in general terms, but I do not think that there is a consultant-led maternity unit on the west coast of Scotland north of Paisley. Do you understand the point that I am making? We can talk about Wick and Airdrie but we can also talk about Wick and Oban, for example. That is my only qualification on what you are saying. The matter is not about Wick compared to the rest of Scotland, it is about Wick sharing issues with many other places. Do you understand the point that I am making? Not everybody in Scotland has a consultant-led maternity unit on their doorstep.

Mr Stone: I understand your point, but I do not agree with it. Do you concede that we should accept the level of service that we have at the moment and seek not to lower it to a common denominator, but to raise up the lesser bits of the service to the level of the rest? We should seek to improve the health service, not to wreck it.

15:00

Malcolm Chisholm: We are certainly seeking to improve the health service, but there is a lot of disagreement and controversy about how that will be done. The debate about the quality of care and how we secure that quality is highly controversial and there is no general rule of thumb that we must have a certain number of consultant-led maternity units. We must consider the matter case by case and we must take account of distance as well as quality.

Rob Gibson (Highlands and Islands) (SNP): Following on from the point that the minister has just discussed, if there is to be a national framework for medicine, it will certainly have to address the geography of Scotland. That has not been addressed by health boards' covering areas that are the size of Highland NHS Board's area, so we expect something better from the national framework. We expect something that takes into account the pockets of population of considerable size, such as the one in Caithness and north Sutherland.

On managed clinical networks, can you envisage as a realistic proposition staff working between centres that are as far apart as Aberdeen, Inverness and Caithness? Secondly, will the review of ambulance and air ambulance services that is taking place be widened out to consider a patient transport strategy that can take into account the questions of geography that I raised in the first place?

Malcolm Chisholm: Rob Gibson's point about geography is important. As you might have noticed, contrasts are always being made between England and Scotland for different purposes, but it always strikes me that one of the fundamental differences is that England has 10 times the population—it is probably 11 times now—and 1.66 times the land mass of Scotland. There are certain objective differences that are important for our discussions; one of the reasons why we have difficulties in respect of health service issues is that ours is a much more sparsely populated country. The corollary of that is that we have to come up with specific rural solutions in many cases, and I fully accept that. That also has training implications, so I welcome the way the committee is engaging with those issues. The committee will, no doubt, ask the royal colleges about them as well.

I replied to Helen Eadie on managed clinical networks, which can work in at least two ways. They can work by people sharing experience without necessarily moving from place to place or through rotations. That is a legitimate matter on which we can put pressure on clinicians. I respect clinicians' advice in clinical areas, but we need to challenge them to work differently in many respects. Working on different sites—this might apply to consultants or to junior doctors—is an important part of the way forward. That practice should certainly be explored, as I said specifically in the debate in Parliament on maternity services in the Highlands.

On transport, all service changes must be accompanied by an appropriate strategy for the ambulance service and for patient transport more generally, although health boards do not have direct control of the latter. I know that Professor Temple highlighted that in his report and in his evidence to the committee. I accept that we must also look imaginatively at transport arrangements when we are talking about health service improvements.

Rob Gibson: Regarding clinical safety, it is obvious that we have to have enough staff trained to do the kind of jobs that we are talking about. Although the First Minister said in his statement on this year's legislative programme that we had trained more doctors and consultants, it is clear that there are not enough of them in specialties such as maternity services. Will the national review have any statement to make about the need to train more consultants in those skills, which are clearly needed?

Malcolm Chisholm: The national framework for service change is not doing everything, although it will have to be mindful of work force issues when it does its work. The problem that you have highlighted has arisen because work force planning in the NHS, as far as I can see, did not exist at all until fairly recently. I can be held responsible for most things, but the failure to train enough radiologists 10 or more years ago is certainly not my responsibility. That is one of the reasons why we have to come up with imaginative solutions now.

There are certain specialties in which we have particular problems; radiology is just one example of that. The committee will explore that in detail in its inquiry and will, no doubt, have comments to make on the Scottish Executive's work on work force planning. However, you cannot say that we are not on the case. You may not like what we are doing, or you may not think that we are doing it adequately, but we are seriously engaged for the first time in a strategy for work force planning and development, and we will welcome your comments.

There are specific strands to that planning and development; for example, part of it is work force planning for consultants and nurses. All that I can say is that the planning is now being done and the numbers are rising more significantly than was the case in the past—although people will always say that they are not rising fast enough. We are making progress but there is obviously a lot more to do, and I welcome the committee's input.

