HEALTH COMMITTEE

Tuesday 2 November 2004

Session 2

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HEALTH COMMITTEE
24th 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)
Mr Stewart Maxwell (West of Scotland) (SNP)
Mrs Nanette Milne (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Rhona Brankin (Deputy Minister for Health and Community Care)
Carolyn Leckie (Central Scotland) (SSP)
Elaine Smith (Coatbridge and Chryston) (Lab)

THE FOLLOWING GAVE EVIDENCE:

Dr Peter Collings (Scottish Executive Health Department)
Mr Andy Kerr (Minister for Health and Community Care)
Professor Stuart Macpherson (NHS Education for Scotland)
Mike Palmer (Scottish Executive Health Department)
Malcolm Wright (NHS Education for Scotland)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 1

Scottish Parliament

Health Committee

Tuesday 2 November 2004

[THE CONVENER *opened the meeting at 14:05*]

Work Force Planning Inquiry

The Convener (Roseanna Cunningham): I welcome Professor Macpherson and Malcolm Wright to the committee. I am sorry about the noise from the drilling that is going on—we are trying to get it stopped. Clearly, while it continues, it is a bit of a nuisance for us all.

Professor Macpherson wants to make it clear that although he is a member of the Conference of Postgraduate Medical Deans of the United Kingdom, he is here to speak for NHS Education for Scotland. Is that right?

Professor Stuart Macpherson (NHS Education for Scotland): Yes. The postgraduate medical deans in Scotland are now part of NHS Education for Scotland.

The Convener: I will kick off with a fairly general question about work force planning. Some weeks ago, we had evidence from the then Minister for Health and Community Care that work force planning in the health service in Scotland was a fairly recent phenomenon. What is your feeling about work force planning and how involved in it have you been? I suspect that you have been fairly involved. Do you agree with the submissions that we have received that argue that work force planning in Scotland appears to be occurring in isolation and is not really taking on board what is happening in the rest of the UK or Europe?

Malcolm Wright (NHS Education for Scotland): It might be helpful if I outline at the beginning NHS Education for Scotland's role in work force planning. As we see the matter, three important elements need to come together. One is service planning, to which Professor Kerr's national review is important. National service planning is important because a number of specialties need to be planned nationally, then regionally and locally.

The Convener: When you say nationally, do you mean in Scotland or the UK?

Malcolm Wright: I mean Scotland-wide. A number of clinical specialties are so small and interdependent that a national overview is required for them, although much of the planning must be done regionally—across three or four health boards—and also locally with local populations. Service planning is important and must come first.

The second element in the equation is work force planning, which is largely about getting the numbers right and ensuring that the work force is properly modelled for the service that has been planned for the future. The third element, which is the one in which we are most closely involved, is work force development. It is about training new doctors, helping to provide continuing professional development for nurses and pharmacists and ensuring that new roles are described and that professionals can develop in their roles.

All three elements are interdependent. We have been actively involved in work force planning for some aspects of the work force, particularly dentistry—on which we recently produced an important report—and psychology. We have also fed into the Scottish Executive's work on medical work force planning. We have different roles in work force planning for different aspects of the work force.

Our sense is that, in the past nine months or so, momentum on work force planning has been gathering. The establishment of the national work force committee, which has various strands, including one group that is considering work force numbers, has been encouraging. That will help us to help to train and deliver the work force for the future.

The Convener: Are you saying that proper work force planning in the health service is really only about a year old?

Malcolm Wright: Work force planning has been carried out in different parts of the service but I have been encouraged over the past nine months or so by the fact that it is really coming together cohesively at the national level. We are very much involved in supporting different elements of that planning.

Professor Macpherson: Work force planning in medicine is extremely difficult—I am sure that lots of previous witnesses have told you that. For a number of reasons, it has become much more difficult in recent years. The committee will already have heard about the working time regulations and modernising medical careers. However, I have to say that work force planning in medicine in Scotland is also difficult because of the presence of England. England is big—10 times bigger than us—and it is not very far away. There is free interchange of doctors across the border and recent initiatives in England have had a significant effect on what we are trying to do in Scotland. We have to take that into account.

It is appropriate that the Executive's work force planning processes have been increasing recently. We now have robust processes in place. Work

force planning is not the responsibility of postgraduate deans; it is the responsibility of the Executive. However, the postgraduate deans have important information to feed into work force planning and we are happy to give that information. I am thinking about information on doctors' training and availability and on what we can train for. However, in the end, the decisions are not ours and the service comes first. That is what we are all here for.

Mr David Davidson (North East Scotland) (Con): I want to be clear about something in Mr Wright's contribution. Does your area of influence include people in pharmacy and dentistry who are not employed directly by the NHS but work as contractors?

Malcolm Wright: Yes.

Shona Robison (Dundee East) (SNP): Professor Macpherson spoke about the free interchange with England. You have described a pool for the health service in England. However, we could consider it the other way round: there could be a large pool for the health service in Scotland to draw on. Why is it not happening that way? Why is the cross-border flow predominantly in one direction?

Professor Macpherson: There is cross-border flow in our direction. Scotland has a good name in medicine and we attract people across the border, at undergraduate and postgraduate level and at consultant level. However, it is my impression that the flow is more in the other direction. Now, I could say that that is because we are so good at training high-quality doctors in Scotland, who are then attracted to jobs in England. That is part of the answer, if I am honest, but many factors are involved.

The situation has not been helped by recent initiatives in England to attract doctors from outwith England. The Department of Health talks about those initiatives being to attract foreign doctors; sometimes I cynically think that it really means Scottish doctors. The reasons for Scottish doctors going to England are many and varied. I am happy to talk about those reasons at length but I suspect that you have heard about them from others who have sat here before.

Shona Robison: Have we missed an opportunity to have robust discussions with the Department of Health in England on recruitment policies that could impact on the Scottish health service? Should we have had more robust discussions to try to prevent the drain of doctors and nurses?

Professor Macpherson: I cannot speak for nurses but I can speak for doctors. It is up to us in Scotland to put processes in place that allow us to retain the doctors whom we train in Scotland. We have put some processes in place but we must do more—we can always do more. With NES's help, we are embarking on a study to discuss with senior trainees, when they achieve their certificate of completion of training, where they plan to go. I can talk about the situation for various levels but, at that senior level, we need to know why those people are going to England.

Shona Robison: Is that what has been happening?

Professor Macpherson: I do such studies as a postgraduate dean but we will now do studies in a co-ordinated way across the whole of Scotland. That will yield information. We need to know whether all those senior trainees are going to England because there is an attraction in private practice, for instance. I am aware that that is true in some specialties but it is not the case in all. We also need to know whether all those senior trainees are going to England because better child care facilities are available in English hospitals; if so, we need to correct the situation in Scotland.

We need to get secure information. I can give the committee information on the trainees who leave the south-east of Scotland training programmes, of whom—disappointingly—about 40 per cent take consultant posts in England. I can also give anecdotal stories from each and every one of them—I promise that the reasons are multitudinous.

14:15

The Convener: Do global figures for the net flow out of Scotland exist? If so, could you provide us with those figures?

Professor Macpherson: Yes.

The Convener: It would be useful for us to see them.

Helen Eadie (Dunfermline East) (Lab): Is every health service employee who leaves the service asked to undertake an exit interview or complete an exit questionnaire? If so, how are the figures analysed, monitored and evaluated?

Malcolm Wright: I understand that that is not done centrally. We are talking in particular about doctors at the point at which they complete their training. Certainly, discussions take place between newly graduated doctors and their postgraduate deans that give us some information as to why people might want to go down south. As Professor Macpherson said, some of the reasons relate to facilities offered by the health service in England. Also, given the fact that approximately half the doctors who graduate from Scottish universities originate from south of the border, there is a strong pull on them to return there for family reasons.

We need to recognise the distinctive way in which the health service in Scotland is developing in comparison with the health service in England. The service in England has retained the internal market, trusts and local flexibility for terms and conditions of service. I am not saying that that is good or bad; it is just the way that it is.

We need to be much smarter about the packages that we put in place to ensure that Scotland is an attractive place in which to work. That could include opportunities for research or educational development. We need to ensure that doctors can have a satisfactory career in Scotland. We need to manage consultants' careers better so that they can work in specialist centres, district general hospitals and remote and rural locations. We could put in place a number of measures to try to counterbalance the situation to some extent.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Do you have figures on the number of trainees who would have stayed in Scotland had positions been advertised or offered to them?

Professor Macpherson: I do not have such figures for medicine, but that is what we are starting to do with the study. Dr Turner is absolutely right: we need to have that sort of information.

If we can see people a year before they achieve consultant status, we could ask them as part of the study what it would take to keep them in Scotland and we could put them in touch with the part of the service that might be able to fulfil their requirements.

Dr Turner: I am aware that financial constraints mean that not all jobs are filled or advertised. Some trainees—possibly just a small proportion—may feel that they were forced into making a decision to leave Scotland to earn money.

Malcolm Wright: We have recognised the need to counsel the specialist registrars a year out of their certificate and communicate much more effectively with the health boards and the regional planning groups. For example, if we know that, right across Scotland, 10 potential consultants in accident and emergency medicine are coming off the specialist training next year, we can ask what vacancies exist. If we do not have 10 vacancies around the country, we can go on to ask what we can do to create posts on a pro-tem or permanent basis. If we were to do that, we could keep some of those doctors in Scotland. I am sure that, with better joined-up working, we could achieve that level of retention.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): The witnesses are correct to say that we have heard worrying evidence of this sort in the past. Increasingly, we have to make the job more attractive for diminishing returns. We have reduced the overall working hours in order to be European Union-compliant. We have also reduced the amount of out-of-hours and weekend working and increased general practitioner and consultant salaries. Despite doing all that, you have just told us about an issue that is even more fundamental to the Scottish system. The majority of doctors to whom I have spoken tell me that they are not in favour of private practice. However, you tell us that we need to give doctors that option to tempt them to stay in Scotland. The majority will have to compromise a general principle to please a minority. There are other issues to do with how we organise our hospitals and a further area of conflict arises in relation to increased specialisation and subspecialisation. Some specialties are obvious, such as specialising in cancer, but others, at the other end of the scale, are not always obvious. That conflict is causing services to collapse throughout Scotland.

