HEALTH COMMITTEE

Tuesday 1 February 2005

Session 2

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HEALTH COMMITTEE
4th Meeting 2005, Session 2

CONVENER

*Roseanna Cunningham (Perth) (SNP)

DEPUTY CONVENER

*Janis Hughes (Glasgow Rutherglen) (Lab)

COMMITTEE MEMBERS

*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)
Alex Fergusson (Galloway and Upper Nithsdale) (Con)

THE FOLLOWING GAVE EVIDENCE:

Dr Elizabeth Bower (Guy's, King's and St Thomas' Dental Institute)
Sandy McDougall (Food Standards Agency Scotland)
Professor Tim Newton (Guy's, King's and St Thomas' Dental Institute)
Professor Alison Williams (Guy's, King's and St Thomas' Dental Institute)

CLERK TO THE COMMITTEE

Simon Watkins

SENIOR ASSISTANT CLERK

Tracey White

ASSISTANT CLERK

Roz Wheeler

LOCATION

Committee Room 2

Scottish Parliament

Health Committee

Tuesday 1 February 2005

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

Items in Private

The Convener (Roseanna Cunningham): While people are coming into the public gallery, I will press on. Item 1 is consideration of whether to take items 8 and 9 in private. Item 8 deals with the Abolition of Prescription Charges (Scotland) Bill; having the discussion in private would allow us to consider alternative options for the handling of the bill. Item 9 concerns the eating disorders inquiry. It is proposed to take that item in private to allow the committee to have a preliminary discussion about the key themes and recommendations for inclusion in our report. The request for such items to be held in private is fairly standard, so is the committee agreed that items 8 and 9 be held in private?

Members *indicated agreement*.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (Scotland) Order 2005 (SSI 2005/34)

14:06

The Convener: Item 2 concerns subordinate legislation. I welcome Rhona Brankin to the committee. She is accompanied by Sandy McDougall from the Food Standards Agency.

The committee is asked to consider under the affirmative procedure the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (Scotland) Order 2005 (SSI 2005/34). The Subordinate Legislation Committee considered the order at its meeting this morning and had no comments to make. Does any member wish to seek clarification from the minister and her official on the order?

Mrs Nanette Milne (North East Scotland) (Con): I have more of a comment than a question. My party has held a specific line on the instruments on amnesic shellfish poisoning and I will oppose the order, as my party will, until such time as end-product testing becomes the norm.

The Convener: That probably does not come as a huge surprise to the minister, but she might wish to make a response.

The Deputy Minister for Health and Community Care (Rhona Brankin): No.

The Convener: I ask the minister to move the motion.

Motion moved,

That the Health Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (Scotland) Order 2005, (SSI 2005/34) be approved.—[*Rhona Brankin*.]

The Convener: The question is, that motion S2M-2333 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

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

ABSTENTIONS

Robison, Shona (Dundee East) (SNP)

The Convener: The result of the division is: For 7, Against 0, Abstentions 1.

Motion agreed to.

Mike Rumbles (West Aberdeenshire and Kincardine) (LD): Convener, will you clarify what the vote was, for my interest?

The Convener: There were seven votes in favour, one abstention and no votes against.

Sweeteners in Food Amendment (Scotland) Regulations 2004 (SSI 2004/548)

The Convener: We move on to consider under the negative procedure the Sweeteners in Food Amendment (Scotland) Regulations 2004 (SSI 2004/548). The Subordinate Legislation Committee's comments on the regulations are included in the committee papers. I see that the minister has gone already. I have not heard any comments from individual members and no motions to annul have been lodged in relation to the instrument. Are we agreed that the committee does not wish to make any recommendation in relation to the instrument?

Members *indicated agreement*.

The Convener: We move on to the item on access to dental health services in Scotland.

Mrs Milne: Convener, I realise that I am way out of order, but I have just caught up with myself and realised that I voted the wrong way. Is there anything that I can do about that?

The Convener: I am sorry. The vote has been taken. There is nothing that you can do about it. Just put it down to inexperience. There was clearly a bit of concern around the table at the time. You have now made it quite clear on the record that yours was an inadvertent failure to vote against the motion.

Dental Services

14:12

The Convener: The next item is on access to dental health services in Scotland. Members will remember that, in April 2004, the committee commissioned researchers from the Guy's, King's and St Thomas' dental institute at King's College London to carry out research into access to dental services in Scotland. The researchers—Professor Tim Newton, Professor Alison Williams and Dr Elizabeth Bower—are in attendance today to present their findings to the committee. That is why the white screen is here, although I imagine that it will be rather difficult to see anything on it, given the level of light that we unexpectedly have today. Members were sent an advance copy of the report with the committee papers and will be able to follow that; I assume that hard copies are also available for members of the public. The document is, as of 2 pm today, a public paper and is reproduced on the committee's web pages. I invite the researchers to present their findings. We hope to confine this section of the meeting to about 20 minutes before we move on to a discussion.

Professor Tim Newton (Guy's, King's and St Thomas' Dental Institute): Thank you for that introduction. As you said, convener, we were commissioned on 1 April 2004 to undertake a survey of the population of Scottish dentists. We took a number of steps to ensure that we reached as many of the dentists working in Scotland as we could. We eventually surveyed 2,852 dentists with addresses in Scotland and working in Scotland, of whom about 75 per cent returned completed questionnaires.

The aim of the survey was to identify those dentists' contribution to the provision of national health service dental services in Scotland and to identify areas where the availability of those services was insufficient to meet need or demand. We took an approach based on a definition of access that was provided by Penchansky and Thomas in the early 1980s and which has been widely used as a way of thinking about access. We did so primarily because one of our concerns was that, in thinking about access to dental services, we were addressing a complex problem with many different facets. Penchansky and Thomas identify five key dimensions: availability, accessibility, accommodation, affordability and acceptability. We focused largely on three of those: availability, accessibility and accommodation. I shall say a little more about each of those dimensions.

Availability is defined as the fit between the provision of services and need. We took three measures of that: dentist to population ratios; the

proportion of time that practitioners would spend in delivering NHS care, as NHS care was our particular focus; and issues about the recruitment and retention of the dental practitioner workforce. We mostly concentrated on dental practitioners, although we also examined professions complementary to dentistry.

14:15

Accessibility is defined as the fit between infrastructure that is provided to access services and the requirements of users. We examined three aspects of that: the proportion of primary care dentists who accept NHS patients; wheelchair access; and distances travelled to surgeries. We looked specifically at the reported furthest distance that a patient travelled to the surgery, which inevitably overestimates the distances that most people are travelling.

Accommodation is largely about facilities. We examined waiting times for treatment and the availability of evening and weekend appointments for patients who were seeking NHS treatment.

We carried out several analyses of dentist to population ratios. The first was the simple ratio of dentists in an area to the population of that area. For the whole of Scotland, we estimate that there are about 5.57 dentists per 10,000 population. The information that we received from health boards is in table 5.6 on page 45 of the report. We then took that simple ratio and corrected it to take account of the amount of time that dentists reported spending on NHS care. If a dentist is spending less than 100 per cent of his time providing NHS care, the ratio will go down. For Scotland, the ratio goes down to 3.53 dentists per 10,000 population. Again, there is variation across the health board areas and those data are in table 5.9 on page 48 of the report.