Mr McNeil: What work is under way, or is planned, to evaluate the impact on patients in respect of clinical safety and quality of care in the services that have already been centralised? I am thinking specifically of maternity services in Argyll and Clyde.

Malcolm Chisholm: It is important to get that information. I do not think that that evaluation has been completed, but the situation is being monitored. The best that I can do is to write to you, or to the committee, with information about exactly where we are in monitoring that. I accept your general point that we have to know what effect the changes are having, but I am not aware of any conclusions having been drawn so far. I shall write to you about that.

Mr McNeil: Is that a confirmation that work is under way to evaluate the impact, convener?

The Convener: I certainly understood that to be the case. Perhaps the minister could clarify what he meant.

Malcolm Chisholm: I can get you the information. It may well be the case that it is not as systematic as you would wish, but I can get you the information that we have on that. I shall send it to you. If you think that it is inadequate, we shall certainly consider doing more detailed work.

The Convener: Would that apply to other areas in which maternity services have been affected by previous changes?

Malcolm Chisholm: I am sure that you are thinking of Perth. If you want me to, I can look into the situation in Perth as well.

The Convener: If evaluation work is going on, I think that we ought to see the results of all the evaluations.

Malcolm Chisholm: I shall try to write a letter that covers as many areas as possible.

Mr Davidson: In your reply to Janis Hughes's question about the definition of clinical safety, you said something along the lines of, "It is up to clinical advice, not me." That is a paraphrase. Do you have in place an independent clinical advisory body to assist you when a health board comes up with a proposal that it claims is based on clinical safety? If you have such a body, who serves on it?

Malcolm Chisholm: You are paraphrasing me rather liberally, let us say. I said, as I have said to Janis Hughes several times, that we would have a rigorous test and that I would not just accept what the boards said to me.

I said that a wise politician would listen carefully to proposals from doctors and nurses, but that does not mean that one would automatically say in every case, "Right, that's fine, you can do that." The proposal would have to be established and proved in a transparent way by boards or clinicians. We would have to listen to advice, but that does not mean that we do not have a role. I said that any decision, ultimately, would be contestable and that people would have to form a judgment. No particular group would make the judgment, if that is what you are asking me. We would take a view collectively. Obviously, there is clinical advice within the Health Department, as well as all the other civil service advice.

Mr Davidson: Put very simply, that advice is not within a health board; it is within your department.

Malcolm Chisholm: Obviously, a large number of health professionals can give such advice within the Health Department.

The Convener: We have probably exhausted clinical safety. Kate Maclean wanted to come in on something different.

Kate Maclean: I have a general issue about the national framework advisory committee, which follows on from Duncan McNeil's first question, and goes way back to when we first took evidence from the minister on the advisory committee. I am still confused about the status of the advisory committee's report. The Health Committee welcomed the setting up of that committee; I, too, welcome it, but I would have welcomed it more five years ago. As I said at a previous meeting, we have had acute services reviews, maternity services reviews, NHS reform and primary medical services legislation. I find it difficult to see what status any report will have.

You said that you will delay consideration of any new proposals until such time as the group has reported, but that you will consider any current proposals. I accept that as a priority you have to take into account clinical safety, but it would be surprising if a health board put forward a proposal that stated that clinical safety factors were not a priority and that they were a lesser consideration.

If the national framework advisory committee reports that some of the changes that have already been made are absolutely wrong for the service, that they will not promote local access to services, and that they will not balance local delivery with the need to have centres of excellence—which is one of the aims of the group—what will happen? Will there be an opportunity to re-examine those decisions?

After we have had so much change, and while we are in the middle of so much change, it confuses me that we now have a group—which is a really good idea—to examine a national framework for the future. What will happen to what is happening now and what has happened in the recent past? Obviously, you cannot go back and change things that happened 20 years ago—you probably would not want to—but what is the status of the report?

Malcolm Chisholm: There is quite a lot in there. The first point is that the acute services review took place just before this Parliament was set up, and it was influential in many ways—for example, it boosted the formation of managed clinical networks—so this report is not the first piece of work. However, it is more comprehensive than the previous review, which was deliberately set up as an acute services review. Wisely, we now like to examine the whole health system, so the current review is looking across the system. Some of the most interesting work of the national framework advisory committee is on what is happening in primary care and the management of chronic disease. That is legitimate, because it is relevant to the model of hospital services.