The solution that you are giving us is more private medicine—I am pleased to see Professor Macpherson shaking his head—and continuing specialisation and subspecialisation. You are saying that if we do not do that, we are going to keep losing doctors to a free-market system in the south that will allow them to develop their careers more fully.

The Convener: Both witnesses want to respond to that.

Malcolm Wright: We can and should focus on specialisation and there are several examples throughout Scotland where that is starting to happen.

Professor Macpherson: Perhaps I should talk about private practice. I said that many reasons took people to England. Private practice is a reason in some, but by no means the majority of, cases and I am not advocating private practice in Scotland at all.

Specialisation is a real issue. As you can see, I have been in the medical profession for a long time; things have changed dramatically and they will change again—and more—in the future. I would like to say why that is the case.

People who are training now are in training for a shorter period of time than was the case when I trained. That policy has come about as a result of the working time regulations. I am sure that you would not disagree that it was a bad thing that, when I was in training, we worked for 100 hours a week and sometimes fell asleep when we should not have done. That cannot happen now, and our young trainees work for 48 hours a week. That means that we have less time to train them and they have less time to train. It is therefore inevitable that the breadth of their abilities will be less at the end of their training.

I am sure that you will not disagree with my second point. The public and the Parliament have become much more demanding of high-quality care, and I thoroughly approve of that. The Bristol report and the General Medical Council are behind that and doctors—particularly surgeons—will now do only those procedures that they do regularly, that they know they can do and where they know the outcomes will be of a high quality. That means that we no longer have the generalist who can and is willing to work across the whole spectrum and perhaps to carry out an operation once every three or six months. I suggest that both the policies that have driven that outcome are commendable, but that is the result of medical specialisation.

Mr McNeil: I enjoyed that insight into the fact that we are getting doctors with a much narrower range of skills, and that the culture values an elbow expert or specialist more than a generalist. Generalists have been talked down. It is your profession and that is the evidence that we have heard. No one has denied it to date.

There is an issue about quality of care in the thrust towards specialisation and subspecialisation. I think that we all agree that it can be proved that specialisation gives us quality care for people with cancer and heart disease. Where is the proof that specialisation and subspecialisation in any other area give us quality of care?

Professor Macpherson: What particular area are you thinking of?

Mr McNeil: Any area other than cancer or heart disease that you can mention where you can prove that we get better quality outcomes. Where is the proof that we get better quality outcomes through specialisation and subspecialisation?

Professor Macpherson: You mentioned the elbow expert—

Mr McNeil: There is no proof.

The Convener: I think that you should let Professor Macpherson answer.

Mr McNeil: Sorry.

Professor Macpherson: I do not have figures with me and I am not here as an expert in orthopaedic surgery. However, Mr McNeil will understand that, if someone does an elbow operation repeatedly and regularly, they are likely to do it better than someone who does it once every three months. We must also acknowledge that, if something went wrong with an operation that a surgeon does only once every three months, the first question that we would ask the surgeon is, "How often do you do this?" If we were told that they did it only once every three months, we would say that that was wrong. We are talking about a change in culture, which we just have to face.

The Convener: Duncan McNeil wants to get back in. I ask him to be brief, because other members have questions.

Mr McNeil: I will leave it at that, but I am sure that Professor Macpherson reads more often than I do the *British Medical Journal*, in which a debate on the issue is taking place. Proof that we can produce quality outcomes through a centralisation process that is driven by specialisation simply does not exist for some of the other specialties. In fact, I would like to know who decides what a specialty is and how, at the end of the day, that is supposed to serve patients. I do not think that the case has been proved; the focus on specialisation is merely fashionable.

The Convener: I am sure that the witnesses can see the general thrust of Duncan McNeil's questioning.

Professor Macpherson: Absolutely.

The Convener: If there is information that would help us in some of those areas, it would be useful if you could provide us with it. It would also be helpful if Duncan McNeil could give us the references to the *British Medical Journal* that he was talking about.

Janis Hughes (Glasgow Rutherglen) (Lab): I have a question on specialisms. It is right and proper for people to question the number of times someone has carried out a procedure so that they can inform themselves about that person's qualifications and the outcomes of the operations that they have performed. However, we discovered the other side of the argument when we went to visit the Western Isles as part of our inquiry. We found out about the dire lack of generalists in such places, because of the current trend towards specialisation and subspecialisation. How do we deal with that situation? There will always be areas of Scotland where generalists are needed desperately. How can we encourage more people to follow that route rather than be attracted by the sexier route of specialism and subspecialism?

Malcolm Wright: A range of things are being done now, which can be done better in the future. For example, we are funding a range of remote and rural fellowships in dentistry, primary care and hospital medicine in various parts of the north of Scotland. Those fellowships allow young doctors to spend a specified length of time in a remote or rural area learning the specialism of generalism—I hope that that is not too much of a mouthful.

The Convener: No. We have heard about that already.

Malcolm Wright: That is one of the elements that will be key to success in sustaining health care in remote and rural communities.

We also need to recognise that the issue is not all about doctors; a range of other health care professionals have an essential role to play. I am thinking about expansion of the role of nurses and allied health professionals. The infrastructure that we have in place to support people working in remote and rural areas is relevant, too. An example of our work in that area is the tele-education project in the north of Scotland. I have visited Aberdeen and Inverness and have participated in a tele-education link with the Western Isles. Such initiatives work very well. Another example is the e-library that has been started up, which some 29 per cent of the health service staff are signed up to use. It is an electronic library of books, journals and focused information on disease groups. In addition, we are just about to fund a new clinical skills centre in Inverness.

All those aspects—getting the infrastructure in place, expanding the roles and remits of other health care professionals and offering support for doctors to pursue the specialism of generalism—are necessary. We are taking a number of measures that, when brought together, can help the provision of care. Professor Macpherson might want to add to that.

Professor Macpherson: That only thing that I want to add is that I apologise slightly for leading the discussion down the route of specialism. The committee should remember that the majority of doctors in Scotland are generalists—they are general practitioners—and that we are also responsible for training them. My personal view is that, if I was trying to run the most efficient health service in the world—I think that that is what we are all trying to do—I would ensure that the best doctors went into general practice. That must be a priority, because that is where the patient first meets the health service. I think that we might have forgotten about that a little in our discussion.

14:30

Mr Davidson: On the same subject, but specifically on surgery, there are serious concerns throughout rural Scotland about attracting sufficient surgeons and about being able to keep them up to speed with the amount of work that is to be done, their training and the boxes that they must tick for the GMC, the clinical standards people and so on once they have been attracted into surgery. If, for the sake of argument, generalist surgeons are trained, it must be ensured that they have the right work load. Therefore, will they automatically have to go on a longer training period in future, which will delay their introduction to providing a service? Will they have to operate on a centrally run rota and work on a peripatetic basis in order to keep up their skills and provide a service?

Professor Macpherson: We are training surgeons for remote and rural surgeries. As I said, if the Scottish health service decides to continue such services, it is our job to try to train people for them. I think that it was mentioned that last week, a surgeon whom we had trained in the north of Scotland took a consultant's post on one of the islands.

We must decide what those people can and cannot do. As I said earlier, if something occurs once every six months, it should probably be dealt with by someone who deals with it regularly. However, surgeons can provide services in those remote and rural communities and we need to train them for those services. We have received co-operation from the royal colleges to allow us to do that and we now have programmes in place, but we must attract people into those programmes. We are working on that through our students rotating through remote and rural hospitals. Our basic surgical training programme in Edinburgh has a slot in Stornoway, on the understanding that people will be attracted to such practices if they see such a practice at that stage in their career. We must do such things to maintain those services.

Mr Davidson: But the rotation of senior staff is a real issue.

Professor Macpherson: It is an issue. It is a problem.

The Convener: How much of what we are discussing is driven by a tendency nowadays to practise defensively, as a result of the fear of litigation?

Professor Macpherson: I think that there is some of that and that that is inevitable, but I think that it has improved the quality for which people are looking, to be honest. It is possible that, 30 years ago, someone in Stornoway, for example, could have carried out an operation that they should not have carried out, but I do not think that that happens now, which is a good thing for Scotland's patients. The scenario that you mention is not entirely negative. People should do only things that they are competent and able to do well in an environment in which such things can be done well for the patient.

The Convener: Mike Rumbles has questions on the Calman review.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): It is interesting that you comment on general practitioners. The evidence that we received from the Royal College of

General Practitioners said that, in its opinion, we will be short of 500 GPs within the next eight years. Calman recommended that there should be an extra 100 doctors, and we have been told that that represents around 15 per cent of the training intake of 700 places.

I am interested in dentists as well as in doctors. In the Parliament last week, we heard the Deputy Minister for Health and Community Care say that 15 per cent more dentists are undergoing training this year than there were previously. Therefore, Calman has suggested an increase of 15 per cent in the number of doctors and there has been a 15 per cent increase in the number of dentists. Is that enough? The Scottish Executive has not yet made a commitment on Calman. Is what he suggests enough, and are enough dentists being trained?