At the next step, we corrected the ratio again, to take account not only of the amount of time that dentists were spending on delivering NHS care, but of whether the dentists were whole-time equivalent. Part-time workers were added together to make whole-time equivalents. We also made a correction on the basis of research into the output of dentists who receive salaries. We know that salaried positions have been created to meet need in certain areas and research suggests that salaried dentists have a lower output than non-salaried dentists. After the figures are corrected on that basis, the overall dentist to population ratio is brought down to 3.35 per 10,000 for Scotland. However, the impact of that correction is probably more marked at the level of the health boards, some of which are more likely to have decided to employ salaried practitioners. Those data are in table 5.11 on page 50 of the report.

We looked at recruitment and retention and found that only approximately 3.5 per cent of those who replied to the question anticipate increasing their NHS commitments. That is a very small proportion. That information is on page 95 of the report. We also found that something like 20 per cent of respondents reported difficulty with recruiting a dentist. A similar proportion reported problems with recruiting dental nurses. That information is on page 91.

On accessibility and the specific issue of accepting NHS patients, there is a distinction between adults and child patients. We found that 37 per cent of primary care practitioners were accepting all categories of adults for NHS care. Of those who were accepting adults, 38 per cent had a waiting time of two weeks or less, so the majority of those who were accepting adult patients had a waiting time of more than two weeks. Those data are on pages 64 and 65 of the report. Sixty-six per cent of dentists were accepting children for NHS care. Of those, 26 per cent had a waiting time of two weeks or less. That is on page 63.

We found that 61 per cent of practitioners worked in a surgery or clinic that was fully wheelchair accessible. Further information on that is on page 71. One thing that we found is that wheelchair access tended to be slightly better in settings other than general dental practices, such as in community dental clinics or in services that had been set up by health boards.

On distance travelled by patients—I emphasise that these are reports of the furthest distance travelled by patients—the average greatest distance to access NHS care is about 24.5 miles, although that varies between health boards. That information can be found on pages 67 and 68. For rural areas, the average greatest distance was 37 miles, compared with 22 miles for towns and cities. That difference is to be expected. People reported on average that the furthest distance for specialist services was longer. There is a set of tables with different specialist services. The distance varies not only by health board, but by the nature of the specialist provision.

Accommodation has two aspects. The average waiting time for routine NHS care was four and a half weeks. There is more information on that on pages 66 and 67. About 35 per cent of dentists provided evening and weekend appointments for NHS patients. That percentage tended to be lower where the services were community dental services, salaried services and so on.

In conclusion, our opinion is that the data raise two sets of issues—Scotland-wide issues and local or health board issues. The Scotland-wide issues include the supply of dentists: bringing in dentists and ensuring a continuous supply. There is also the question of incentives for dentists to

continue working in the NHS or to return to working in the NHS. On the local issues, we present a model that suggests that access is a complex, multifaceted construct and that the facets differ by health board, so that different health boards face different challenges.

With the table that commences on page 6, we tried to show that access issues vary across health boards. I take as a random example Argyll and Clyde. Given that the area is quite deprived, it would be expected to have high need. It has a good proportion of dentists who spend their time working for NHS Scotland. It scores well on accessibility. Patients travel short distances. It also has short waiting times and lots of dentists offering evening and weekend appointments.

Contrast that with the Western Isles, which is at the other end of the table. It is an area with less deprivation. It has a good proportion of dentists providing services for NHS Scotland, but the whole-time equivalence is lower than we would expect, particularly when we take out the salaried practitioners. It has middling accessibility, but the accommodation, in terms of waiting times and evening and weekend appointments, is among the worst in all the health board areas. Different health boards have different access challenges.

The Convener: Thank you. That was a good bit shorter than 20 minutes. Members should remember that we are considering a piece of academic research; they should direct their questions towards its findings. I do not know the extent to which Professors Newton and Williams and Dr Bower are prepared to speculate about some of the other questions that might lead from the report findings.

Mike Rumbles: I will focus absolutely on the report. Professors Newton and Williams and Dr Bower have done a very good job for the committee. The report is very detailed. Thank you.

I want to look at some of the statistics. You point out:

"Overall, 26% of dentists had decreased their *NHSScotland* time in the recent past".

What do you mean by "recent past"? You go on to say:

"only 37% were accepting all categories of adults as new patients."

You have pointed out two real difficulties. Further to that, on page 9, you say:

"A significant increase in *NHSScotland* provision, required to meet"—

The Convener: I am sorry to interrupt you, Mike. I remind you that the peach-coloured copy of the report has a different pagination from that of the published report. We need to be careful when we mention page numbers.

Mike Rumbles: Thank you, convener. On page 5 of the published report, just ahead of the paragraph on conclusions, you say:

"A significant increase in *NHSScotland* provision, required to meet pledges to make free *NHSScotland* check-ups available to all by 2007"—

that is a partnership agreement pledge and a ministerial pledge—

"and improve access to dental services, is more likely to succeed where the incentives on offer appeal to the greatest proportion of dentists."

I understand that entirely and I heartily agree with it. You are saying that, given that a lot of dentists have left the NHS, incentives are a short-term measure to bring them back. However, you conclude that section with the strong sentence:

"This is unlikely to be achieved with the type of incentives currently available."

Your academic research is highlighting a problem with the commitment that the Executive has made to meet that pledge. You are saying that people need to be brought back into the NHS in order to solve the problem, but that the Executive's current initiatives are unlikely to achieve that aim. Am I correct?

The Convener: Be brave! Go ahead, Professor Newton.

Professor Newton: Several points arise from the question. I will take the last point first. Certainly, it is my opinion that the Executive is unlikely to be able to fulfil the promise to deliver on the check-ups. Based on the information that we received from respondents, the current incentives would not be sufficient for people to return to the NHS or for them to continue working in it. On a more positive note, people identified some incentives that they felt might work. However, those incentives tended to relate more to the infrastructure of their practices.

Mike Rumbles: The point that I have been making for some substantial time is that, if dentists have left the NHS, they need to be brought back. The incentives that the Executive has produced have not brought them back as yet. Your report implies that, if the Executive is going to bring them back, it will have to be more radical in its approach. If we are to solve the dental crisis in Scotland, we will have to deal with both long-term and short-term issues. Surely, in this instance, we are talking about a short-term issue; long-term issues include such matters as the training of more dentists. Do you agree that to get more dentists back into the NHS we have to address the issues that they have raised? For instance, you

say in the paragraph before the one that I just quoted:

"The most frequently endorsed incentive was a significant increase in the fee per item of treatment (55% primary care dentists)."

Am I correct to say that that has not been addressed so far?

14:30

Professor Newton: I confirm that that was the most frequently endorsed incentive. The question whether it has been addressed is completely unrelated to our research.

Mike Rumbles: But you discovered in the response from the dentists that that is what most of them think.

Professor Newton: There are two sets of data. We asked specifically about the incentives that would encourage people to commit more to the NHS. That is the source of the incentives data. We also collected more qualitative data about what people said would drive them back, based on a range of comments. Those comments cannot be said to be entirely representative of the population of Scotland, because we did not go about collecting the data systematically.

Mike Rumbles: I have one more question, which is on your presentation of the data. You focused on the health boards and in your bibliography you list all the material relating to health boards. I notice from the bibliography that you did not access any of the information gained through parliamentary questions about access to dentists. In your table—I refer to the report that I was given last Thursday—you point out that, in Grampian, which is the area that I come from, the number of dentists per 10,000 people is 7.48. You also point out that the number of dentists working in the NHS is almost half that figure, which is the second lowest in Scotland.

