HEALTH COMMITTEE

Tuesday 7 November 2006

Session 2

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HEALTH COMMITTEE
24th Meeting 2006, 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)
*Mrs Nanette Milne (North East Scotland) (Con)
*Shona Robison (Dundee East) (SNP)
*Euan Robson (Roxburgh and Berwickshire) (LD)
*Dr Jean Turner (Strathkelvin and Bearsden) (Ind)

COMMITTEE SUBSTITUTES

Mr Kenneth Macintosh (Eastwood) (Lab)
Dave Petrie (Highlands and Islands) (Con)
Margaret Smith (Edinburgh West) (LD)

*attended

THE FOLLOWING ALSO ATTENDED:

Bill Butler (Glasgow Anniesland) (Lab)
Ms Rosemary Byrne (South of Scotland) (Sol)

THE FOLLOWING GAVE EVIDENCE:

Mr Andy Kerr (Minister for Health and Community Care)
Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland)

CLERKS TO THE COMMITTEE

Karen O'Hanlon
Simon Watkins

ASSISTANT CLERK

David Simpson

LOCATION

Committee Room 4

Scottish Parliament

Health Committee

Tuesday 7 November 2006

[THE CONVENER *opened the meeting at 14:00*]

Health Board Elections (Scotland) Bill: Stage 1

The Convener (Roseanna Cunningham): I welcome the minister and Bill Butler to the meeting. As is our normal practice, I will bring Bill Butler into the discussion once the members of the committee have had an opportunity to ask questions.

Item 1 on the agenda is our third evidence-taking session on the Health Board Elections (Scotland) Bill. The Scottish Executive has given us a memorandum that recommends against further consideration of the bill. The submission provides the background for today's session.

The minister might want to make an opening statement before we move to questions.

The Minister for Health and Community Care (Mr Andy Kerr): As I have said to Bill Butler previously, I am sympathetic to the bill's concern about the level of public engagement with health boards about the planning and delivery of services. However, I remain of the view that the bill is not the way by which we will resolve that issue.

As we set out in our memorandum, we recognise the crucial importance of public engagement. That has been done in a number of ways and, in my view, we have made substantial improvements in an attempt to address some of the concerns. There are now senior councillors on national health service boards and there is a statutory duty on boards to involve the public. We have set up the independent Scottish health council as well as the community health partnerships, which each have a public partnership forum. Further, we hold the annual reviews of the NHS boards in public. There is a time issue involved. We should let those other measures bed in and allow confidence to build in the public engagement and involvement that they provide. I am pleased to note that many other witnesses to whom the committee has spoken have supported that view.

The bill is therefore unnecessary. It adds nothing to the programme. Indeed, it undermines the current clear and unambiguous lines of accountability from NHS boards to ministers and, through ministers, to the Parliament. I am of the view that local boards with a majority of elected members will inevitably lead to competing mandates at a national and local level and will create conflict that will detract from our core purpose of creating a better health service and improving health in our communities. I think that it would create a degree of uncertainty about who is accountable for what and, in future, health ministers might find it difficult to implement important national policies, which will have been debated in the Scottish Parliament. The bill could lead to the fragmentation of our national health service and undermine the founding fathers' vision of what the national health service should be. Further, it might result in a postcode lottery with regard to the provision of services.

I understand the points that Bill Butler makes about public involvement and I share some of his concerns. I would argue that the steps that we have taken need to be given time to bed in and I am sure that the bill is not an answer to the concerns that have been expressed.

Helen Eadie (Dunfermline East) (Lab): The Scottish Parliament information centre gave us information about the situation in New Zealand and I have conducted a little bit more research in that regard. Have you had any discussions with representatives from New Zealand about how their system is working? SPICe tells us that there is clarity with regard to the objectives that have been set by the New Zealand Government and the district health boards that have been elected. The key issue that is of the utmost concern to you relates to the competing mandates. However, it appears that that issue can be addressed through the way in which the remit and the framework are set. Could you comment on the New Zealand situation, which is quite appealing to those of us who are interested in supporting the bill?

Mr Kerr: I have had no direct discussions about the New Zealand example. I have considered the legislation that was brought in by the New Zealand Government. Kevin Woods has some further detail about that. I have to say that, when one looks at the Crown monitors that have been put in place by the New Zealand Government to—in my view—control the directly elected health boards, I am not sure that that takes us any further, in terms of methodology, towards addressing the concern that Bill Butler raises about public involvement in the process. In New Zealand, it is almost as if they have created elected health boards and then created a system by which central Government can direct those directly elected health boards. By contrast, in Scotland, there are clear and unambiguous lines of responsibility involving the elected Scottish Parliament, the Health Committee and me as the minister responsible—every year, I

write 2,000 letters and my department answers 1,500 parliamentary questions.