Professor Macpherson: Calman reported on undergraduate numbers, but the issue is much more elongated. I am happy to see more medical students being trained in Scotland, although I should point out to members a fact that I am sure they already know. Proportionately, many more medical students are trained in Scotland than in the other parts of the United Kingdom, which are desperately trying to catch up with us. However, I am much more interested in whether we can retain those graduates in Scotland. At the moment, we retain the majority of them, but we must work at retaining more. Not many students leave when they graduate. Under the current arrangements, they tend to spend their first year in pre-registration house officer posts in Scotland, but a third of them leave after that. Some come into Scotland at that point, but we lose a third of the graduates that we have produced. As I said, we then lose people at the end of specialist registrar training.

As a postgraduate dean, my answer on Calman is, by all means approve Calman, and by all means approve the extra students, but recognise that we will have to have jobs for them to flow into. There is no point in our training them and then letting them leave Scotland. We have got to have the capacity to accommodate them at postgraduate level.

Mike Rumbles: You say that we need to have jobs for the graduates. To give you an example, the general practice in Braemar in the north-east of Scotland is the only practice in Grampian that is not in the out-of-hours system; it has opted out. I keep being told that that will be a problem in the future, because we will not get a replacement GP for the rural and remote practice in Braemar when the current GP leaves, which he will do at some time. Similar situations apply in the western Highlands and other places.

We are being told that we do not train enough doctors and GPs to fill the places, and you said that we have to have jobs for the graduates to go to. Should we provide training in the specialism of being a rural and remote GP? Would that be an answer?

Professor Macpherson: That would be an answer. We discussed the training of remote and rural surgeons and physicians, which we are already doing. In fact, we are also training general practitioners in remote and rural practice. We take GPs who have done their basic training into fellowships in remote and rural practice, as Mr Wright mentioned; that experience is attracting those GPs into permanent positions in general practice in remote and rural Scotland. That bit, therefore, is working but I emphasise the distance between that and Calman. There are lots of steps in between, and we have to address each and every one of them. Just putting more medical students in at the bottom will not solve the problem. We have to work out ways of retaining them in Scotland.

Mike Rumbles: I hear what you are saying, but I am trying to anticipate the Scottish Executive's reaction to the Calman report, with which it has not yet come forward. You say that if the reaction is that we need more GPs and therefore that we need to change the system further down the line, that will be in addition to taking on the original recruits. You are not saying that it is an either/or situation, are you?

Professor Macpherson: No. The medical student who graduates is totipotential, and can become a general practitioner, a surgeon, a physician or whatever you like. If we need more general practitioners, we need to have more training places for them, and we need to ensure that our graduates find their way into them.

Malcolm Wright: First, we have increased the number of GP registrars who are going through the training schemes. We are slightly over-established for those posts at the moment.

The second point to note is the impact of the new general medical services contract, and the flexibility that it gives to practices, not just in employing doctors, but in employing a range of other health care professionals who can perform roles that were previously performed by GPs. There is a lot more flexibility in the new GMS contract. I mentioned before the need to develop the roles of nurses and allied health professionals—that will be one of the solutions in the current work force.

Mike Rumbles: No comment has been made about dentists, but since we closed one of the three dental schools 10 years ago there has been a crisis, which has become apparent only in the past few years. As I mentioned, there has been a small increase in the number of dentists. What should we be doing?

Malcolm Wright: Much of that is predicated on the outcome of the new terms and conditions for dental practitioners in Scotland, which will set the scene as to whether dentists will want to stay in the NHS in Scotland. Putting that to one side, there are two points. First, the output from the dental schools is increasing. This year it is 116, and by 2006 it will be up to 134, which is a substantial increase. In the detailed work force modelling that we have done, it is possible to envisage a balanced position within dentistry in Scotland by 2008. That does not take into account the work that is going on to train other professionals in dentistry. For example, 40 people will be going through dental hygiene and dental therapy courses and graduating in 2007. A number of measures have been put in place that have not yet borne fruit but which will bear fruit as the numbers come through.

Dr Turner: Will you comment on the changes in the health service that we have been discussing, which involve centralisation, a reduction in the number of beds, a reduction in buildings—which in itself means a reduction in beds—and structure and training for general practitioners?

It is especially obvious that GPs in remote areas need to be robust, and that they need more confidence and experience to work further away from hospitals. That also applies in cities, where more work is being allocated to the general practitioners. We not only need people; we need training.

Professor Macpherson: I would like to change the training that is given for general practice. I do not understand why general practice training is so short. I was a surgeon before I became a postgraduate dean. General practice involves the whole breadth of things, and it seems to me that training to be a GP ought to take longer than learning a specialty. Traditionally, however, general practice training has been very short. That is under review and I sincerely hope that two things will happen. First, I hope that general practice training will lengthen. Secondly, I hope that the component of that training that takes place in general practice will lengthen.

At the moment, we train general practitioners in hospital for two years and in general practice for only one year. I do not think that that is satisfactory. The evidence is that, at the end of that shortened period of training, very few general practitioners go immediately into a permanent general practice post. Instead, they take up other posts until they feel more confident. I would like to lengthen general practice training, and I would like more of it to take place in general practice.

If we need to attract general practitioners to remote and rural areas—which we do—I quite agree that some of their training should take place in remote and rural areas. I have had some communication from my colleague in the north, Professor Needham, who has recently gained approval from the joint committee on general practice training to take trainees to Shetland, the Western Isles, Orkney and Caithness. It is hoped that that will attract people to take up permanent positions in those areas.

Mr McNeil: You indicate that simply getting more people in through the door is not the solution. That evidence has been led in the past. It has also been suggested that we have a better chance of retaining in Scotland those who train in Scotland, and that we usually lose those who move down south, as they tend to stay there. Furthermore, we turn away about 100 people a year who have a very high standard of qualification. What could be done to rectify that and to get more Scots, who would be more liable to complete their careers and stay in Scotland, to train in Scotland?

Professor Macpherson: If, by that question, you are addressing the matter of admission to medical school, you should not address it to me. However, I used to be the admissions dean for the University of Glasgow medical school, so I can talk about that. The admissions processes for medical schools across the country need to be fair and even handed. We cannot discriminate, and I am sure that you would support that. We have to apply the same criteria across the board. We cannot discriminate in favour of Scottish applicants.

As I have said, Scottish medical schools are well known. Scotland produces good doctors. We attract a large number of medical students from other parts of the United Kingdom. The percentage of medical students from outwith Scotland reflects the percentage of the qualified applicant population.

Helen Eadie: You have spoken about the length of time between entry into medical school and becoming a doctor and then a consultant. You mention in your written evidence that

"A major unresolved challenge is the time required to engineer significant workforce change."

Throughout your evidence, you have stated—as have others—that there is often insufficient flexibility in the system to allow change to occur. Could you outline the flexibility that is required?

Malcolm Wright: For me, there is an issue about flexibility between the different professional groups. The national work force committee is taking forward the issue of developing roles—for example, developments around nurse consultants and those in allied health professions and devising new roles for radiographers. There are significant shortages of consultant radiologists around the

country, which will not be sorted out quickly. However, there are opportunities for extending the role of radiographers by giving them accredited training that will allow them to do duties that previously only consultant radiologists have done. We are increasingly considering that kind of flexibility.

Professor Macpherson: As far as medicine is concerned, the more specialised the population that delivers the service, the harder it is for them to change. Therefore, I would like more general practitioners to be involved for part of their time in hospital service, because in their GP role they remain generalists with specialist interests—for example, diabetes. If diabetes disappeared tomorrow, we could retrain GPs quickly to develop a specialist interest in areas in which we are still working. A surgeon, on the other hand, can do only surgery, so it would be difficult to go back to the beginning and retrain them.

The Convener: We have exhausted our allocated time for both of you. I thank you for the clarity of your evidence, which we have all found useful. The evidence that we are given is not always so straightforward and clear.

Budget Process 2005-06

14:45

The Convener: I welcome the witnesses for agenda item 2, particularly the Minister for Health and Community Care. Am I right in saying that this is the minister's first appearance before the Health Committee in his new role?

The Minister for Health and Community Care (Mr Andy Kerr): Bar the motion on amnesic shellfish poisoning—that was a minor show.

The Convener: That is right. I had forgotten that you were here for subordinate legislation. I invite you to make a brief statement to the committee.

Mr Kerr: This is my first substantive appearance before the committee and I am pleased to be here.

Members have before them the spending review 2004 figures. The committee is primarily discussing the 2005-06 budget, but we have also announced headline figures for 2006-07 and 2007-08, which show respective increases in resources of 8 per cent and just under 8 per cent. The corresponding figures for capital, which it is important to mention, are 8 per cent and 16 per cent.

Some of the figures are not fully broken down and there are a number of reasons for that. First, we are updating the needs assessment formula—the Arbuthnott formula—and that will affect allocations to boards. Secondly, we have the resources that we need and I am working on an announcement for December on further plans to improve services to patients, which will use some of the extra resources. Thirdly, the amounts that are required for primary care are dependent on negotiations with various professions that have yet to take place.

The committee has taken a keen interest in two particular issues: pay modernisation and measuring increased outputs from increased resources. Most of our budgets and most increases go on NHS staff pay. That is an important point. I am fed up with the phrase "the black hole" being used in relation to pay, because what it implies is not the case. Resources are spent on our staff, who are key players in health provision, to ensure that patients receive a high standard of service. That high standard is reflected in the satisfaction surveys that we conduct in the health system. At my first substantive appearance before the committee, it is fair that I say that I have met some highly skilled and motivated people. I recognise that those people are not only highly trained but highly committed to the public who rely so much on the service. Clearly, we want to reward those staff properly. We need systems that

facilitate service improvement, which is where much of our resources go. Spending money on staff and on pay modernisation to recognise the contribution that staff make is not putting money down a black hole.