We have information from a parliamentary question about local authorities throughout Scotland. I refer to information about Aberdeenshire, because it is my area, but it applies elsewhere in Scotland. The interesting thing is that Aberdeenshire, which is part of Grampian, has by far the lowest number of dentists per head of population of anywhere in Scotland. However, that does not come across in the way that you have produced the statistical tables. For instance, the parliamentary answer that I received stated that in Aberdeenshire the number of dentists per 100,000 people is 24.2, which is the lowest in Scotland. It might have been helpful if, rather than focusing just on health board areas, you had cut the data down further. The point that I am making is that, if we take Grampian as an example, the fact that the rural areas have the worst figures in Scotland does not come across, because the large city of Aberdeen has two to three times as many dentists as the rural hinterland does.

Professor Newton: A number of issues, including availability of data, meant that we had to operate at health board level. There was also an ethical issue—once we got down to too fine detail, it became possible to identify practitioners, which we wanted to avoid. There is certainly variation between health boards.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): I have a couple of questions on the report and your conclusions. First, is it fair to say that the report concludes that the closer people are to dentists, the poorer their dental health? I am thinking of deprived communities. For Argyll and Clyde, you refer to the level of services available, the number of dentists available and the number of dentists available at weekends and so on. That is commendable, but what comes through in the report is that dental health is not just down to the number of dentists. That is my opinion; I will let you come back on it.

Will you explain your statement that

"there may be a degree of non-response bias in the findings"?

That is a serious flaw in terms of how dentistry is taken forward in future.

Page 7 of your report states:

"The availability of professionals complementary to dentistry (PCDs) was not considered."

That is fundamental, because we all recognise that, as in other areas of health service delivery, team work is essential. The report states that the people working around a dentist can increase output productivity by 40 per cent. To exclude those people, then come to conclusions is a major omission in a report such as this. I seek your response to that.

On recruitment and training, Mike Rumbles mentioned the focus on leavers. According to information that we received recently from the Scottish Parliament information centre, the dental profession blocked the number of dentists in the 1980s or early 1990s and slowed down their recruitment because it felt that there were too many. Is that not the case? We are dealing with that situation now, and it has been exacerbated by the leavers. Dentists bear some responsibility for the crisis.

Will you comment on section 1.5, on page 28, which states:

"Dental service utilisation alone does not necessarily enhance or maintain oral health … oral health enhancing activities might include oral health promotion, water fluoridation, education, legislation (for example, with regard

to smoking) and addressing social, cultural and economic deprivation."

Does that not square with your earlier example of the deprived communities in Argyll and Clyde?

Professor Newton: I will take non-response bias first. We compared the characteristics of people who did and did not reply. It appears that there was a better response rate from some health boards than from others and that, on average, those who replied were earlier in their careers by about three years. Perhaps people at the end of their career had no incentive to respond to the questionnaire.

We need to address professionals complementary to dentistry. However, doing so is difficult with a survey of this type, because of the nature of registers. It is difficult to get information on how many PCDs there are and where they are, particularly for dental nurses. We experienced that problem when we did work in England.

On recruitment and retention, I was involved in the workforce document that NHS Education for Scotland produced. It produced an excellent model of workforce supply and demand. It is a great document, and it addresses many of the Scotland-wide issues that I discussed earlier.

We are based in the department that covers public health, so we always endorse a public health approach. There are massive opportunities, not just for improving oral health, but for joined-up thinking, because if one decreases deprivation or improves job opportunities—which are public health issues—health at all levels will be improved.

Finally, there does seem to be a correlation between dentists and health, but that does not tell us why. It is likely that practitioners respond to need. If they perceive areas as being ones where there is a lot of work to be done, and where they can work within the system and get paid for it, they will go to those areas of high need. There are many possibilities.

The Convener: Thank you. Is there anything in particular that you want to come back on, Duncan? I am conscious that many members are trying to ask their questions.

Mr McNeil: From my point of view, the overall weakness of the document is that it concentrates too much on how many dentists we have. It expects that if we increase the number of dentists, the situation will be improved. It might be our fault and we might have got the report that we asked for, but there is a focus on the responses from dentists, some of whom have derogatory attitudes, such as the one who would rather be on the golf course than return to dentistry. That indicates where we are.

The Convener: In fairness, all research simply throws up more questions. It would be almost impossible to provide a 100 per cent definitive anything. Perhaps what we need to take from the report is that other areas need to be explored and that this is not the Health Committee's treatment of the issue once and for all.

Professor Newton: In some ways, I agree entirely about the dentist to population ratios, but issues such as distances travelled are unlikely to change. If more PCDs are to be provided, they will be based in surgeries. Current guidance says that they should work to the prescription and under the supervision of dental practitioners, so they are likely to be in the same surgeries, so the distance travelled, the availability of appointments and other similar issues might still be applicable.

Mr McNeil: But the people who have the shortest distances to travel have the worst dental health. I am talking about those in Lanarkshire and Glasgow where there are more dentists.

Professor Alison Williams (Guy's, King's and St Thomas' Dental Institute): A challenge for our study was that we did not have data about levels of oral health. We are making certain assumptions because we do not have data, particularly at health board level, about oral health and what patients require. Do they require only emergency care or do they want care to be long term? Those data are definitely missing and ought to be gathered, because we have to put both sides of the equation together. We will not know until we have the information.

The Convener: A couple of specific questions arise out of this part of the discussion. The summary at the beginning of the report indicates a long list of areas where there is a lack of information. You have just referred to one of them. Did the lack of information surprise you or was it expected? Secondly, you have talked about classifying where the non-response comes from. There was a huge variation in non-response from health board to health board. Does not that create difficulties in considering some health board information? Thirdly, Duncan McNeil raised a point about other professionals allied to dentists. Is there not a table of international comparisons that considers areas such as Scandinavia, where the suggestion is that if people moved over to preventive dentistry, other professionals would be involved and the number employed would have to increase significantly to achieve the required results. Am I just misreading that?

Professor Newton: It is not surprising that there were gaps in the data. The dental health services research unit provides a comprehensive picture of dental health in Scotland and it is very good.

The Convener: The gaps do not surprise you. You enumerate the areas where there is a lack of information but you do not find it surprising.

Professor Newton: No.

I do not envisage non-response being a massive problem, although I do not have much to support that. However, more caution should be exercised if a health board is smaller, because that will allow for more variation.

The comparison with other health care systems is useful, but they work on a different basis with different funding and different goals, so one always needs to be cautious about making such comparisons.

14:45

Helen Eadie (Dunfermline East) (Lab): I start by congratulating the team on its detailed and thorough report. No matter how much we all try to pick holes in it, the fact that we have it is good news, as it will allow us to progress from where we are now. One of the difficulties that the committee has had has been in getting a benchmark for ourselves.

Last week, I was at a public meeting that was called by my constituents, and I would say that dental services are the single biggest issue that has affected my constituency in the past six months. I would like the panel to comment on the timescale of the report. I note from the papers that I have read so far that you seem to have been sending out different stages of the questionnaires to people from about July last year. In fact, that was when everything in my area just blew up and we lost our NHS services. Will you amplify on the timescale for the questionnaire a little?