Dr Kevin Woods (Scottish Executive Health Department and NHS Scotland): The key legislation in New Zealand is the Public Health and Disability Act 2000, which makes clear that the mandate that is to be given primacy is that of the national Government. The legislation includes a range of provisions to ensure that local health boards follow the direction that the national Government wants the health service in New Zealand to go in. For example, it specifies strategic plans and annual plans, all of which require a formal sign-off by the Minister of Health. There are also considerable powers in the act to enable the New Zealand Government to intervene if the performance of boards is deemed to be unsatisfactory in some way. Indeed, as the minister said, there is a specific power for the minister to appoint Crown monitors, who attend meetings of local health boards and have access to all their information. The act says that the three functions of a Crown monitor are to

"a) observe the decision-making processes, and the decisions of the board:

(b) assist the board in understanding the policies and wishes of the Government so that they can be appropriately reflected in board decisions:

(c) advise the Minister on any matters relating to the DHB, the board, or its performance."

Further, as you would expect, there are powers of direction and powers of removal at the disposal of ministers in that system. That gives you an indication of the potential for intervention by the national Government in district health board matters. The legislation incorporates a raft of control procedures and legislation to ensure that the views of the national Government are carried through.

Helen Eadie: In that case, where do you see problems occurring with regard to what you aspire to achieve and what the communities in Scotland aspire to achieve? The New Zealand system seems to involve clear objectives that would match the national priorities. I am not clear about where the conflict arises between your policy and what is happening in New Zealand.

Mr Kerr: The conflict lies at the heart of what Bill Butler's bill seeks to do. What is the point of having directly elected boards if the Government is simply going to establish processes that will control them? I would argue that the systems that we have currently involving elected leaders from local authorities, the Scottish health council and statutory duties to engage are much more effective and will deliver a greater sense of involvement than some other shift. Given that what is proposed is a bureaucratic arrangement as well as a democratic arrangement, and that it will double the size of boards in the process as well, I do not think that the bill would deliver what it seeks to do.

I go back to the first principle that I outlined. I share the concerns about the desire to involve the public more widely in the work of our boards. Nevertheless, I do not think that the bill is the right way in which to deliver that. The New Zealand example is a good one. On the one hand, the Government gives directly elected boards. On the other, because of the need to have a national health service for cancer, paediatrics, neurosciences services and the waiting times centre in Clydebank—all those big issues that are so important to our performance—we need a degree of central management of our national health service.

Shona Robison (Dundee East) (SNP): In your memorandum, under the heading of "Public Involvement", you refer to

"the Annual Reviews with all NHS Boards."

You state:

"These meetings will take place in public, scrutinise Boards' performance and ensure accountability for local communities."

Can you tell us how many members of the public have attended the annual reviews? Are the public given the opportunity to question the health boards or the minister about their plans and policies?

Mr Kerr: I cannot give you figures off the top of my head. The attendances at annual reviews have been widely variable. I recall that the NHS Tayside meeting was fairly busy although other meetings were not so busy. I will reflect on that and get back to you if we can provide information on that specific point. I am not sure whether we gathered people's names. The meeting in Glasgow a year ago was extremely busy with members of the public. I apologise for not having that information, but I can say that there was a good sprinkling of the local interested population.

There is also involvement of patient groups, who are, in effect, local people. That is now an integral part of the annual review process. Not only did we advertise the annual reviews; a part of the annual review process is put aside specifically for patients, patient groups and carers. That is an effective part of the process.

The Scottish public are not slow in coming forward with matters that they want to raise with either the Health Department or the minister, as I said earlier. Prior to devolution, the Secretary of State for Scotland received 1,500 PQs; we currently receive 2,000 PQs for health alone. There is also a greater involvement of elected members who represent the views of communities. So, there are other ways and

measures that I think are equally effective in involving people in the workings of our national health service.

Dr Woods: Some of the attendances at reviews have been huge and the interest has been such that we have had to televise them to be shown in adjoining lecture theatres.