One of the unsaid things in all the debates about centralisation is that new things are happening in the community. My headline message is that some things will have to be more specialised, but probably more things will have to be localised.

The acute services review, and white papers and so on in between, have covered the issues, albeit not as exhaustively as is required. "Partnership for Care" had a general framework for some of the changes but you could always say that it would have been better if the review had been set up the year before or the year before that. There is no answer to that. All that we can say is, notwithstanding the changes that took place in the previous session, we all know that the issues were not as highly charged or centre stage in the previous session as they are now. There were exceptions, but in general terms the issues were not as prominent on the national stage as they are now; I do not think anyone could say otherwise. In that sense, the formation of the group is timely, although it could always be said that it would have been better if the group had been formed earlier.

You asked about the status of the national framework advisory group's report. I do not know what you would want me to say. Basically, I will take the same attitude to the report as I take more generally to the clinical advice that I receive. I will examine the findings very carefully, but members would expect me—and, ultimately, the Parliament—to have the ultimate say on the matter. Perhaps the committee might want to

challenge some of the group's findings, but I will treat it with the highest respect because I know that its members are leaders in their field. As I said on the radio the other morning, the group is superb. I cannot think of any other group that has been created out of the Health Department recently that is of such a high calibre, and I cannot imagine why I would want to ignore it.

15:15

Kate Maclean: I agree absolutely about the quality of the group's membership. I have a great deal of time for the members of whom I have local knowledge. However, it is inevitable that such a group was going to become a straw to be clutched at by people all over Scotland who are concerned about their services. It was probably not the best time to set up the group and, in fact, much of its good work will be somewhat marred by the current controversy and by the fact that people are trying to use it for their own local reasons.

I do not have any local axe to grind; as far as health services are concerned, I am happy with the way that things are going in Dundee and I do not face the problems that other members face. Having said that, it is difficult to see any way round the fact that the work will be clouded by people with specific local interests. Indeed, it is difficult to see how you will be able to look at the group's report objectively.

Malcolm Chisholm: That is why there is an opportunity to create some space around this matter and I hope that, collectively, we have been able to do that. The group very much looks forward to engaging with the public on the issues. Okay, we have discussed exceptions, but as I say we have created a bit of space in which to open up a debate. Members can always say that it would have been better to set up the group last year to inform whatever decisions have been taken since then. However, the same can be said of any good work that is done. I cannot really answer that kind of question. I am not disagreeing with you, but I think that it is better to do it now than not to do it at all.

Shona Robison: I think that your answer to Kate Maclean's question was fairly honest. However, you seem to be saying that you are driven by events and are simply responding to crises and, in particular, to political pressure from Duncan McNeil—all credit to him—and the others who have come to your door. Suddenly, you have had to come up with something to stem the tide. That is hardly the way to run a health service. In fact, it is really not fair to the services on which decisions have already been taken, because if you had decided to set up the group a year ago, they might have been in the other basket. What will you say to communities in which the decisions have been made? In response to my first question, you said that you will not reconsider those decisions. Where is the fairness in any of that to any of those people?

Malcolm Chisholm: With all due respect to Duncan McNeil and everyone else, I set up the national framework advisory group several months ago. As a result, it is clear that I wanted such a national framework.

Shona Robison: But the letter is fairly recent.

Malcolm Chisholm: At the end of the letter, I simply said that "I would confirm"; I did not say anything in it that contradicted any of my previous comments. I was clarifying matters, which is obviously a desirable thing to do.

My answer to your question is the same as the one that I gave to Kate Maclean. People can always say that it would have been better to set up the group in any year that you might care to mention. My point is that the group was set up at that particular time and, in order for it to do its work properly, it is desirable to create as much space as possible for the group to engage in the national discussion with the people of Scotland about creating the framework. We could say that if that had happened in 2001, it would have influenced what happened in Glasgow, for example. However, there is no answer to that. A process is under way and we cannot just shut down everything and say that we are going to abolish everything that happened in the past four years because the group was not set up then. That would not be a credible way in which to go on.