I would also like you to comment on another point. We should bear in mind the fact that if one NHS dentist who covers three or four areas of a constituency goes away, we lose virtually all the provision in an area, as has happened in my area of Fife. Not just one area is affected; a big area is affected.

Will you comment on definitions? On page 22 of the report, you mention preventive and restorative dentistry. I can quite see where you are coming from, because we all understand that education is important, but for the older age group, restorative dentistry is also important. There are all sorts of issues to do with health, but cosmetic issues are also involved. I would like you to amplify that point, too.

Finally, I do not see any reference in your report to measures that the Scottish Executive has taken. When I did some research in my area, I found that four out of the five constituencies—my constituency was the odd one out—had not received major financial contributions towards improving dentistry services.

My final point—I am sorry, that makes two final points—is about the starting salary. I was amazed to learn at the public meeting I attended that the starting salary for a dentist is around £35,000. I was gobsmacked when I heard that from the Fife dental health official who is in charge of dental services in Fife. I would like to know whether the starting salary for a dentist is really as low as that.

Professor Newton: I defer to Elizabeth Bower on the timescale.

Dr Elizabeth Bower (Guy's, King's and St Thomas' Dental Institute): We did three mail-outs of the same questionnaire. We sent questionnaires to everybody the first time round in June of last year. Then, about three weeks later, in July, we sent a second round of the same questionnaire to the non-respondents. About three or four weeks after that, we sent a third round of the same questionnaire to the final set of non-respondents. The whole thing took about two months and a week from start to finish.

Helen Eadie: That was when my situation blew up. It demonstrates that the position when you took the snapshot has now changed. That is not my fault or your fault; it is a fact of life that the dates are the same.

Professor Newton: The point about prevention and restoration is enormously valid. As the population gets older, there will be two types of need: preventive needs at the early stage of people's life and restorative needs for those who are retaining their teeth longer. We will need different types of skills and probably a different type of workforce.

Helen Eadie: The point that I was driving at is that there does not seem to be a definition of what a patient or a consumer of services can expect from the NHS. As science moves forward, so do the possibilities for treatment. For example, there are implants nowadays instead of false teeth. Therefore, the question is the kind of treatment that a patient can legitimately aspire to have from the NHS.

Professor Williams: We need data on health needs. Quantifying those is probably beyond the report's scope, although we could provide our own opinions. We have highlighted specialist services, in particular restorative dentistry, that will become increasingly important. Treatments such as implants or root canal work have become much more important. The challenge for manpower planning is that the type of dentistry that is being delivered has changed radically recently.

Helen Eadie: We have a growing elderly population, so restorative dentistry will become a bigger issue.

Professor Williams: Yes. Personally, I believe that we might have been slow to realise that in dental training.

The Convener: Have all Helen Eadie's points been dealt with?

Helen Eadie: There was the Scottish Executive funding.

Professor Newton: On steps that the Scottish Executive has taken, our report coincided with the publication of the workforce report. I honestly feel that information on funding would be better coming from the Executive, because I would be bound to forget something.

Dentists have a starting salary of £35,000. I think that most dentists who work in the NHS are required to do a vocational training year and so their salary is lower than £35,000 for that year, but then they gain quickly.

Helen Eadie: I am surprised by that. I think that that salary is very low.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): I thank the witnesses very much for the report. I think that it has convinced us that we need a lot more dentists. Dental and oral health is extremely important for people's general health. However, it is clear that we do not have enough dentists at present and probably do not have enough to achieve what the Executive would like to achieve.

The issue that particularly interests me is the situation in deprived areas in Argyll and Clyde, greater Glasgow and Lanarkshire, which have the greatest incidence of caries among five-year-olds. I think that the report also says that the greatest uptake of registration with dental services is in deprived areas. Therefore, there must be other reasons why people in deprived areas need dental care; it is not that they are careless, because if the dental care is available, people will register for it and can be dealt with.

Another interesting but shocking aspect of the report was the dramatic change in the figures when whole-time equivalence was taken into account. They went from around five to around three—I do not have the figures in front of me. The fact that the difference was so vast stunned me. That brought Scotland way down the table, compared with Norway. However, the report has convinced me that—

The Convener: Is there a question?

Dr Turner: Yes. I want the witnesses to confirm that something is true. It was a big report to read and to understand, but I think that it says that if the services are provided, people will register for them and go to their dentist.

Dr Bower: Yes. The report said that.

Professor Newton: May I pick up on your second point? Once we consider whole-time equivalence, the dentist to population ratio goes down. That correction has not been done for the other countries, so it might be erroneous to compare the lower figure with the figures for Europe. It is probably more accurate to take the unadjusted dentist to population ratio and compare that with the figures for Europe.

Dr Turner: I think that you said that there was difficulty in recruiting dental nurses, but only in deprived areas. Am I correct in that or have I misunderstood?

Dr Bower: That was a statistical finding. If we do a number of statistical tests, we will probably find that one becomes significant. We tested every group of dental professionals and that group happened to be significant. Overall, there was no relationship between recruitment and retention and deprivation.

Dr Turner: Was there any indication why there might be recruitment difficulties? Were there any personal comments?

Dr Bower: We received a number of written comments. In appendix 1, we report the qualitative data. As we said, we cannot say that the data are representative, because they were not collected in such a way as to be representative. However, one of the issues on page 114 is the recruitment and retention of dentists in rural areas.

The Convener: May I clarify that dentists were questioned, not dental nurses, so any comments would only be secondary comments from people who might not necessarily know?

Dr Turner: One comment on page 113 of the report, under the heading, "Lack of cost effectiveness of NHS hygienists", states that it was "Too expensive to employ me", and refers to the fee structure. It is something to do with payments, so there might be something to look at in the pay structure.

Professor Newton: That is the perception of the practitioners, not the hygienists.

Dr Turner: Not the hygienists?

The Convener: As I understand it, the questionnaire went only to practitioners, not to any of the allied occupations.

Dr Turner: I am sorry; I misread the report. It states:

"'Too expensive to employ one [hygienist] *at present – fee structure."*

So it was too expensive for the dentist to employ a hygienist, although in the long run it might have been helpful if the practice had employed one.

Mr McNeil: It was not in the researchers' remit to examine the low-pay issues for dental nurses and others. The low pay in that area is an absolute shame.

The Convener: Other issues arise out of the research that we can come back to.

Mrs Milne: I was not aware that I would be attending this meeting, and I did not see the papers until last night, so naturally I have only given the whole thing a fairly cursory look. I am impressed by the amount of work that has been done. It is fascinating reading.

As the convener said, research only opens up more questions, as this research does on issues such as deprivation versus provision, why dental health is poor in deprived areas when there are plenty of dentists, incentives for working in the NHS, part-time working and the increasing number of women dentists. I know that the research did not go into hospital dentistry, but it is probably another factor. For me, the research has opened up many other issues that probably need to be considered.

My only question is a fairly simple one on the administration of the questionnaire. We were told that it went out over the summer months. Could the number of non-respondents tie in with summer vacations, because July and August are traditional holiday months in Scotland? I wonder whether that had a bearing on the number of non-respondents.

Dr Bower: We probably would have got a greater response rate to the first mail-out if it had been done in a different month, but overall the study was conducted over a significantly long period, and it is unlikely that a dentist would have been away for two months. I think that we pestered them so much that in the end they sent in their questionnaires. I do not think that the response rate would have been greater at another time of the year.