In all the annual reviews, we now have the benefit of an independent commentary from the Scottish health council on the work that boards are doing to involve the public and patients. Part of the day is set aside to allow the minister to hear directly from patients and members of the public who have been selected by the Scottish health council to come and represent their views, rather than being invited to participate by us or by the health board. We think that that is a very useful way of hearing directly about local concerns. The issues that emerge in those conversations are then shared by the minister in feedback at the annual review meeting itself. There may well be issues relating to individual matters that people have raised, which we follow up with the boards.

Shona Robison: It would be useful if you could get back to us with a bit more information on the annual reviews—for example, how many of the audience members are staff and how many are members of the public? Perhaps you can answer my specific question about whether the public are given an opportunity to question health boards and the minister at the annual reviews.

14:15

Mr Kerr: No, there is no such direct opportunity. However, I am sure that you and other members are aware that, as soon as the reviews are over, I go to where the public are sitting and have conversations that are not on the record. I have thought the idea through but, currently, I think that it would be difficult to do what you suggest. I go along to the annual review with the purpose of reviewing the whole of the workings of the board, from sexual health services and health improvement to acute settings, accident and emergency services and other such issues. I am not saying that I rule out what you suggest for future reviews, but the difficulty is that if we engage the public to that degree, there is the potential for the focus of the review to be moved around in such a way that the review is not a systematic assessment of the workings of the board.

I am not saying that the annual review process is perfect, but it is getting better as we go along. We have learned from the past how to do it better. I do not rule out what you suggest in the future, but I want to ensure that we protect the review's focus. Not everybody is interested in talking about sexual health or children's services. Not everybody wants to talk about best value, service improvement or patient journeys. I want to ensure that we cover all the workings of the board. Nonetheless, I believe that we must always seek to improve patient and public involvement in that process.

Shona Robison: I am not sure how you can claim that the annual reviews ensure the accountability of boards to local communities if those communities cannot question either you or the health boards at these meetings. If, as you claim, the reviews aim to ensure accountability, surely the public should have the right to raise whatever questions they wish to raise.

Mr Kerr: With respect, the Scottish health council brings together 12 to 15 patients, carers and service users. Those might be children with special needs, carers, cancer patients or patients with diabetes. I think that that is a good engagement that takes the temperature of local community views on services. We have also heard from elderly people and elderly people's groups through the work of the Scottish health council. I will be able to demonstrate that in correspondence with you. We have been able to attract those people along for a significantly positive engagement on how they feel about their health service and the direction of health services. I have to say that we have received, on the whole, very positive responses from those engagements.

Those people are selected not by me or by the board but by the Scottish health council, which brings people to us to have those conversations. I think that that is quality time that then feeds through into the annual review process. We have sorted some problems out locally when we have had to, and we have reflected on some of the more systematic issues during the reviews. I hope that those will be resolved by the next time that I visit.

Dr Woods: To paraphrase what someone else said, accountability is a process, not an event. We must remember that health boards hold public meetings every month to set out their plans and policies. They hold those meetings in public and there are rules about notice being given of the meetings. We have been trying to build on that process in a variety of ways. In our community health partnerships, for instance, the work of public partnership forums is extremely important in engaging people in the work of boards. That is all part of a process of developing the kind of dialogue that everybody around the table wants to see.

The Convener: There is slight amusement about this exchange, as I suspect that our constituents have a very different notion of the

definition of accountability. That may be where some of the issues arise.

Dr Jean Turner (Strathkelvin and Bearsden) (Ind): Thank you for your opening statement, minister, which set out why you are not in favour of the bill. I agree that a lot has been done to ensure public involvement and consultation, which must have been done at great cost—I do not know whether you could put a figure on that.

As far as the public are concerned, consultation meetings are something that we go along to in the hope that our views will be taken on board. After the consultation, we like to see the ways in which our views have been taken on board. I think that the general public still do not feel that that has happened. You are engaging with more people, but I do not know whether we are getting anything other than what the health boards want to get across to us. At one of those consultation meetings, a health board member who was on the group of which I was also a member said, "I am glad to have you here. It is so good to be able to get our point across." We all felt that that was exactly the point of the meeting. So much expense is going into trying to get the health boards' point across, and there is conflict between the public and the health boards.

Mr Kerr: I would not dispute much of what you have said, but I am not sure whether there will ever be such a thing as perfect consultation. I strongly believe that we must endeavour to engage more, as we do on our strategies on coronary heart disease, cancer and diabetes, for example. We involve people in the process and therefore deliver a better service, but the system is by no means perfect. However, the question is whether the problem can be solved by having directly elected health boards. The suggestion seems to be that it would be like waving a wand and that, with a majority of elected members on the board, consultation would be perfect, everyone would accept that that was the case and engagement would be all that we want it to be.