The other point, of course, is that there is a dynamic. The changes that anybody makes evolve, and other things emerge. Therefore, in that sense, Glasgow's decisions are not set in stone. There may be other bits that Glasgow wants to look at. As a result of the framework, we know that Glasgow—partly because of encouragement and, indeed, instruction from ourselves—is engaged in discussions with Argyll and Clyde NHS Board on services that cross its boundaries. Therefore, even in Glasgow, the final word has not happened.

Glasgow has well-developed policies and my only regret is that it did not come to some issues earlier. We cannot say that it must hang around for another few months and not progress its plans, which are already late in terms of the longer perspective. However, that is not to say that Glasgow must get ahead only with its plans; it can still take on board other issues, such as Argyll and Clyde NHS Board or whatever it happens to be.

Shona Robison: Yes, I know, but you were the one who used the word "heat" or "pressure", or whatever it was. What is there now that was not there two years ago that has made you respond and write this letter?

Malcolm Chisholm: I was referring at that stage to setting up the group. In a way, I gave two answers to Duncan McNeil. I accept that you can say that the group should have been set up in any year that you care to mention since the Parliament began. Equally, however, it is particularly apposite that the group exists now because there has never been more interest in these issues on the national stage. It seems to me that, when there is so much public interest, this is an ideal time for the group to do its work. That was all that I was saying. I was referring to the group rather than to my letter as such.

The Convener: Carolyn Leckie has a question on funding.

Carolyn Leckie: I have a couple of specific questions on the terms of reference of Professor David Kerr's group. In opening, though—

The Convener: Can we not have a speech, but go straight to questions, please?

Carolyn Leckie: It is a question.

The Convener: Right.

Carolyn Leckie: My direct question follows on from the discussion. Clinical safety is being claimed as the basis for decisions, but it is being done according to the current parameters—we do not have consultants who are prepared to work out of Wick and Inverness. However, clinical safety would not be an issue if we had consultants who were prepared to work out of those places. Are you saying that you will intervene to create the conditions that will allow clinical safety? Or are you just going to accept it within the set parameters?

My other questions are related more widely to the vision of the future of the NHS—on which we need to concentrate—and the terms of reference of Professor David Kerr's group. I have the same questions for you as I asked Professor Kerr. Will the review be wide ranging and needs based? Will it calculate the need and the unmet need that exist, put forward a vision of an ideal service and offer the public choices about that service? If not, will the report be based on the status quo in terms of the available resources, funding mechanisms, training programmes and medical and other NHS personnel? Will the report have the scope to set out a vision that we can choose?

The last bullet point in paragraph 6 of the advisory group's terms of reference is:

"to facilitate re-configuration through alternative means of funding and resource allocation."

That suggests to me that the premise is that the status quo for funding new projects—that is, the private finance initiative—will continue. I ask you to give the group the terms of reference to examine critically the effect of PFI not only on funding, but on the volume and quality of available services.

In your considerations in the run-up to the service change, will you look beyond the official NHS board submissions, particularly the medical submissions, and consider as having equal merit the submissions of other members of the NHS team and the public, including the submissions to consultations that were not included in the final consultation reports?

Clinical safety and clinical conditions are often referred to, but they are not the only definition of health; health involves psychological and sociological well-being. Will there be a critical examination of the trade-off between physical condition and psychological and sociological condition? That is the pertinent ideological issue that affects the decision about Wick or wherever. I am not aware of a thorough critical examination of that issue or of previous centralisations and the creation of super-hospitals, or even of—

The Convener: Will you bring your question to a close, please?

Carolyn Leckie: Yes. I have one additional question. To give a specific example on maternity services, an audit was not conducted in relation to the closure of Rutherglen maternity hospital, which predated the proposal for the closure of the Queen Mother's hospital. In my experience, as a midwife who worked there, the claimed improvements in quality have not happened. In fact, the number of home births and domino births has gone down. Are the figures available and, if not, will the minister make them available?

Malcolm Chisholm: Do you want a succinct answer to that, convener?

The Convener: Please.

Malcolm Chisholm: There were six questions, the first of which relates directly to Janis Hughes's point. I repeat that we will require a rigorous test of clinical safety. We will certainly need to be convinced that NHS boards have explored all the options and possibilities. There might be a clinical safety problem, but the challenge to boards is to try, with clinicians, to find a solution. We will not accept the argument that clinical safety is an issue and nothing can be done about it; boards will have to demonstrate that they have explored all the alternatives. Various alternatives have been described this afternoon, such as staff working at different sites.