Janis Hughes (Glasgow Rutherglen) (Lab): Table 5.7, on page 46, is headed "Dentist to population ratios for other European countries". It refers to Scandinavian countries having

"a history of providing prevention based dental services"

and states that

"Such comparisons should be undertaken with … caution … Countries with large numbers of dental auxiliaries may therefore require fewer dentists to meet the needs of the population."

Does that imply that considering different ways of working could be beneficial?

Jean Turner mentioned dental hygienists being too expensive to employ. However, the report states that having a dental hygienist can increase a dentist's output by 33 per cent. The figures that are used in the later part of the report—the part that Jean Turner mentioned—about the costs, especially if people do not turn up, do not seem to square with the cost effectiveness of a hygienist, who can increase a dentist's output by 33 per cent.

15:00

Professor Newton: I confess that I am not a dentist. As I understand it, because of the way that dentistry works, dental practices are run like small businesses. If I make a business decision to employ a hygienist, there are costs in having a nurse for that hygienist, in having and maintaining a chair and in running the hygienist's appointments. The hygienist will also expect a salary. I would have to balance those costs against the income from the fees for the treatments. Dentists tell us that that balance does not work. They bear all the costs of employing a hygienist but the fees that come in do not meet those costs.

Janis Hughes: You say that the figures do not take the differing use of PCDs among countries into consideration. You also say that countries with a large number of dental auxiliaries require fewer dentists to meet the need. Are we talking about more flexible working and about aiming to be similar to Scandinavian countries?

Professor Newton: I preface my remarks by saying that this is entirely my opinion. I think that the issue is something to do with how dentists are paid. All the money for the work that they do comes in as income to them, so employing somebody could be seen as taking income away from them unless it is really cost effective. If the system takes away many of the costs of employing somebody, so that it works better, dentists can say that employing somebody will increase all their output by a certain amount and so it is a rational decision. At the moment, they consider the matter in terms of the practice being a small business, and employing somebody just not being cost effective for their business.

Janis Hughes: The decision is based purely on costings rather than on the fact that more preventive measures might be beneficial. Is that right?

Professor Newton: I guess that, in the end, they need to balance the books.

Shona Robison (Dundee East) (SNP): I thank the authors for the report, which is a very good piece of work. The response rate perhaps tells its own story about the fact that there is a good motivation out there to do something about the situation. I think that we should look in more detail at some of the figures in the report.

My point follows on from Janis Hughes's point about the comparisons between Scotland and other European countries. I accept that such comparisons come with a health warning, but it is quite striking that the dentist to population ratio in Scotland is half that in Denmark and Norway. I refer also to Duncan McNeil's point. Do you agree that although the issue is partly to do with numbers, it is also partly to do with what dentists do and what they are paid to do? The line that jumps out at me from your section on European comparators on page 46 is:

"These countries have a history of providing prevention based dental services".

Did it emerge from your research that part of the fee-structure problem is also to do with what dentists are paid to do? An answer might be provided by the fact that, although there may be a higher number of dentists per head of population in the most deprived areas, those dentists may not be concentrating on preventive work because of the nature of a fee structure that does not reward that. That might explain why we have not seen an improvement in dental health in some of our more deprived areas, despite the fact that such areas may have more dentists per head of population than more affluent areas have. Has that emerged from your study of what Scandinavian countries have done?

Professor Williams: It is important to appreciate that the way in which Denmark delivers care for schoolchildren is by way of a school-based service. That explains the increase in the number of dentists. It is also worth saying that the dentists are working with a captive audience of patients.

Although I do not know for sure, one could assume that, because that sort of preventive ethos is built in from a young age, the population should have a better level of dental health. I assume that it is likely that the incentive to attend regularly for minimal courses of treatment will also be encouraged throughout adulthood. Another problem is that, in looking at the number of registrations alone, one does not get an idea about what happens after people have registered. We do not know whether they register but do not attend for a course of treatment.

It may be that the situation is like the one that we found in deprived areas where there is a good level of registration but one cannot be sure whether treatment is being delivered. In an ideal world, in order to tackle the problem, one would follow the Scandinavian model. That said, quite a lot of state control is involved in the delivery of that model of care. Part of schoolchildren's routine is to go the dentist. The dentists are on school premises or close to them. Denmark takes a wholly different attitude to the provision of dentistry and quite a big change would have to take place in this country in terms of cost and attitude if we were to follow that model. Although the Danish model is ideal, it is expensive.

Shona Robison: It would be useful to get a little more detail about the Danish experience and the delivery of dentistry through schools. What percentage of the adult populations in Scandinavian countries and in this country undergo preventive dental work? Do you have that information?

Professor Williams: Not at our fingertips. We would have to make further inquiries on the subject. I am sure that the information is available.

Professor Newton: Two different things are involved: one is prevention of disease and the other is the curing of disease. The system of fees per item of treatment is an excellent model for ensuring that disease gets treated because it provides an incentive in that regard. However, in its current form, it provides little incentive to deliver prevention. We need to strike a balance between the two. That said, different health boards need to strike different balances between the two. The two things can be delivered by different people with different skills. The picture is complex.

Shona Robison: Did that come through in the dentists' responses? Did they suggest what kind of fee structure they want to see? Did they say that they want to take on more preventive work but that they would have to be recompensed for it?

Dr Bower: The biggest incentive would be an increase in the fee per item of treatment. If that system were to be retained, I assume that a way of inducing dentists to do prevention work within a structure of fees per item would have to be found.

Shona Robison: Would prevention work be regarded as an item of treatment?

Dr Bower: It might be; I do not know.

Professor Newton: One model that we could look at is medicine. Much of the health promotion and prevention work is done by practice nurses who are employed by general medical practices. Certainly, that is the case in England. The way in which medicine is funded is very different, however. General medical practitioners get a great deal of support to employ the people who do those kinds of functions.

The Convener: Before we close this part of the discussion, I have two small points of clarification. The committee will have a follow-up discussion and you are welcome to stay and listen to it. I hope that it will last only 10 or 15 minutes. The first of my two points concerns table 5.6 on pages 45 and 46 of the report. Two health board sets of statistics are missing. The omission leapt out at me because one of them happens to be Tayside

NHS Board, which covers the area for which I am an elected member. What is that all about?

Professor Newton: We received our copy of the report only today. A quick look through it suggests that some transcription errors crept in from the version that we produced. In the table to which you refer, the entries for Dumfries and Galloway NHS Board and Greater Glasgow NHS Board have gone over two lines, but the numbers have not been spaced to allow for that.

The Convener: I see; we just have to move the figures down.

Professor Newton: The same thing has happened in the table on pages 6 and 7.

The Convener: Is table 1 basically the qualitative overview of the situation in the various categories? It deals with deprivation levels and various categories within availability and accessibility.

Professor Newton: Yes. The values are low, medium and high.

The Convener: Will you confirm that the NHS Scotland work that dentists do can be as little as work for the handful of patients who are left on the NHS list of a dentist who has no intention of ever signing up another NHS patient? Would such a dentist still register as an NHS Scotland dentist?

Professor Newton: Yes.

The Convener: So the table makes no qualitative assessment between those dentists.

Professor Newton: That is correct.

The Convener: I just needed to clarify that. The difficulty is that the information does not accord with some of our personal anecdotal experience, but that clarification probably explains why.