I sympathise with the sentiment, but I believe strongly that the proposed solution will not address the concerns. Given the way in which you posed your question and described the situation to me, I am not certain whether it is your view that a directly elected health board would solve the problems. Attitudes might not change and there might still be an issue over whether people can get their points across in that environment. It is a big risk to take with our national health service. The bill is an attempt to address a concern, which I think that we share, through a mechanism that I am not sure will solve the problem.

Dr Turner: I think that having elected people on the board is a risk worth taking. Last week, Helen Tyrrell, from Voluntary Health Scotland, said:

> "the public have great capacity to make sensible, informed decisions about the vast bulk of local health service configuration, change and provision. We do not always credit them with enough of that capability and we must make all possible efforts to foster such participation".—[*Official Report, Health Committee*, 31 October 2006; c 3170.]

At our meeting the previous week, a councillor suggested that he was not sure whether primary care ought to be part of the NHS. There would be a great debate on a health board if more people on it had different opinions. The impression that we get when we sit in on health boards is that there is not an awful lot of discussion. When Dr Cumming gave evidence last week, he described the amount of paperwork that people are given before they go to a meeting. He receives the papers at the same time as those who sit round the table, but he just sits in and observes. They hardly have time to take in all the facts in the papers and often there is very little discussion. I cannot see what there is to lose by having elected members of the public on health boards. Vastly different opinions could be represented, which might be good because, as I have said before, if someone stays in Kinloch Rannoch—

The Convener: Can you please formulate a question to the minister?

Dr Turner: I have to explain why I think that there might be a better discussion if different people are elected. We have different opinions.

The Convener: A question.

Dr Turner: The question is that I still cannot see why it would not be good to have members of the public on the board. If someone lives in Kinloch Rannoch and their services are to be provided in Dundee, they can give their opinions on the transport difficulties, lack of services and so on. Those issues might not be in the head of someone who lives nearer to Dundee. The same is true for Glasgow if someone lives up the west coast. I cannot see where the minister is coming from and why he thinks that elected boards would be so detrimental.

Mr Kerr: To be fair, I think that I said that we must balance the risks. I am not sure whether we will ever get to the holy grail of consultation that Jean Turner has described. I am not sure that we can invite someone from every town, village and hamlet in every part of Scotland to be democratically elected to our health boards and therefore make decisions. We must bear in mind the significant risks of fragmentation and confused mandates. We must consider the possibility of postcode delivery of services. We must also consider the manageable size of a board and how it conducts its business. Those are significant challenges for us.

With due respect, I am not sure that directly elected health boards, which you seek to impose on the service, would solve the problem. Jean Turner and I disagree on the matter. It has not been my experience in the past and I do not think that it would be the experience in the future that such a step would solve the problem. The big risk is that the proposal could fragment the service and destabilise the progress that we are making in Scotland on our national health service. It would also confuse mandates.

Janis Hughes (Glasgow Rutherglen) (Lab): You summed up the situation by saying that there is no such thing as perfect consultation. However, it is not just about consultation. Although it is possible to spend an awful lot of money consulting widely, the problem often lies in how the responses to the consultation are evaluated. There is often no right or wrong answer; often an answer suits some communities but not others. What is your opinion on how directly elected boards could make a difference to the evaluation of the consultation process?

Mr Kerr: To be honest, I am not sure that directly elected boards would make a difference. My concern would be that we end up with sectional interests being represented—the people who speak up for children's services, sexual health services and mental health services, for instance—rather than those who might speak up for big, visible issues relating to some of the bigger decisions about the health service that have been made in recent times. That worries me.

Secondly, I would note the experience in other sectors. For instance, schools have been reconfigured and invested in. Some new schools have been built, while others have closed. Primary school estates are reducing because of the falling population in that age group. I am not sure that what people say about how a directly elected local authority deals with consultation responses on education closures is any different from some of the concerns that folk have about health.

When things go well for a community where there has been change in the health service, the vast majority of folk are silent. They accept the decision and just think, "That's very good, thanks very much." The communities that are less inclined to support a change will make more noise. What does that do? I go back to the point about being sympathetic to the idea that we need to involve people more in services and in moving those services on. My argument is that we have been doing that for four years.