One of my key messages is that boards must be imaginative. As the status quo is not an option, we must consider how to change and improve the service, which involves the two-way movement that I keep on describing. As many services as possible should be kept local that can safely be

kept local, as I also keep saying. Within that, boards must be challenged to be as imaginative as possible and to consider all the options. There might sometimes be a suspicion that boards have not explored every option. The challenge of the past week or two has been to me, but also to boards, to ensure that they carry out the process in the best and most imaginative way possible.

The second question was about unmet need. The advisory group has been given a wide remit to consider such issues. The members do not have political axes to grind—the group includes clinicians, members of the public and a small number of managers. The fact that managers are on the group has been highlighted, but if I recall correctly, there is only one chief executive. The group can consider the issues and describe its vision of an ideal service, which may well range beyond what I, or even some members, think is affordable. My only caveat is that, at the end of the day, there is no point in describing services that nobody could conceive are within the Parliament's budget. The group will have a vision and it will not be as constrained as politicians might be by what is affordable, but at the end of the day, everybody must describe something that is deliverable within the available resources.

The group will not specifically consider the use of PFI schemes. No doubt somebody can do that major piece of work, but I do not think that the group would regard itself as qualified to consider that aspect.

Carolyn Leckie asked whether I would listen to all NHS staff—I always seek to do that.

With regard to the final question, I am not aware of particular information on Rutherglen but I can look into that and add it to my general letter about those matters. Carolyn Leckie is right that some NHS staff might take a different view to others; that is just a fact of life. We have to listen to as wide a range of people as possible and I cannot disagree with the general point about psychological well-being and so on. In a way, it is another angle on Jamie Stone's question. We have to consider a range of issues. There is clinical safety and quality of care, and access and general well-being are part of that. The situation is complex; I will be mindful of that and hope that others will be as well.

15:30

Carolyn Leckie: Can I come back on one wee specific point on PFI?

The Convener: No, thank you. You have had quite long enough and I want to bring this to a close.

I have a couple of questions for the minister and then he can go. Minister—

Carolyn Leckie: The group has a specific remit to facilitate reconfiguration through alternative funding but it does not have a remit to examine PFI.

The Convener: One specific—

Malcolm Chisholm: I am sorry, but Carolyn Leckie has a fair point and I should answer it.

Carolyn Leckie: Thanks.

Malcolm Chisholm: You were hanging the point about PFI on the part of the group's remit that concerns alternative funding, but that is not what is meant. Alternative funding does not refer to more private funding, as you seem to suggest. The issue is couched in general terms. Of course, you see the issue in relation to the budget and the fact that most money is channelled through NHS boards. Is that always the best way? Should money be channelled directly to managed clinical networks? Should more money be channelled to regional confederations of NHS boards? That is what we are thinking about rather than PFI specifically. That is what I had in mind when the remit was set, but who knows? The group might come back and say that it wants more PFI; I do not think that that is entirely likely, but it could say that.

Carolyn Leckie: Or none.

The Convener: I have a couple of questions, one of which, for obvious reasons, is very specific. The Tayside acute maternity services business case is to be submitted later this year. Will that submission be caught within the non-moratorium moratorium? Some service changes have already been made, but the business case has not been submitted yet. Where is it going to fall?

Malcolm Chisholm: I know that you did not support the fundamental decisions about maternity services in Tayside, but they have been made and I have approved them.

The Convener: So the fact that the business case will not be submitted until later is neither here nor there.

Malcolm Chisholm: No.

The Convener: I would like to clarify one point. Throughout your evidence, you have talked about the things over which you have control and those over which you do not have control: the things that you can say yes and no to. You referred specifically to the training requirements that you would not get into—I think that that is a reserved matter, although I am not 100 per cent certain. That was very clear. You were also clear that there was an issue about clinical safety; in theory, you could override decisions, but you would be wary of doing so, albeit that you would look critically at any arguments that were based on clinical safety.

Are there other areas in which you consider that you do not have the right to say yea or nay? There seems to be some confusion about what a health board can go ahead and do autonomously and what requires permission from you.

Malcolm Chisholm: That is the heart of the matter and I have been caught in the middle in discussions with the Health Committee. I am usually accused of having too much control; now, of course, criticism has swung in the opposite direction. We need to get a bit of balance.