I share the committee's frustration on outputs, which are an issue that I need to resolve. We need to be able to analyse the many good things that are happening in the health service and to report on them more adequately. During my early visits to places such as the Leith community treatment centre and other general practices, and in my visits to general hospitals and university hospitals, I have seen the big changes that are taking place. I am sure that committee members are already familiar with those changes.

So that we know more, and so that we can hold our health board colleagues to account more appropriately, I have written to all health boards to ask them to highlight what they believe have been the key service improvements. The responses are coming in as we speak. In addition to receiving those big headline messages, we also want to ensure that we address the data deficit. As I have said previously, that is very important to me. Many new things are happening in the health service that are good for the patient, but we need to capture those things and account for them appropriately.

Finally, on resources, the amount of money that is provided is always important, but it is recognised that spending on the service is at unprecedented levels. We need to ensure that the money is spent properly, and I hope to make an announcement on that to Parliament in December. That is roughly how I see the budgetary position at the moment. In December, I hope to announce further information on how the resources will be spent in favour of the Scottish patient and the Scottish public.

Shona Robison: The committee's adviser, Andrew Walker, has produced some interesting figures, which are based on the cost pressures that have been identified by Audit Scotland and other sources. In 2003-04, such cost pressures accounted for 71 per cent of the new money that was allocated to health boards. As the minister will know, three health boards ended that financial year in deficit. The adviser suggests that that percentage figure will rise to 82 per cent for 2004-05 and to 141 per cent for 2005-06; although we do not have figures for 2006-07 or 2007-08, I assume that that figure will continue to increase. In other words, although new money is being provided, the immense cost pressures are greater than the new moneys that are being made available. That suggests that more health boards are likely to end the coming financial year and the following financial year in deficit. Is that a concern?

Mr Kerr: It would be a concern if I shared the adviser's view. With due respect to Mr Walker—whom I have met only fleetingly in the parliamentary campus—I question some of those figures, which I have had a quick look at only in the past five minutes or so. Are the figures cumulative or year on year? I question some of the resource allocations, especially in the first section of the statistics, which were made available to us just prior to today's meeting. I am more than happy to meet Mr Walker to ensure that we come to a common understanding about whether the moneys in the table that he has produced are cumulative or year on year. That makes a substantial difference to the calculations.

Secondly, by dealing only with new moneys, the adviser's paper does not make a fair assessment of the position of the health service. We are dealing with a substantial budget that is undergoing changes in the way that it is used. I think that the adviser's analysis does not take due cognisance of the on-going reconfiguration and redesign of services in our national health service. Those changes are providing some extremely focused benefits for the general public who use the service.

In terms of future provisioning and analysis of the money that is left over for new initiatives, what cognisance has been taken of service redesign and reconfiguration, which also have an impact on our resources? Further, where do the base figures come from? Were they the base figures for 2002-03? Again, depending on what base was used in the first instance, the bottom line of the grid that I have just received could be questioned, as could the position that is put by the member.

I would be happy to engage with the committee on this matter. I have serious doubts about some of the content of the adviser's paper, but I believe that we should reflect on the fact that the health service is changing. We should be dealing with the whole budget because it is being used to deliver service reconfiguration and redesign in ways that will provide better productivity, which will allow resources to be spent elsewhere in the service.

Shona Robison: We suspected that you would not be in a position to respond to the figures in detail, given that you have only just seen them. A meeting would be helpful, but it would also be helpful if you could provide your alternative analysis and figures to ensure that we are comparing apples with apples and pears with pears. There is cause for concern with regard to the general trend of the figures. You might dispute some of the detail of the figures, but if the cost pressures are a trend, there is certainly cause for

concern. Obviously, we look forward to being reassured by the minister on that point.

Mr Kerr: I am happy to do that. Obviously, I would rather not do it in such an adversarial manner. Instead of providing alternatives to the views of the special adviser to the committee, I would rather that the officials worked together to come to a common understanding of some of the questions. I am happy for that engagement to take place. I am not sure whether the member is referring to the fact that, on one occasion she says that the NHS is awash with cash, while on another occasion she says that it is starved of cash.

Shona Robison: We are not being adversarial.

Mr Kerr: I think that you are, to a degree. I am happy to establish various points through discussions with the special adviser.

The Convener: The special adviser is happy to meet your officials and discuss the various points. The committee will decide whether that should be an accompanied discussion.

Mr Davidson: I will start with a simple question about comments that were made by both you, in your former role as Minister for Finance and Public Services, and the First Minister. You talked about 2 per cent savings in health—where in the health service system will those savings appear?

Mr Kerr: We should beware of simple questions, as there are no such things.

The efficient government contributions to the health service come largely from procurement. Peter Collings might be able to give us some more accurate figures about the contribution that has come from that direction. Further contributions have come from the service redesign initiatives that have been undertaken through the centre for change and innovation.

Dr Peter Collings (Scottish Executive Health Department): We have a target of saving £50 million on NHS procurement by the financial year 2006-07 and we would hope to have done better than that by the end of the period relating to the efficient government announcement. We have also kicked off a project for shared services, which will mean that payroll and financial systems will be provided once for NHS Scotland rather than around 20 times as happens at the moment. There are further projects to do with benchmarking and the estates, which should lead to savings.

Those are the kind of areas that we are considering. More detail will be available when the efficient government plan is published.

Mr Davidson: I presume that the 2 per cent figure applies only to the areas that you have detailed, as opposed to it being 2 per cent of the global sum, which was the impression that the First Minister gave.

Dr Collings: The amounts that I am referring to add up to 2 per cent of the total sum. We have some specific savings that add up to 2 per cent of the total health budget.

Mr Davidson: I have some specific questions on what appears to be your budget—I say "appears to be" because there might be qualifications.

Over the past few years, the ministry has emphasised the delivery of more care in the community. However, over three years, there appears to have been a reduction in the money that is spent on community care. As the previous witnesses said, there has been a reduction in funding for the postgraduate education of all types of medical professionals, not just doctors. There does not appear to be any increase in the funding for the ambulance service, yet the previous Minister for Health and Community Care talked about the ambulance service helping out with regard to out-of-hours care. Further, no inflation figures seem to have been built into the drugs budgets. Can you be a bit more precise about those questions?

15:00

Mr Kerr: I will try to. If I miss one of them out, I will try to return to it.

The drugs budget is an estimation of what we see in terms of our ability to purchase better. I hope that, if we purchase properly and effectively, through some of the work that we are undertaking, we can obtain a reduction in that line of the budget and spend that money elsewhere in the service.

The vast majority of community care funding goes through the grant-aided expenditure line in the local government settlement. There is also work going on within the centre for change and innovation and with the Convention of Scottish Local Authorities and others to ensure that we do that work more effectively and efficiently. There are a number of aspects to that that I think are important. Also important are the targets that we have set for the health service around care of the elderly within their home settings and the targets that we have laid out to provide more care and support to keep people at home as opposed to their entering the health system through the acute or general hospital structures.

If we get this right, I am convinced that all those measures, taken as a package—and working with the acute doctors in our health service, who are beginning to work more effectively across GP practice boundaries to provide care in local

settings—will allow us to achieve our targets within the resources that we have allocated to them.

On training, I defer to Mike Palmer, as he deals with our work force planning.

Mike Palmer (Scottish Executive Health Department): On postgraduate medical education, the amount of investment in junior doctor numbers and the doctors that we have in training has been increasing year on year since devolution, so that we have had an increase in doctor numbers of 14 per cent over the period. The increase has been across senior house officer, specialist registrar and pre-registration house officer grades. That is all extra investment that is going into postgraduate medical education.

For the first time, the new consultant contract gives consultants a protected amount of time in each working week, under their job plan, for supporting professional activities such as those that they are asked by employers to undertake to supervise postgraduate medical education. A range of measures is being progressed to ensure that we protect the balance that is required between service delivery from consultants and their responsibilities for postgraduate medical education. Indeed, we undertook a constructive and positive piece of work with the royal colleges earlier this year in order to issue joint guidance that was agreed between the British Medical Association, the Scottish Executive Health Department, the royal colleges and the employers. The objective was to ensure that, in the delivery of a new consultant contract, consultants' postgraduate medical education needs were balanced properly and appropriately against service delivery needs. A range of measures and initiatives has been taken to ensure that that investment is protected and sustained.

Mr Davidson: It has been mentioned that three health boards are having difficulty in matching their budgets, and that situation is likely to get worse. A statement has been made regarding support for Argyll and Clyde. Do you have enough money in reserve to transfer that statement of support across the whole of the potential problem? If so, what is the basis of that reserve and where does it come from?

Mr Kerr: I expect any public organisation to live within its budget. What I have said to the individual patients who rely on the service, especially in Argyll and Clyde, is that they can rest assured that the service will continue and that health care will continue to be provided for them. I will need to look carefully at the position of that health board. I have indicated that I will not underwrite the board's capital difficulty, but that I will deal with the revenue implications to ensure that the services continue. I am due to meet the health board very soon—either tomorrow or the next day—to have a real look at the recovery plans that it is putting in place and to ensure their viability.

I will go no further with regard to that particular health authority. On the generic question about authorities that project a deficit, I fully expect the boards to deal with the projected deficits by taking measures within their areas.

Mr Davidson: Do you have a reserve?

Mr Kerr: The Executive always has a reserve. It would be unwise for a finance minister not to have a reserve. However, I do not see the reduction of health board deficits as a valuable use of it—the boards should be able to sort out those matters from within their boundaries.