The diabetes plan, the coronary heart disease plan and the cancer plan all involve patients, carers, families and community representatives. The bill offers another way of doing that, but my view is based on the balance of risk in the potential effects of the proposed legislation. It is also a matter of allowing some of the things that we have been doing to bed in more effectively. I think that we can deal with things in a different way.

Janis Hughes: Under the heading "Delivery", your written submission states:

> "This Bill would make no difference whatsoever to the achievement of this principal purpose and would, potentially, distract Boards through the implementation of this Bill's proposals."

Could you elaborate on what you mean by that?

Mr Kerr: That can be exemplified by a number of issues. Could we lose the opportunity to plan services regionally? We are delivering as many services as we can as locally as possible, correctly in my view, but it is also necessary to specialise. On occasions, the location of specialist services and equipment must be determined on a regional basis. If a democratically elected board wants to keep a facility in a certain location, how will that affect the roll-out of national services? That potential effect of the proposed strategy worries me greatly. There are also issues around national services. Delivery could be affected. The priority that we in the centre place on policies that the Parliament has agreed would undoubtedly be put at risk, with people in different parts of the country seeing things differently.

One example might be investing in a magnetic resonance imaging scanner—an MRI scanner—versus investing in a sexual health clinic. How do we measure the importance of those choices for communities? How do we ensure that we have a national service? The national health service is funded by taxpayers equally in every part of Scotland. The effect of the bill might be to vary that service around the country, which would mean things being done in a different way in different areas and the risk of losing some of our sense of an integrated, collaborative health service, with its partnership working. That would be a substantial risk under the bill.

Mr Duncan McNeil (Greenock and Inverclyde) (Lab): You mentioned dual mandates and the vested interests that could almost be said to exist already on health boards, which can cause a lot of concern. The British Medical Association's agenda—the doctors' agenda—is expressed on health boards; the royal colleges have their agenda expressed on health boards; general practitioners express their agenda; consultants express their agenda. I am not yet convinced by the evidence that we have heard about the idea of creating a public, elected voice to balance all those agendas.

Do you accept that there are big problems with vested interests on health boards, as they are

perceived by the public? The employees of boards vote things through, which is a perceived problem. People perceive that the public agenda is not being articulated as effectively as it could be. That is a real problem.

14:30

Mr Kerr: There are lay members of boards and local authority leaders or senior councillors serve on them. Those people do not have what you describe as vested interests, so there is a balance in the structure of boards.

The matter is also about information and how we exchange it. For example, when the Kerr report was in its formative stages, there was engagement with patients about the proposed planned care centres, which would be able to offer 99.9 per cent delivery of services because they would not be interrupted by the need to provide accident and emergency services. The A and E services would be provided separately in so-called hot hospitals, which the Kerr report calls level 3 hospitals. People said that that was a good idea, and similarly they agreed that it would be a good idea to take more diagnostics into the community. During that engagement, people genuinely bought into those strategies.

The problem arises when we try to translate that into communities. As you know, I have many debates with communities throughout Scotland. Often, people buy into the concept but they say, "No, but not our hospital. Can we do it there, please, but not here and now? Can we do it later and do it over there?" Whether we call it a vested interest or not, boards take time to provide information, to consult and to prove that they have consulted through the Scottish health council. One problem is that, by the time we get to discussions with the community, opinions have been too strictly formed and there is an immediate counter-reaction to the proposals. I am not sure that that would change under directly elected boards.

As Duncan McNeil said, the medical bodies are represented on the boards, but there are also lay members and elected members who should act as a counterweight.

Mr McNeil: That is the point I am getting at—I do not know whether there is a counterweight, although, having heard the evidence, I do not know whether Bill Butler's bill would achieve what we want.

To put the matter in another way, only one of the groups that I mentioned does not have a veto. Boards cannot proceed with their plans unless the doctors and the royal colleges tick the box, but they can proceed without the public's consent. As well as a veto, the other groups have a greater say and they are more able to make their argument because they are supported by health board officials and academic studies. It is difficult for lay people to get support to present alternatives on behalf of the communities they represent, so there is an imbalance. I am not convinced that the bill would correct it, but there is an imbalance that acts against the communities that we seek to serve.

Mr Kerr: With due respect, I do not agree that that the lay members of boards are not informed and not tooled up with the arguments. That is an assumption too far.