Professor Newton: Those data are available in more detail in the report.

The Convener: Yes, but that is the qualitative overview.

Dr Bower: We also took into account the percentage of dentists' time for which they saw NHS patients. If an NHS dentist saw NHS patients for only 10 per cent of their working time, that would be calculated into the whole-time equivalent.

The Convener: I thank the three witnesses for attending the meeting to present a long and detailed piece of research. We need to remember that when we ask a question, that is the question that is answered. If we think that we should have asked other questions or more detailed questions, that is a matter for us.

I expect us to want to return to some of the issues, but I thank the witnesses on the committee's behalf for the work that they have done. I invite them to stay for the brief discussion that will follow, but if they have to take a flight back down south, they are of course free to go.

We move on to the second part of our discussion of dental health services, which is about what we wish to do now with the research that is available to us. When we last considered our forward work plan, we agreed to consider bidding for parliamentary time to have a chamber debate that was based on the research. Do committee members still wish to proceed in that way?

Mike Rumbles: Very much so. The report is excellent and has given us much food for thought. It will provide the basis for an informative debate in the chamber, which would be a useful exercise. The report was an innovation in committee working. Rather than taking formal evidence, producing a report and proceeding to a debate, we decided to try a different approach, which has worked well. We have a good and detailed report, so I would like us to do what we said that we would do by proceeding to a bid for a debate in the chamber.

Shona Robison: I agree. Such a debate would interest not only members, all of whom have pressures in their constituencies, but the public, for whom the matter is a major priority and who I am sure would want to watch and listen to that debate carefully. We should proceed to bid for a debate. Good information is available and it could be fleshed out in a debate, which would be a useful way to proceed.

Mrs Milne: Given what I have heard this afternoon, I thoroughly agree. Matters have come to light, such as the fact that some deprived areas have a supply of dentists that is reasonable or better than that in more prosperous areas. Many members would never have realised that; I certainly did not think it. To make public such matters in a chamber debate would be informative for everyone.

Dr Turner: I agree with what has been said. The report is excellent. We need to debate it and go into other matters. A debate might point to another follow-up to find out what dentists think and how we can pay them in different ways to keep them in the service.

Mr McNeil: Will we just go on the report? Will we take no other evidence? Do we have an opportunity to take soundings from people who work alongside dentists?

The Convener: The intention is simply to go on the report. The committee has limited capacity to schedule time for evidence and to do so would

affect considerably our ability to debate the issue in the Parliament timeously. We should get a debate on the issue while the data are still relatively recent. The longer we wait, the more the data will be challengeable because they will be out of date. Helen Eadie has already illustrated graphically that that can happen quickly in dental services. I am inclined to say that we should go directly with the research.

Janis Hughes: I seek guidance from the clerks on what the timescale is likely to be.

Simon Watkins (Clerk): The Conveners Group is requesting bids for committee time for its next meeting, although quite often there are more bids than there is time for. The earliest that the debate could be is in March.

The Convener: As the committee agrees that we should have a debate on the issue, I seek authorisation to draw up a suitable motion, in liaison with committee members, so that we can proceed.

Members *indicated agreement*.

The Convener: I thank the researchers for their work.

I will now suspend the meeting briefly to allow members of the public and press to leave.

15:16

Meeting suspended.

15:22

On resuming—

Petitions

Chronic Pain Management (PE374)

Myalgic Encephalomyelitis (PE398)

Multiple Sclerosis (Respite Homes) (PE572)

The Convener: If members will take their seats, we will resume the meeting.

We are joined by Alex Fergusson MSP for the agenda item on petitions. A paper that outlines the current petitions for consideration has been circulated to members. The paper highlights a few concerns about the length of time for which a number of the petitions have been under consideration. Rather than straightforward closure, the paper suggests an alternative approach to the handling of those petitions, which is to invite the Minister for Health and Community Care to attend a future meeting to respond to any outstanding issues. In the past, we have tended to maintain the life of petitions by requesting further information or views from the Executive, sometimes frequently. Of course, that procedure can get information from the Executive, but it is not always particularly helpful and it can lead to an unnecessary lengthening of the time that is taken to deal with petitions, which is not good news for the committee, the petitioners or the Parliament.

The current batch of petitions before the committee consists of petitions that have been under consideration for an extended period. Cover notes have been attached to each petition to outline possible action, on the basis of the action that the committee has taken to date. However, I would like the committee to consider an alternative approach to the petitions.

The petitions on which the committee has achieved its objective—the Executive or non-departmental public body has agreed to undertake work that the committee requested—can, in my view, be closed. They are petition PE374, on chronic pain services; PE398 on myalgic encephalomyelitis and chronic fatigue syndrome; and PE572, on multiple sclerosis respite care. Alex Fergusson is here in respect of one of those petitions, PE398. I give him the chance to say something about not closing that petition.

Alex Fergusson (Galloway and Upper Nithsdale) (Con): If I may, convener, I would like to say something. Frankly, I would be rather disturbed if the committee did agree to close the petition at this point. If I may briefly explain why, I would appreciate that opportunity.

Discussion on the petition has been delayed for many years pending responses from the health boards, prompted by the Executive's request for action following a report produced by the Scottish Executive short-life action group that was established in 2002 following a debate in the Parliament on ME. It has taken more than two years since the initiation of that short-life action group to get to this stage.

The health board responses, which have been the cause of delay in the consideration of the petition by the committee, have only recently been brought together and published. Frankly, I think that they highlight the total inadequacy with which the subject is being treated by the health boards across Scotland. It is a piecemeal and haphazard approach, which is in direct contrast to that south of the border, where £8.6 million has been set aside by the Government to fund a nationwide approach to ME and CFS.

Furthermore, we have come across a fundamental difficulty in the approach of the Executive. I would like to quote briefly from a letter of 26 August 2002, when John McAllion, who previously convened the cross-party group on ME, wrote to Malcolm Chisholm, then the Minister for Health and Community Care, to ask whether a Scottish needs assessment programme would be considered by the short-life action group. The reply states:

"A SNAP report can take anything from 18 months to 2 years to produce. It was our hope that the Short Life Action Group would be able to produce suggestions for improvements more rapidly."

However, that short-life action group was never given any epidemiological remit.

Rather worryingly, two years later, in response to another letter from an individual member of the cross-party group, the Executive stated:

"You will have seen that the process of making pump-priming funding available for autism services which Mr McCabe described in his last letter to you took almost four years before the funding was released, and that was based on very clear recommendations made by a Scottish Needs Assessment Programme, for which there is no equivalent for CFS/ME."

Two years previously, the Executive said that it did not need a SNAP assessment. Two years later, we were told that, because there is not a SNAP assessment, no funding can be ring fenced for ME.

Finally, I point out that there is a significant lack of communication between health boards and patients in that respect, which is very much contrary to the policy document "A New Public Involvement Structure for NHSScotland: Patient Focus and Public Involvement", in which paragraph 13 states:

"it is no longer good enough to simply do things ***to*** people; a modern healthcare service must do things ***with*** the people it serves."

However, according to Greater Glasgow NHS Board, the ME Association, which was the official patients representative on a working group, handed over to the Glasgow ME patients group in 2002. One meeting was held—not with the full group—in 2004, and a suggested further meeting in May 2004 did not take place. I am arguing that patient involvement, as set out in the Scottish Executive's strategy and policy, is not happening in that instance.