I raised another dimension in response to Jean Turner's question. Once I have approved a plan, do I then want to approve every little bit of its implementation? The view could be taken that we do not control enough of the micro-decisions, but my general point is that the big things come to us and then boards have a certain amount of freedom in the implementation process.

My point about training, which was quite narrow, referred to the supervision of consultants during training. As you pointed out, insofar as there is political control over that, it is a reserved matter. My more general point is that it is not appropriate for politicians to say that it is perfectly okay for junior doctors to work at night without a consultant being on the premises. It is not appropriate for me to say that. I said that we had to apply hard tests to clinical safety and that, therefore, we were going to listen very carefully. I would not say that the issue was completely off limits.

The main substance of what I am saying is that we have control over most of the areas in question, although control might not be the right word. We have control, but that control is within the framework of things such as the working time regulations, which have not even come up today. We have control, but we have to work within a framework that we do not have the power to overturn. We work within a framework of external policies and of issues such as training requirements; within that, the Scottish Executive and Scottish Parliament have control.

The Convener: With reference to the wider issues that we have been discussing, you would sign off a general plan that had been given to you by a health board, but once you had done that, you would have no more to do with how the health board chose to interpret specific service delivery in that context.

Malcolm Chisholm: That is the general way in which we proceed. However, in the case of Glasgow, the Parliament took a view on named services, so we have reserved any final decision on them. Apart from that modification and one or two others such as the decision to reconsider the accident and emergency department this year, we generally approved Glasgow's strategy. That is the view we have taken and it is up to the health board to implement it.

The Convener: Will that also apply to the out-of-hours service?

Malcolm Chisholm: The out-of-hours service is a different issue. Those services do not come to the centre for approval.

The Convener: I think that we have exhausted today's questions, although I am sure that everyone could have gone on for longer. I thank the minister for coming along and giving us his time. No doubt we will see him again in the future.

There will be a break while we change witnesses.

15:36

Meeting suspended.

15:41

On resuming—

Committee Away Day

The Convener: Item 6 is to consider matters arising from the away day. As I was not at the away day, I will not make any input into the discussion, other than to direct members' attention to various matters. There is a clear recommendation that we agree to adopt options A to F, which are outlined in the paper that was sent out with the agenda, and to consider decisions on individual petitions at our meeting on 28 September. Is everybody happy with that?

Members *indicated agreement.*

The Convener: Various recommendations were made on the work-force planning inquiry, which was also discussed at the away day. The committee is asked to agree to focus the inquiry on service delivery, and in particular on the service requirement, the resources that are available, how resources are deployed and how they should be deployed. Does everyone agree with those four areas of focus?

Members *indicated agreement.*

The Convener: We are also asked to agree to focus on the following professions in relation to recruitment and retention: consultants, general practitioners, allied health professionals, and nurses and midwives. Is everybody happy with that recommendation?

Members *indicated agreement.*

The Convener: Do we agree to complete the report by December 2004?

Shona Robison: I have a point of clarification. I think that it was mentioned that we would produce an interim report by the end of the year. It might be worth clarifying that, in case we do not quite finish the full report.

The Convener: The paper asks the committee to agree

"To aim to complete its report by December 2004."

Perhaps it is open.

Mr McNeil: I want to pick up on a matter that you raised earlier, which I am sure that we have discussed: whether the training of doctors is reserved. Is it reserved and, if it is, how do we deal with that?

The Convener: Perhaps in the short term we could ask the Scottish Parliament information centre to produce a paper for us on the specifics of what is reserved and what is not. Depending on that paper, we can move on to other issues.

Mr McNeil: Leading on from that is the fact that we discussed with our colleagues on the Westminster Health Committee—who are also taking evidence from the royal colleges—how we can dovetail with them. That might be useful if the issue is reserved and we want to create flexibility to allow the professions to adapt to Scotland's geography, rather than to the major conurbations of England.

Mr Davidson: One issue is the role of the European Parliament, which is beginning to interfere—I would say meddle—in many ways with regulations on the registration of staff, their qualifications and where they were taught, which relates to clinical safety.

The Convener: I think that we are all agreed that we should get input from SPICe on the interfaces between this Parliament, Westminster and the European Parliament on the various training issues, and perhaps on working issues, because this is not just to do with training. Once we have seen that information—I presume that SPICe will be able to do it quickly; I am getting a nod from the corner—we can consider whether we want to proceed.

Item 7 will be taken in private.

15:46

Meeting continued in private until 16:24.

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