Mr McNeil: I welcome what you are saying about patient care, minister. Are you also saying that you do not rule out the abolition of Argyll and Clyde NHS Board?

Mr Kerr: I do not rule it out. As has been noted in the press and elsewhere, I want to consider the recovery plan and structural issues in Argyll and Clyde NHS Board, such as how it has been set up and how it is managed. I rule nothing out and I rule nothing in. I want people to read right to the end of this sentence in the *Official Report* of the meeting: abolition is a possibility, as is my acceptance of the recovery plan, after which the board could get on with its business.

Mr McNeil: Your primary concern will be the patients who receive the services.

Mr Kerr: My primary concern will be to ensure that health care services are provided for individuals in that locality.

Shona Robison: What does the situation suggest about the ministerial intervention two years ago? What lessons will be learned from the obvious failure of that intervention?

Mr Kerr: That is the purpose of my meetings. The reading that I have done suggests that some of the issues that are being faced go back to before 2000. I need to understand what actions were taken as a result of the intervention; I need to know whether the work that is being carried out addresses the core issues and will therefore place the health board back on an even keel, or whether there is a structural problem that cannot be managed out through the recovery plan. I do not undermine those who are trying to resolve the problem—I hold them in high regard. However, I need to work out whether we have set them a fair task in asking them to resolve the difficulty with the running of Argyll and Clyde NHS Board and whether we can expect a recovery plan to be successful. I will not make judgments until I have had a proper discussion with those people.

The issues go back several years. We have taken a number of measures that, to date, have proven to be unsuccessful. I need clarity about the recovery plan and whether it will be successful and, if it is proven that it will not be successful, what decision the Executive will take. That clearly requires a full discussion and further reflection.

Shona Robison: I presume that, in the past two years, it must have been reported to the Health Department that matters were not going well. We have not just landed here out of the blue. Some responsibility for the situation must rest with your department.

Mr Kerr: If the issue is about the allocation of blame, I am happy to accept—

Shona Robison: It is about learning lessons.

Mr Kerr: We replaced a number of senior managers on the board. To learn the lessons, we must assess whether the task of recovery that we set for them was fair or whether the structure and organisation of services in Argyll and Clyde NHS Board makes it difficult to provide those services.

Ministers have taken action, but there needs to be flow-through. Just because a new management team has been put in place to tackle the recurring deficit and structural problem, that does not mean that, even after 18 months, the issue will be sorted out. There is not an overnight solution. I must reassure myself that the board has a strategy that addresses the key issues and will make the health board sustainable in the longer term.

Bluntly, another management team or set of recovery plans ain't any use—we need a long-term fix. That is what the critical discussions that I will have will be about. I will not say at this stage how I will approach the matter, because a range of options are available to me, from saying, "Thank you very much, that is a fine recovery plan and I am confident that it will work," to saying, "I'm sorry, I do not think that that will work in the long term, so we must address structural issues and a number of steps may have to be taken." There is a range of prospects, but I have not yet had the opportunity to meet the people in the front line to discuss those prospects.

Shona Robison: In your response to Duncan McNeil, you suggested that disbanding Argyll and Clyde NHS Board was not ruled out. That would be a serious step, but it could not happen in isolation. If you were to take that step, you would have to consider a general reorganisation of health boards. The impact of such a disbandment on the west of Scotland would be immense. Are you seriously suggesting that the problems of one health board may lead to a complete restructuring of health boards?

Mr Kerr: I do not think that a general restructuring of all Scotland's health boards would be a valuable exercise right now. I have sent a strong message to individual health board chiefs and chairs saying that they must plan their services more regionally, taking account of their relationships with neighbouring boards and with national centres for particular services. I am not impressed by the lack of regional planning and the lack of understanding that a decision in one health board can impact on other health boards. Because of a lack of discussion, plans have not fitted together for Scotland. There has been a problem, but the solution is not necessarily a full-scale restructuring of health boards. However, I do not rule that out if the boards do not get their act together and work together across boundaries to provide better services for patients. We are dealing in perceptions and there will be a meeting tomorrow.

To get back to Shona Robison's original question about Argyll and Clyde, I would say that, if any minister went down the route of disbanding the board, a full assessment of the implications would be carried out. At least three neighbouring health boards would be affected, but we would not take such a step without thinking through the consequences.

Mike Rumbles: I want to move the focus of the questions on to targets for maximum waiting times for patients. A lot of resources are going in that direction and the Executive has achieved its first target, which relates to treatment for in-patients within nine months of diagnosis. However, the Executive has also set targets for maximum waiting times for patients for consultation and treatment. The Executive aims to reduce waiting times further and an announcement is expected in spring next year.

The first target of nine months has been achieved and, as of next year, we will have two major targets of six months. Would it not be more sensible to wait until we see whether the Executive, by focusing its resources, manages to achieve one target—and it is important that patients do not wait more than six months—before announcing further targets? We should evaluate the success first.

Mr Kerr: That is a view, Mike. I will not say that it would be the wrong approach, but I will say that the evidence that I have is that we will be able to meet the targets. The pressure from patients is that we should deal with waiting times much more effectively. I would not set targets without full discussion with all the professionals and service providers, to ensure that we set targets that are stretching and demanding but not unreasonable.

I am wary of setting too many targets. Health board chiefs and chairs have said to me, "Just tell

us what you want to do; don't give us all these targets." Across the Executive, not just in the health service, we have sought to reduce the number of targets. We have not simply dropped them and forgotten about them; we have ensured that they are subsumed under the portfolios of ministers. We will ensure that the targets are still met, but the issue will no longer be so much about having publicly owned, accountable targets. We are reducing the focus to ensure that the correct work is being done.

We are making great progress on waiting times. It is a serious issue and we are putting serious money into it. However, there is enough patient demand and there are—if I may be blunt—enough resources through the spending review to allow us to be more challenging, particularly with service-specific targets, and to ensure that we deal with communities' concerns about the health service. Targeting in the health service is critical, because, after all, one person's target is another person's diversion from another activity. As a result, we must ensure that we provide the full additional resources that are needed for service-specific targets so that our approach does not have any consequences for delivery elsewhere in the service.

I do not rule out any further use of targets, because they are a useful and indeed valid way of holding our health boards to account over the public's perception of the service and ensuring that the public are well represented in the health relationship. We have received enough data about our progress on our top-line targets and do not think it unacceptable to introduce other targets as and when we are ready to do so.

15:15

Mike Rumbles: But I am talking about major targets. We must not forget that the vast majority of people are seen relatively quickly. However, as a constituency MSP—and I am sure that the minister has had the same experience—I find that people seem to contact me more about waiting times than about almost any other issue. I am not criticising targets—indeed, it is important that we have specific, measurable, achievable, realistic and time-related targets—but surely we should focus on the fact that we have met the target that has already been set.

Mr Kerr: Perhaps we misunderstood each other. Setting condition-specific targets for an individual procedure or episode will have an impact on the overall target, which in this case is waiting times. The two aspects work with each other to help us to achieve our overall target. My job is to ensure that the targets are sensible and link up. In my discussions with the royal colleges, the health board chairs and chiefs and consumers, I will make it clear that those targets can be made sense of and met.

Kate Maclean (Dundee West) (Lab): There has been a lot of discussion about targets, which are an important issue. When I was a member of the Finance Committee, we requested a reduction in the number of targets and asked for more outcome-based targets, because we were finding it difficult to see how things were being achieved. It appears that the number of targets has been reduced from 14 to nine but, on page 53 of the budget document, five old targets have been subsumed under target 1, which brings us back up to 14 again.

Earlier, you said that old targets have been dropped only where they have been achieved. However, it is not clear whether targets for hospital-acquired infections, additional nurses and midwives and so on were met before they were dropped. As far as target 1 is concerned, instead of having specific targets for smoking and alcohol consumption, we now have a general aim. It worries me that the two issues that have the most impact on health and the health budget are no longer covered by specific targets. I do not think that the previous targets for reducing smoking were all that ambitious, but we have thrown the baby out with the bathwater. On the earlier question about whether additional burdens are contributing to deficits in health boards, that can be discussed between officials and we could receive hard figures, but the question of targets has to be handled differently. I am just worried that we have missed the mark on this occasion.

Mr Kerr: I am happy to correspond, through the convener, with Kate Maclean on that point. I have an explanation of every target that we have had and of where that target has gone. On occasion, targets have been subsumed under other targets, but some targets no longer exist because they have been achieved. There are also targets that find themselves placed elsewhere because of the way in which we do things. For example, there are individual targets within the tobacco control action plan and the dietary action plan. We have reduced the number of targets by absorbing them within other targets, by deleting them because they have been achieved or by picking them up elsewhere in the system.

Health improvement strikes me as the most important issue that we have to deal with. Although we spend a lot of time on targets and on the acute sector, the overall direction that I shall be taking will be a rigorous one that will refocus resources and effort into health improvement. I shall therefore want to come back to the committee on targets concerning the areas—diet, smoking cessation and physical activity—that are dealt with in "Partnership for Care: Scotland's

Health White Paper" and in other documents. We have also set ourselves targets that are relevant to treatments, to ensure that people do not die of specific diseases and that they are treated quickly and effectively. Those are also valid targets, so there are two sides to the question.

I shall reflect on the point that was made about whether the targets are better. As Minister for Finance and Public Services, I was keen to ensure in my discussions with individual portfolio ministers that we did not have any targets that were not SMART. I take some of the points that have been made, but it would probably be the subject of another paper or correspondence if I were to give you the all the details of the issue.