I could go on for a long time, as I am sure you are aware, but I will not. Basically, I think that the evidence that we have seen shows that there is a continuing need for a centre of excellence, in whatever shape or form it may take, as requested in the petition, and that the petition's other requests are equally valid. The current approach has done virtually nothing for three years on the issue, and it is doing nothing for the 10,000 to 20,000 acknowledged ME sufferers in Scotland, who are costing the economy greatly and whose plight I believe deserves the fullest attention of the committee and of the Parliament.

Janis Hughes: We have already discussed how we have proceeded with this petition and other similar petitions over the past few years. This petition is slightly different, in that we have been waiting for a long time for the health boards to tell us what they have been doing in response to ME and chronic fatigue syndrome, and we have only recently received that information. One thing that the information shows is that provision for patients suffering from ME or CFS is patchy, to say the least, across the country. Given that that information has only recently been made available, it would be helpful to put the petition with the other petitions on which we said that we would request further information from the minister, depending on the information that we get back from the cross-party group on ME, following its scrutiny of the information from health boards. I suggest that we add the petition to the other petitions that we were going to discuss at a session with the minister.

15:30

The Convener: We have not quite agreed that we are going to do that. However, I ask that we agree simply to close consideration of at least petition PE374, which is on chronic pain management, and petition PE572, which is on multiple sclerosis respite care. We have an issue with petition PE398, which is on ME and chronic fatigue syndrome, and that petition is clearly a different matter. No member has any objection to consideration of petitions PE374 and PE572 being closed today.

We have had representations from Alex Fergusson and Janis Hughes not to close consideration of petition PE398 today. Do members agree with them?

Members *indicated agreement*.

The Convener: Petition PE398 now joins the group of petitions that we must consider how to proceed with.

Shona Robison: I want to ask Alex Fergusson about what he said about the postcode lottery with respect to the different responses of health boards. Perhaps he could say something about Tayside NHS Board's response, which is rather disappointing. It seems to say that no action is intended, particularly on inclusion in the health plan, which really means that nothing will happen. Is that a typical or atypical health board response?

Alex Fergusson: I am glad that you used the phrase "postcode lottery"—I meant to use it when I spoke, but forgot. I should also have explained at the beginning that I am here to represent the cross-party group on ME rather than as an individual or to represent my party.

The response that you mention is not typical. I used the words "piecemeal" and "haphazard" to describe the responses; they vary. Quite a lot of action is being taken in Dumfries and Galloway, Fife and Lothian but, to be frank, nothing is being done in Dundee, Orkney and Shetland. Health boards will make their responses to the Scottish Executive sound as good and as proactive as they can—I do not mean that unkindly—so the response from Dundee was worrying, to say the least. That is what the chief medical officer said when he presented the report to the cross-party group around a month ago. It is probably not too strong to say that he intended to rap a few knuckles over the response. There is a range of responses, from Dundee at one end to probably Fife, Lothian and Dumfries and Galloway at the other, with everything in between.

Helen Eadie: Convener, will you clarify for the *Official Report* that, although we are closing consideration of the petitions today, we are doing so not in a spirit of unwillingness to take issues forward but because of limitations on the committee's time? Members of the public will read reports of the business that we are conducting and might not understand why we have closed consideration of petitions. Committee members understand that we have done the maximum that we can do within the constraints that we face and I hope that the clerk will make clear when he writes to the petitioners the reasons why the petitions have been closed. I support what Janis Hughes, Shona Robison and other members have said about a winding-up session with ministers on petitions that we have agreed to progress further. There are certainly a number of serious issues that all of us would like to do even more work on, but there is a limit to what we can do.

The Convener: We are agreeing to close some petitions today and to move towards the closure of the remainder because the committee has exhausted its ability to progress the issues. There would be no great point in keeping the petitions open, because in the short or medium term we will not be able to address the issues that they raise and close the gap between what we are trying to find out and what we have found out. That does not preclude our addressing issues in future that are related to matters that are raised in the petitions. From time to time, when our workload permits, we will decide to proceed with inquiries, such as our inquiry into eating disorders services. The fact that petitions are closing does not mean that the committee will never again consider the issues that they raise.

We have decided to close two petitions and we have decided not to close PE398. We must consider how we will deal with the group of petitions that PE398 now joins.

Alex Fergusson: Have the responses from the health boards in relation to PE398 been circulated to members of the committee?

The Convener: Yes. Everything that comes in is circulated to members, so that they know exactly what is happening.

Epilepsy Service Provision (PE247)

Autistic Spectrum Disorder (PE452)

Psychiatric Services (PE538)

Autism (Treatment) (PE577)

Heavy Metal Poisoning (PE474)

Aphasia (PE475)

The Convener: A number of petitions remain open for consideration, in addition to PE398, on ME and chronic fatigue syndrome, which we have just discussed. Normally we would examine each petition in turn and decide on a course of action. I suggest that instead of taking that approach, we invite the Minister for Health and Community Care to attend a committee meeting on a specified day, probably in April or May, between stages 1 and 2 of our consideration of the Smoking, Health and Social Care (Scotland) Bill, so that we can address some of the outstanding issues in respect of the petitions. I suggest that it would be the intention of the committee to close the petitions at the end of the session with the minister, on the basis that by that stage everything will have been done to

exhaust what the committee can do about the petitions. Does the committee agree to proceed on that basis?

Members *indicated agreement*.

Post-mortem Examinations (PE406)

The Convener: I should also note that a new petition, PE406, has been referred to the committee. The petition is about post-mortem examinations, which is a matter that is likely to be covered in a forthcoming Executive bill. Is the committee content to hold the petition until the bill has been introduced, which is likely to happen towards the end of the year?

Members *indicated agreement*.

Workforce Planning (Chamber Event)

15:38

The Convener: Item 7 is a brief discussion of the proposed chamber event on workforce planning. The Conveners Group has approved in principle support for the event and the Presiding Officer has given us permission to use the chamber. I invite members' views about proposed dates for the event. Two dates have been identified that seem likely to be the most useful: Monday 21 March, which members might consider a little too soon; and Monday 11 April, which is the Monday immediately after the Easter recess. Do members have strong feelings about either date?

Mike Rumbles: Should we go for the later date?

Helen Eadie: We should hold the event on the later date.

The Convener: Is it the general opinion of the committee that 11 April is preferable to 21 March?

Members *indicated agreement*.

The Convener: In that case, we will go ahead and start to make the various logistical arrangements that are required to ensure that the event works.

Each and every member of the committee has been faced in the recent past, or is faced at the moment, with strong campaigns in their constituencies in respect of one aspect or another of the proposals on the way in which the NHS is configured. I ask members to nominate two or three individuals from groups in their areas to participate in the public debate that we are sponsoring, because that will ensure that the widest possible variety of voices is heard. There is a danger that we will simply go to some of the usual suspects, but I do not want to do that. I want to ensure that some of the people who have been most active during the past few years are given an opportunity to be part of the debate. I do not know whether members have strong views about that. I hope that we can all identify some appropriate individuals from our areas to come to the debate.

Mr McNeil: There may be criticism from some people about that. We identified and engaged with people during the inquiry process and our evidence taking, and those people should form the target group that we bring to the final conclusion, rather than MSPs from the committee identifying people from their areas. I do not know how we have arrived at this situation.

The Convener: First, I do not regard the public debate as a conclusion to the work that has gone before. We are using our report as a springboard

for the public debate, but we should remember that we said that we will return to the issues when Professor David Kerr reports. Secondly, I do not want the public debate simply to be a debate between the various institutions that are involved. If we simply go back to the people who gave us evidence, the danger is that we will just replicate what has gone before. I want to give the wider public an opportunity to be directly involved, and given the nature of the geographical areas that are represented by members of the committee I would have thought that we could provide the names of a wide range of people in Scotland who can come forward and be part of the debate.

Mrs Milne: How many people do you envisage being involved?

The Convener: The event will be held in the chamber.

Mrs Milne: Would it be possible to include the people who have just been mentioned as well as the members of the public whom we invite?

The Convener: Of course. We will invite many of what might be termed the usual suspects, but I want to go beyond that. The event is called a public debate, and I would like to try to include some individual members of the public, and not simply members of the various—

Mr McNeil: You have said that already. We are not excluding the people who have been campaigning. I do not know why you are suggesting a different method. What about Jamie Stone and some of the other people who have been dealing with campaigns, such as Maureen Macmillan? To me, the point has not been well argued about why, by giving members the opportunity to select people in their own back yards, we should depart from the practice of the clerks and others identifying people to bring to the committee.

The Convener: I am not asking you to select people. I am asking you to put forward suggestions, because the clerks are not necessarily in a position to know in every area of Scotland who might be most representative of the on-going campaigns. I am keen to ensure that the campaigns that have been proceeding in various areas of Scotland are represented. If there are identifiable gaps in respect of the geographical spread of the committee, that can be dealt with by the clerks individually going to see members from some of the areas that are not represented here, such as the Western Isles or Caithness and Sutherland. That is fair enough, but my suggestion is simply to ensure the widest possible access to the debate.

15:45

Shona Robison: The guiding principle should be that the debate goes as wide as possible. We should build on the contact that we have made with people so far, but we should also take other organisations into account—[*Interruption.*]. Could we have a bit of silence, please? There are some organisations that we did not contact when we were out and about previously, simply because of where we went.

Roseanna Cunningham has a point about those who find themselves slightly outside the groups concerned, but who might have some useful input to give. I think that we should see what the clerks come up with, with members' input, and see where that gets us, without being too prescriptive.

The Convener: A detailed proposal will still have to come before the committee. At this stage, we have an agreement in principle for the use of the chamber and an agreement in principle for the event from the Conveners Group. There will be cost factors to consider, and we still have to agree a final invitation list. A detailed paper on that will be required. I ask members to think beyond the usual suspects. There is a danger of having a repetitive and sterile debate if we do not ensure that the widest possible areas of the public are given access to the debate.

Mr McNeil: Who are the usual suspects?

The Convener: We could go through the various people from whom we have taken evidence on workforce planning.

Mr McNeil: So we are excluding them, then.

The Convener: No, we are not going to exclude them. It is not an either/or situation; it is a them-plus situation. I want to ensure that the plus part of that encompasses the widest spread possible.

Mike Rumbles: Never mind abstinence plus—this is invitations plus. Your suggestion is absolutely right, convener. The wider debate that we aim to hold is possible. I understand what you are saying: the clerks will work up a guest list, and you are inviting members of the committee to contribute to that guest list. I do not think that there is anything wrong with that.

Kate Maclean (Dundee West) (Lab): Such events are better if more than just the usual suspects take part. I am not entirely convinced, however, that people who have been involved in specific campaigns for specific facilities are necessarily the people who will be able to give the most to the debate. When people get involved in campaigns for facilities and services, it is largely due to an emotional attachment to those facilities and services. They will not necessarily know what the workforce reasoning behind some of the decisions or proposals has been. In some areas,

there have not been campaigns over specific facilities. I hope that we will be able to nominate people whom we feel are able to put something into the debate.

The Convener: The point is to have a debate, and a debate means having more than one side to the argument. I want to ensure that the people you are talking about, who might have been arguing from a narrow perspective, are exposed to some of the other issues and arguments that will come out during the debate. That means including both sides. There is often a tendency to downplay some of the arguments. Arguments that stem from emotions still have to be taken on board by everybody. The people who are making those arguments are our voters, and they are customers of the national health service. We need to make it possible for people to express themselves as openly and widely as possible.

Kate Maclean: I do not think that anybody is suggesting that that should not be the case. It is a matter of how much people might have to contribute to the debate.

The Convener: We all have a fair idea about which people from our own areas might be the most capable of contributing to the debate, and about who might find it more difficult. I ask members to give some names, and we will go to them. Not everybody will agree to participate, but I want to ensure that people have the opportunity to be part of the debate. The Kerr review is going around Scotland, and that presumably involves talking to some of those people, too. We must make sure that their views are heard.

Helen Eadie: I am cautious about using my position as a committee member to put myself in a more privileged position than my colleagues from other parts of Fife, for example. In Fife, there are other Labour and Liberal Democrat constituency members as well as Mid Scotland and Fife list members.

My concern is that we ensure that workforce planning is considered across all the health board areas. It would not be difficult for me to nominate three people in my constituency who would say that progress has been made in Fife, but other constituents might feel that they still wanted to fight the fight. Some might say that patient involvement was good. I would be able to choose people in my constituency who could give us both sides of the argument. As committee members, we must be careful that we do not have too privileged a position; there are other members to consider. I take on board the fact that you said that we would just be putting our names into a pot, but I hope that the issue will be considered from the perspective of health care across Scotland.

The Convener: I rely on the common sense of committee members, which I hope would tell them whether they were in any way exploiting their position to choose only from a narrow group of people. I trust that if members identify that some of their colleagues might be more able to contribute names, they will encourage them to do so. Our discussion is in the public domain; we are not having it behind the scenes. All MSPs can read about, understand and find out about what we are proposing. I hope that there will be widespread publicity regarding the public debate.

I repeat that I am keen to ensure that we do not simply go back to the panels of witnesses that we always ask when we take evidence. We are talking about a public debate rather than evidence taking. It is about having an argument, or perhaps a discussion, that will take our report on to the next stage.

Kate Maclean: As part of our inquiry, we went to different parts of Scotland and had meetings with members of the public. When we were putting the report together, we did not take evidence just from the representatives of professional bodies; we took evidence from a wide range of people. I would not want there to be a belief that our report lacked input from people who were not the usual suspects. That was certainly not the case.

The Convener: No, but when we took evidence, we did not want to go down the road of speaking to people who represented individual campaigns in particular areas. There were good reasons for that; it would not have been appropriate to have done that. We could not have spoken to one group and then not spoken to others. The event that we are talking about is of a different kind; it will be a public debate in the chamber. We must think outside the box when it comes to how we should handle the debate, so that it does not simply become a talking heads event.

Kate Maclean: It is about workforce planning.

The Convener: Absolutely; it comes on the back of our report.

Helen Eadie: Will you ensure that there is a geographical spread? Given that there are 15 health boards, we need to ensure that we get appropriate people from all over Scotland.

The Convener: Yes. I repeat that I rely on the common sense of every member of the committee—including me—and of the clerks, so that we do not end up with a biased set of participants in the public debate. I remind everyone that the committee has agreed to hold such an event. We will have detailed discussions about its logistics once a proposal has been drawn up.

Item 8 will be held in private, so we now end the public business.

15:53

Meeting continued in private until 16:05.

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