Helen Eadie: I shall stick to the theme of targets. Looking at the Scottish Executive website and reading some of the papers, I noticed that there seemed to be a subtle change. I am particularly concerned about dental health—I know that other colleagues share my concern. It seems that there has been a shift in dental health towards new targets, with the emphasis primarily on dental disease in children and a shift away from the previous targets shown on the Scottish Executive website. That causes me concern, especially in relation to the target for reducing health inequalities by increasing the improvement across a range of indicators. If you have good dental health, you will have a good diet, because you can eat carrots, apples and other good fruit. If you do not have good dental health, that causes problems.

As I said, a subtle change seems to have taken place in the targets. I support the idea of targets, because politics is always about the language of priorities and I think that targets can help us all to sing from the same hymn sheet when we are trying to address some of the nation's key issues. I represent one of the poorest communities in Fife and I know that you want to address health inequalities, minister, but I do not see how the new targets will do that.

Mr Kerr: The subtle difference between the two documents clearly did not escape you. On the generic issue of dentistry, the Executive recognises the problem and accepts that what we are doing just now is not sustainable. That is why there is a substantial consultation on the whole question of dentistry, to which I hope to respond before the end of the year. Details of our work to ensure that provision is made available to communities will come out of the response to that consultation.

On the subtle change that you have asked about, I can only look at the two targets, compare them and get back to you with more detail about what the change means in terms of service delivery. In all our plans, including the work force plan, we are setting our future projection of a work force to take account of some of the changes and the problems that we have with delivery. I shall look more closely into the point that you raise and get back to you on it.

Mr Davidson: I have a brief question on the back of that, which links targets in general health improvement to other silos and agencies in the Scottish Executive. Can you detail the budget agreements that you have reached with other ministers on cross-cutting in health improvement?

Mr Kerr: We have come to and will continue to come to substantive agreements with other ministers, particularly with the Minister for Education and Young People on healthy diets, the quality of school meal provision and the physical activity task force. There has been substantial cross-cutting in the budget with regard to justice, specifically on the treatment and prevention of drugs misuse. I recall that the figures were £6 million for dietary matters and about £5 million for the drugs initiative. Basically, those are health moneys that work outside silos and across portfolios in the Executive. Likewise, resources go in the other direction. A number of ministerial cross-cutting sub-groups exist to ensure not only that each minister is aware of their individual responsibilities within departments, but that resources that are required to deal with issues generally are aggregated into the middle. We are getting better at that.

Mr Davidson: I have a quick question on the back of Kate Maclean's comment. I, too, spent some time on the Finance Committee and I recall that we asked for clear flags to be put in the budget documents from individual ministers to show which moneys go into cross-cutting initiatives. Would you be good enough to send us a quick paper on that?

Mr Kerr: Sure. I just asked Peter Collings whether we had clear flags. I know what the issues are, which is why I can point to the £6 million for diet and the £5 million for drug action and prevention. I am happy to deal with that point as quickly as possible.

Shona Robison: The £6 million for diet is welcome, but am I correct in saying that you do not have a target for a reduction in obesity levels?

Mr Kerr: I do not think that we do, but we work through agencies and partners and, as I begin to focus my efforts in relation to health improvement, I will return to that issue, because it should be our primary focus.

Janis Hughes: I have a couple of questions on blocked beds. Whether we agree or disagree with targets, we would all agree that, where they are set, they must be evaluable. The second part of the target on blocked beds states that the number

of people who wait more than six weeks will be reduced to a minimum, which seems to be based more on opinion than on an evaluable target. How do you plan to measure that? Have you costed the blocked-bed target?

Mr Kerr: First, I have some experience of the issue from my time as minister responsible for local government. We are doing better at local co-ordination, but not well enough. Although COSLA and health boards are working more effectively on the joint agenda, performance is not as good as it should be. It is getting better, but it is not good enough.

Target 6 is for a 20 per cent reduction year on year between 2005 and 2008, which equates to taking around 400 blocked beds out of the system per annum. That suggests a minimum of about 800 beds. However, we want to get the figure down, because we do not want anyone to have to wait for more than six weeks. A 20 per cent reduction per annum is realistic and is backed up by the resources that are required to provide the right care settings.

There is also the issue of chronic disease management and the idea that we should stop people going into hospital in the first place. The work that is being carried out by the centre for change and innovation and the acute consultants will help us to achieve that target from both ends. In other words, it will, first, get people out of the system when they should not be in the system and enable them to get to appropriate care settings and, secondly, it will stop people going into the system in the first place. We hope that that two-pronged approach, which will be resourced by the Executive, will be successful.

15:30

Janis Hughes: You have spoken about partnership working, with COSLA being the main partner. Is the target that you are talking about only for the NHS? Does there have to be a separate target for local authorities, or is there just the one target?

Mr Kerr: There is one target, for which both the NHS and local authorities are accountable in their respective roles. More and more community planning is taking effect in local government and more is being done on the joint future agenda and other collaborative work, which I hope will continue and begin to address the problems and needs of the service user, as opposed to the interests of health boards and local authorities. I am not satisfied with what is going on now. There have been improvements, but we can do much better. To reiterate, both the NHS and local authorities are responsible for what is a joint target and we need to keep up the pressure to ensure that it is met.

Janis Hughes: You said that a costing has been made. As I am sure our adviser will confirm later, it is always difficult to track where the money is. I am not sure that a specific costing can really be made. Are you saying that it would be easy for us to find out from the budget documents exactly how much money has been allocated to deal with blocked beds?

Mr Kerr: I will let Peter Collings answer that point in detail. It is difficult: when a constituency MSP sits down with the local health board and local authority representatives, they find that the board and the authority tend to blame each other for the people who fall through the net. That is not acceptable. As Minister for Finance and Public Services, I put onerous conditions on the release of any resources so as to ensure that we tracked that money through. We will find out in a few seconds just how successful that was.

Dr Collings: In financial terms, a large part of joint working falls on the local authority side rather than on the health board side. As part of its submission on the spending review, COSLA put in what it thought was required in order to achieve the planned reductions. That was taken into account in the local authority settlement and it will be taken into account in the grant-aided expenditure allocations when they are announced.

Dr Turner: I have a question on targets and blocked beds. The Executive's target 9 for health and community care was to

"reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient two or more times in a single year by 20% compared with 2004-05, to release capacity in hospitals."

That is a specific figure. We all know that it is cheaper to treat people in the community, but the big problem is that a revolving-door pattern can sometimes emerge. If somebody comes out of hospital and is not that fit, they can go back in very quickly. There are costs involved in that. The target is admirable, but I was wondering about the workings and the cost behind it. How many people are affected? What would the trend be, even without a target? What would the cost be?

Mr Kerr: I do not know off the top of my head the number of people who are affected. Peter Collings might be able to help with that but, if not, we will correspond with Dr Turner. The issue relates to some of the discussions that are, and have been, taking place on the subject of service improvement.

On chronic disease management, there is an issue of how we provide the right service through general practices and community health care settings and how we ensure that the required

support is given so as to avoid the chronic diseases developing in the first place. I see that as part of a continuing trend of more and more services being provided in local settings, ensuring that the needs of the individual patient are put first. We have banked some of the innovations in that service area in relation to our ability to reduce the proportion of older people admitted as set out in that target.

Chronic disease management is about the roles of the consultant and the hospital and their relationships with the GP in the local health care setting, as well as about the adaptations being made and about service providers going to the patient, as opposed to the patient going to them. Community health partnerships will play a significant role, too. The issue is about how we see the service developing. We are content to set a target that we can reduce if we get things right, as I am sure we will. We need to deal with individuals differently with respect to their health care provision.

Dr Turner: You expect that it will take a long time for the numbers to reduce, which is why you have set the target for 2008.

Mr Kerr: I just cannot place the number in my mind—I have forgotten it. I am happy to correspond with Dr Turner on the detail of the numbers and the implications of the 20 per cent target. Off the top of my head, I remember that the figure for bedblockers is 20 per cent, but I cannot remember the other figures.

Kate Maclean: I have a wee issue to raise on the targets, which is that it would be useful to have comparative figures. For example, instead of target 9 saying that the aim is to

"reduce the proportion of older people (aged 65+) who are admitted as an emergency inpatient",

the target would start by saying, "Last year, X amount were admitted". If we had those figures for all nine targets, we could get the issues more clearly into perspective. Is that possible?

Mr Kerr: It is possible. The chief economic adviser audits all our targets in order to ensure that they are measurable and gives us his comments on them. The scrutiny process should ensure that the information can be provided. That is no problem.

The Convener: My question relates to blocked beds and emergency admissions. Next year, the committee plans to undertake a long-term study on the impact of the various pieces of community care legislation. Target 7 says that you will

"increase the number of older people receiving intensive home care to 30% of all older people receiving long term care."

Although, again, you may not be able to give us the information off the top of your head, do you know what the current percentage is? As Kate Maclean said, it would be useful to have that information. Perhaps you could undertake to have the information sent to us. Do you have the figure for the costs involved in meeting the 30 per cent target?

Mr Kerr: I am happy to provide that information.

Mr Davidson: Can you give the committee an update on where you are in relation to the care home sector and COSLA? At last, they appear to be singing from the same hymn sheet—in the past, the Minister for Health and Community Care appeared to be holding back progress. The relationship between the care home sector and COSLA is the meat in the sandwich, so to speak, and it impacts on some of the targets.

Mr Kerr: In my role as Minister for Finance and Public Services, I did not share the view that the Executive was the problem. Significant resources were committed in order to resolve the problems in the sector. As the issue developed into a big crisis—three years ago, I think it was—we made it absolutely clear that, although the problem was not our problem, we would deal with it. However, we also said that COSLA and the care home sector had to deal with the issue using their normal negotiation procedures. We gave them the task of resolving matters and not always asking central Government to deal with the problem for them.

I am advised that, as we are still in negotiations, it is best that I go no further on that point. Members have to recollect and respect what the Executive did in the first place to resolve a particular problem at a particular time, making it clear to the two key parties that they would subsequently have to fix the problem themselves. Let us see how the negotiations continue.

Mr Davidson: I look forward to seeing the results of the negotiations and to hearing about your input. Given that the situation impacts directly on the Executive's targets, I find it strange that you appear to be so detached. Surely we are talking about key players.

Mr Kerr: With due respect, local authorities are elected bodies with their own responsibilities. If I were to direct the authorities from the centre on every issue, people would ask why we should bother to have local government in the first place. Local authorities have a job to do and they should do it in a mature fashion, as should the care home providers.

The Convener: I said at the outset that, if we got ahead of ourselves in terms of time, I would give you the opportunity to make a few closing remarks, given that I asked for your opening

statement to be brief. Do you wish to say anything at this point?

Mr Kerr: No, thank you. Obviously, I have a number of pieces of correspondence to deal with as a result of the questions. I am more than happy to accept some of the points that were made over objectives and targets. I look forward to dealing with the issue that Andrew Walker raised about the table.

The Convener: Given that we hope to discuss the draft budget report a fortnight from today, we are under some pressure of time. You have made a number of commitments to give us further information and that puts some difficulties on our work programme. Are the commitments that you gave us manageable in the timescale?

Mr Kerr: I would hope so, especially as regards the points that have been made on the targets.

The Convener: Thank you. I understand that we will hear from you again next week as part of our work force planning inquiry.

Mr Kerr: Thank you.

The Convener: Before we have a five-minute suspension, I ask the committee to agree that, when we discuss the draft budget report a fortnight today, we do so in private. Is that agreed?

Members *indicated agreement*.

15:40

Meeting suspended.

15:47

On resuming—

Breastfeeding etc (Scotland) Bill: Stage 2

The Convener: I welcome Elaine Smith MSP, whose member's bill we are considering at stage 2, and Carolyn Leckie, who has lodged amendments to the bill. I also welcome the Deputy Minister for Health and Community Care, Rhona Brankin, to her second Health Committee meeting in her new guise.

Section 1—Offence of preventing or stopping a child from being fed milk

The Convener: Amendment 1 is grouped with amendment 2.

Carolyn Leckie (Central Scotland) (SSP): Amendment 1 is my preferred one and I believe that it would be helpful. Elaine Smith and the committee have done a great job in getting the bill to this stage. I hope that their work has helped to put to rest some myths and prejudices and that we can now take the debate on the mother-baby dynamic a stage further.

I have lodged amendment 1 because I am a wee bit concerned that the bill's definition of a child as being a person under two years conveys a retrograde message that would allow someone to challenge a mother who was nursing an older child. Obviously, the mother would be protected from harassment or assault by existing legislation, but the bill will not preserve her right not to be challenged in or removed from a public place or licensed premises when she is breastfeeding.

The breastfeeding relationship between a mother and a baby is a dynamic one that is about them alone, and no person or legislation should interfere in that by giving the impression that an acceptable time limit for breastfeeding has been set. It has been shown that breast milk adapts physiologically to the age and needs of a breastfed child. The composition of breast milk changes as a child grows—including children older than two.

As I said during the stage 1 debate, I breastfed both my children, and I breastfed my oldest daughter until she was two years and two months. At that age, children are articulate and can participate in a discussion. In general, children do not breastfeed often at that age, but breastfeeding can be a comfort if they fall over, for example. A scenario can be imagined in which a child falls over in a dining area, hurts themselves and wants a breastfeed as a comfort. One day before a child's second birthday, that would be okay and

nobody would be in a position to challenge what was happening—the mother and child would be protected by law. However, the day after the child's second birthday, they could be challenged—although obviously not harassed. There is a potential contradiction, which could inhibit the mother-baby dynamic.

Not many mothers breastfeed children at the age of two, although I hope that the number who do so will increase. The lower the age limit in the bill, the more impetus there will be to wean as that age approaches, so that the child is no longer breastfeeding by that age. However, who would define a child as being two or under?

Children come in varying sizes. By setting the age limit at two, it is possible that mothers who have larger children who look as though they might be two will be asked their child's age. I am a wee bit worried about that, which is why I want to remove the definition of "child", to leave it open ended and to leave the decision in the domain of the mother-baby dynamic. I want to leave the definition up to the mother and the baby; I do not want to leave it up to anybody else to cast an opinion or to be able to make a challenge.

I have spoken to Elaine Smith and I appreciate the arguments for setting an age limit. That is why I lodged amendment 2, which might be necessary to set the age at five and so take the matter beyond the realm of being an issue. Setting the age at two could be an issue; it would leave a grey area and the potential for mothers and children to be challenged. It would also send out a wee bit of a negative message about breastfeeding older children. There is still prejudice about that, which needs to be challenged, because it is there only because of the sexual objectification of women and women's breasts. Some people find the idea unpalatable, and that needs to be directly challenged.

I lodged amendment 1 so that there would be no definition and no interference. If amendment 1 is unacceptable, I will move amendment 2, which would take the age to five, taking it beyond the realm of possibility that anyone would be caught in the grey area that I mentioned.

I move amendment 1.

The Convener: If amendment 1 is agreed to, amendment 2 will be pre-empted. The amendments are grouped together, so we are dealing with them together.

Carolyn Leckie: I have moved amendment 1 and I will move amendment 2, but I prefer amendment 1.

The Convener: You cannot move amendment 2 yet.

Shona Robison: I oppose amendments 1 and 2. In particular, I oppose amendment 1, because we must consider where we are with breastfeeding in Scotland. Scotland is a nation with one of the worst breastfeeding rates in Europe because of public attitudes towards breastfeeding, particularly among young mothers, who—unfortunately—too often still see it as not for them. I have supported the bill because of the important public message that it sends out in reassuring people that breastfeeding is a normal activity that should be encouraged. My concern about amendment 1 is that it could send out a message that runs counter to that message, as it could be subject to ridicule. Elaine Smith has steered a careful path in the bill to ensure that breastfeeding is presented in comfortable terms.

We need to take a big step to increase breastfeeding rates, and I do not think that that would be helped by the impression—albeit an unfair impression—that there is no upper age limit on breastfeeding in public. That would be seized upon by those who would want to seize upon it for whatever reason. Such a provision could be severely misrepresented and could deeply damage the major thrust of the bill, and that would be a retrograde step.

I oppose amendment 1 on those grounds and I look forward to hearing what Elaine Smith has to say about it.

Mike Rumbles: It is important to put on the public record once again the fact that the bill will not introduce an upper age limit on breastfeeding. The bill is not about that; it does not give new rights to mothers and babies, because they already have those rights. Specifically, the bill creates a new criminal offence of deliberately preventing or stopping

"a person in charge of a child"

who is under two

"from feeding milk to that child in a public place".

That is what the bill is about, so it is nonsense to talk about allowing children to be fed their mother's milk at any age.

With the bill, we will create a criminal offence, which must be absolutely specific. Elaine Smith and those who have worked on the bill have done an awful lot of work on the issue. We will hear from Elaine Smith in a moment, but I think that it is better to go with what the proposer of the bill suggests rather than open a can of worms.

Kate Maclean: I do not support either of the amendments, but not because I am anti-breastfeeding—I am pro-breastfeeding and breastfed both my kids, about 25 years ago, when it was unfashionable to do so and not even many health professionals promoted it. It was difficult,

and I have experienced not being allowed to breastfeed a small baby in public.

We must set an age limit and I think that two is a good age. Beyond that age, kids can understand the concept that they will get something later on and can eat and drink through means other than breastfeeding. I know that one of Elaine Smith's aims is to promote breastfeeding, but if we are talking simply about people being able to feed their babies in public, I do not think that it necessarily should be a criminal act to stop people breastfeeding a baby who is older than two, given that there are other methods of feeding such babies. As Mike Rumbles said, the bill will not introduce an upper age limit on breastfeeding. People should be allowed and encouraged to breastfeed their children for as long as that is suitable and beneficial for the child and the mother.

I am not comfortable with raising the limit in the bill to five and I understand that there would be legal problems if we had no limit. I am happy to support the bill—I supported it at stage 1—and I congratulate Elaine Smith on introducing it, but I am not prepared to support the amendments.

16:00

The Deputy Minister for Health and Community Care (Rhona Brankin): Like other women who have spoken, I breastfed both my daughters when they were little, in some quite difficult situations.

The Executive supports the bill. We are of the opinion that its primary aim is to improve children's health. The Executive is committed to giving every child in Scotland the best possible start in life and to a programme of supporting and promoting breastfeeding, which includes the development of a breastfeeding strategy in the coming year. That work is important and I look forward to doing it.

I have considered Carolyn Leckie's amendments, both of which we resist for similar reasons to those that members have given. There is a long way to go to encourage women to breastfeed. It is in no way a universally accepted part of our culture, and the rate of breastfeeding among women is still much lower than we would like. We do not yet have 50 per cent of women breastfeeding at six weeks, although it is in the first six weeks of a child's life that the benefits of breastfeeding are most pronounced. Therefore, we feel that we must focus our promotional efforts at the very start of a child's life; indeed, the World Health Organisation's position emphasises the importance of the first two years.

The difficult issues surrounding the bill have been mentioned. Given the current lack of understanding among the general population about breastfeeding and its benefits, increasing the age limit could have negative consequences both for the bill and for the whole image of breastfeeding. Keeping an age limit of two years in no way makes breastfeeding in public beyond that age illegal. The huge challenge for us is to increase the number of women who want to breastfeed their babies and to encourage women to breastfeed for around six months. We feel that, for the purpose of the bill, the age limit of two years is appropriate and helpful and will offer protection to the vast majority of women who wish to breastfeed for longer than six months.

Elaine Smith (Coatbridge and Chryston) (Lab): I am pleased that Carolyn Leckie has lodged these amendments. The more that we debate the subject, the better that will be for raising awareness and making society consider and challenge the prejudices and misconceptions that it has about breastfeeding.

Research into the issue reveals that the norm around the world for weaning from breastfeeding is between two and four years. In some cultures, the child is older; for example, Indian custody law decrees that any child under six years must reside with their mother because they are considered to be of suckling age. Other primates feed their young for years rather than for months, and research that compares humans to primates suggests that humans' natural weaning age from the breast is a minimum of two and a half years and a maximum of between six and seven years. There is a lot of variation. We humans might consider ourselves to be smarter than primates, but perhaps we are not as smart about infant nutrition as we might like to think that we are.

I have no doubt that, if a big drug company was making a profit from breast milk, we would all be well aware of the nutritional benefits of feeding our children for as long as the mother and child both want. Some research shows that the benefits continue for as long as breastfeeding continues—Carolyn Leckie mentioned that. Personally, I believe that it should be entirely up to mums and babies, with no stigma attached to it. It is normal, nurturing, maternal behaviour and should be supported as such by society.

However, we do not live in a breastfeeding culture in Scotland. The reality is that even small babies who are utterly dependent on their mother's milk can be viewed askance when feeding in public and women and their babies can be segregated or ejected from public places and licensed premises; the committee will know that, having looked into the matter. The bill is intended to offer protection in the law and to promote breastfeeding, thus assisting a change in attitudes and empowering breastfeeding women and

children. As the minister said, changing attitudes is a big issue.

I turn specifically to the two amendments and address amendment 1 first. When changing the law, the legislation must be clear, unambiguous and precise. Leaving the term "child" undefined would not be good law. Without a definition, "child" could mean anyone from one day old to 18 years old. Carolyn Leckie asked how it could be proved that a child was older or younger than two. That would have to happen if a case was being prosecuted and a procurator fiscal was involved. We have other age-related laws—someone has to be 14 to go into certain licensed premises, 16 to buy cigarettes and 18 to buy alcohol—so there are precedents. As the bill creates a criminal offence, the term "child" needs to be defined so that everybody knows exactly what the offence entails. Therefore, amendment 1 must be rejected on the basic principles of good Scots law.

Amendment 2 deals with a more substantive issue. The steering group discussed various ages. At one point, I suggested the age of five years old, but that was pretty arbitrary; we could have chosen any age. We had many meetings and the issue was batted back and forth. According to the research on weaning, seven years old might be a more appropriate cut-off point, given that that is what the research on primates says. The age of two years old was put in the bill, because that is the age that the WHO recommends, rather than the ages of one year old or three years old. There was a logic to the choice of two years of age. In addition, the commonsense point was made—which Kate Maclean has reiterated—that most children who are under the age of two, unlike older children, cannot understand the concept of waiting for a feed. Older children can communicate their feelings, wants and needs; they do not breastfeed exclusively or as frequently as children who are under two; and they can eat other things. Ultimately, the bill seeks to safeguard and protect the right of very young children to feed.

The steering group took the decision to mention a specific age for the purposes of the bill. It thought that, given that the issue is highly contentious, the committee might want to consider the matter at stage 2, depending on the evidence that it had taken and its deliberations at stage 1. At stage 1, the committee concluded that it was appropriate to define "child" for the purposes of the bill.

Carolyn Leckie mentioned some of the reasons for the decline in breastfeeding in Scotland. I will not go into those, as I have outlined them before, but I think that the factor that affects societal views on the feeding of toddlers, in particular, is the result of the sexualisation of women's breasts and prevailing cultural attitudes towards breastfeeding as a whole. If the bill is passed, the benefits that will accrue as regards changing attitudes and making breastfeeding more culturally acceptable will roll out to benefit children who are older than two.

As Mike Rumbles said, it should be noted that the status quo will prevail in relation to children who are older than two, so it will not be illegal to breastfeed children of that age. The Executive could perhaps turn its mind to promoting the benefits of breastfeeding for as long as mums and babies want to continue with it. That is a practical suggestion that the Executive could consider as part of its duty under the section on promotion.

Although some children are breastfed for more than two years, the majority are weaned off the breast far too early. That is evidenced by the fact that the Executive's target on breastfeeding for next year is that 50 per cent of mothers should still be breastfeeding their babies at six weeks. That target is far from being met because, at present, less than 40 per cent of mothers are still breastfeeding at that stage.

The realpolitik of the situation is that it represents quite a quantum leap in the United Kingdom for a legislature to enshrine in law protection and promotion of breastfeeding; Scotland would be the first country in the UK to do that. Attitudes towards small, dependent children must be changed. I hope that that will mean that a situation evolves in which all breastfeeding will be embraced as normal, nurturing maternal behaviour.

At stage 1, the committee gave much time and thought to the definition of "child", alongside all the other issues. It was right to conclude that an age should be included in the bill—the definition of "child" is appropriate for the purposes of the bill. If the committee decides to support amendment 2, I would be relaxed about that in that it is the committee's prerogative to do so. However, I would want to ask why it should opt for an age limit of five rather than one of six, which, as I mentioned, applies in Indian culture, or one of seven years old, to which the research on primates points. Indeed, why not opt for a limit of eight years old?

I believe that society should support women in breastfeeding their children for as long as they want to do so, but I must stand by the definition that the bill sets out, which was agreed on by the steering group after many meetings and much deliberation. There is a certain logic to it.

I thank the committee for its scrutiny of the bill and for its robust stage 1 report.

Carolyn Leckie: I found the discussion illuminating. I point out that the WHO global strategy for infant and young child feeding, which

was adopted at the world health assembly in 2002, was careful not to set an upper limit on the duration of breast feeding.

Elaine Smith asked why not have an upper limit of six or seven years of age. That begs the question why have an upper limit of two years of age. My preference is that there should be no reference to an age limit, because breastfeeding is about the mother-baby dynamic. In lodging an amendment that defines "child" as a person who is under five years of age, I recognised the cultural reality in Britain, but sought to ensure that there would be no women who breastfeed their babies who might perceive themselves as being discriminated against by the bill.

I will deal with Mike Rumbles's point. It would not be a criminal offence to challenge a breastfeeding mother of a child who is two years old and older, so that is discrimination, because it would be a criminal offence to challenge a mother who is breastfeeding a child aged under two. Why should there be that differentiation? Why should a mother and her baby's relationship be protected when the baby is under the age of two but not when the baby is over the age of two? The onus should be on those who argue for that to explain why such an arbitrary age limit is necessary. If it is a crime to hit one person and not a crime to hit another, that is discrimination, and that is a potential problem with the bill.

On Kate Maclean's point, there is limited understanding of what the breastfeeding relationship with an older child becomes. It is quite naive to use the argument that because the children are older, they understand and can wait for food and drink. In my experience as a health professional and a mother, and as someone who initiated a breastfeeding support group through the National Childbirth Trust when my children were small, the breastfeeding relationship moves from being an exclusively nutritional relationship to being a nutritional and emotional relationship, and by the time a child is older, the relationship can be predominantly an emotional one. When a child is looking for comfort—a child who is not breastfeeding might be comforted by a dummy tit—it is not acceptable to say to the child, "You have hurt yourself. You are crying and upset, but you need to wait because we could be challenged in this place". I am sure that there are people who know that when that kind of breastfeeding relationship has been established with their child, there is only one thing that can shut them up and stop them crying until they are weaned, and that is to breastfeed them. For some children, the mother-baby relationship could be damaged if it is artificially interrupted.

It is unfortunate that we have to define what a child is. I understand the pressures, but it would be helpful to leave the definition loose and not to convey any impression. I have chosen the age of five because I recognise the cultural realities in Britain and that it is unlikely that any mothers and children would still be breastfeeding by the time the child is of school age, or would feel that they were being discriminated against.

It is open to members to lodge other amendments and to choose another age—three, four, six or seven—at stage 3 if that is the argument; but I do not believe that that is the argument. If people ask me why I have proposed the age of five, I will ask "Why two?" because there are definitely still babies of that age being breastfed in this country, and I am sticking up for them.

The Convener: Are you pressing amendment 1?

Carolyn Leckie: I am pressing amendment 1.

The Convener: The question is, that amendment 1 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

AGAINST

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

The Convener: The result of the division is: For 0, Against 9, Abstentions 0.

Amendment 1 disagreed to.

Amendment 2 moved—[Carolyn Leckie].

The Convener: The question is, that amendment 2 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

AGAINST

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

The Convener: The result of the division is: For 0, Against 9, Abstentions 0.

Amendment 2 disagreed to.

Sections 1 to 5 agreed to.

Long title agreed to.

The Convener: That ends stage 2 consideration of the bill. I thank everyone for coming along.

Subordinate Legislation

Mental Health (Advance Statements) (Prescribed Class or Persons) (Scotland) (No 2) Regulations 2004 (SSI 2004/429)

Mental Health (Patient Representation) (Prescribed Persons) (Scotland) (No 2) Regulations 2004 (SSI 2004/430)

The Convener: There is one final item. We have been asked to consider the two negative instruments that are shown on the agenda. The Subordinate Legislation Committee has no comments to make on either instrument, I have received no comments from members and no motions to annul have been lodged. Are we agreed that the committee does not wish to make any recommendation in relation to the instruments?

Members *indicated agreement*.

Meeting closed at 16:15.

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