I believe that, when we explain strategies to communities and small groups of patients and carers, we begin to get a sense of buy-in to what we are trying to achieve. We will never have a perfect situation. There will always be an imbalance between the weight of the community and that of someone who has been working on proposals for service change for 18 months.

My job, at the centre, is to adjudicate. My job is to test the board's ideas to destruction, to make sure that they fit with the community's interests, that lives will not be put at risk, and that the strategy is the right one for the future. It is my job to ensure that there is a balance so that, in exchange for a service change or reconfiguration, there is investment in primary care in the community, and that, for every development in acute care, there is work to improve health and well-being. To me, that is a directly accountable process.

I believe that, with the bill's proposal of an elected majority plus one, we are in danger of turning that clarity into ambiguity. It is my job to be held accountable in the Parliament and elsewhere for any decisions I take on health boards' proposals for service changes. I listen to communities, balance the arguments and make decisions. On many occasions we have changed health boards' proposals, and we will continue to do so.

Mrs Nanette Milne (North East Scotland) (Con): I have to say that I am not sure about the bill, but many interesting points have been raised this afternoon. All of us—including, I know, the minister—have been involved in situations in which whole communities oppose certain health board proposals. Indeed, I was involved in a case that required the Scottish health council to be brought in and the consultation to be repeated. The end result was still opposed by a vast majority of that community.

I am not convinced that the bill is the right way to address this matter, but it is clear that no one has got it right yet. Can you suggest any alternative approaches that we can consider?

Mr Kerr: I am not sure that any community in Scotland willingly undergoes changes to its service. My task is to decide whether such changes bring added benefits to the whole community.

I should point out that the public, local government and parliamentarians bought into the principles of the Kerr report, because they realised that we needed to shift the balance of care; to improve diagnostics; to do much more about health improvement; and to establish, for example, planned elective centres and emergency level 3 centres. However, such an approach requires a tough decision-making process. I am quite often told, "You'll have blood on your hands" if I take a certain decision. Well, after reading information and evidence from health boards that show, for example, that a particular service is unsustainable and that it might well put lives at risk, I know that there will be blood on my hands if I do not take the decision. We face real challenges in this matter, which brings me back to the need for a clear and unambiguous system.

I read all my press cuttings. I know what happens to the decisions I make. I know where the accountability lines are drawn. In response to Nanette Milne, and with all due respect to Bill Butler, I do not know whether his approach resolves any of those issues. Are we saying that the service should no longer be national, that we should get rid of regional strategies, and that everything should be allowed to stagnate? Over the past 10 years, day-case rates have increased markedly, but such an increase could not have happened without a change to the nature of our acute sector. Accident and emergency and trauma medicine have improved massively in the past five years, but there is no way we can retain such skills in every location. Moreover, the role of the Scottish Ambulance Service and paramedics has changed.

Those are the major issues that we face and, sometimes, communities, individuals, families, friends and relatives have not caught up with some of the changes that have been required to deal with them. Our job as parliamentarians and policy makers is to take some of those tough decisions. In my view, the lines of accountability are very clear, because I feel it every day.

The Convener: Can you think of any situation in which a health board backed away from its preferred option because of public pressure during the consultation?

Mr Kerr: Significant changes have been made to services in Glasgow, particularly children's services. In the Borders, due to significant public pressure, investment was made in other services such as the establishment of a dental centre and outreach facilities for elderly care that would not have been provided under the scheme that had been proposed. We can reflect and come back to the committee on that question.

The Convener: It would be a useful exercise.

Mr Kerr: Perhaps another example would be the cancer services in Monklands.

The Convener: The public perception is that although the consultation takes place, the health board gets the result it wanted in the first place. It would be useful to hear of examples when that has not been the case.

Shona Robison: I have a very quick question. Did the 2003 Labour Party manifesto contain a commitment to consult on directly elected health boards? If so, why has that consultation not been carried out? If you agreed at the time to carry out that consultation, what has changed since then?

Mr Kerr: I am not sure whether that question is in order, convener. I thought that I was here as the Executive's Minister for Health and Community Care rather than as a Labour Party member. However, I can clarify that, because Bill Butler produced his bill and carried out a consultation, that manifesto commitment was met.

Shona Robison: That is interesting. I would have thought that a manifesto commitment would be for the Executive to carry out, but the Executive has not carried it out. Perhaps you will answer my second question: when the commitment appeared, were you signed up to it?

Mr Kerr: Of course—we signed up to a consultation.

Shona Robison: Has your view changed since then?

Mr Kerr: My view on a consultation was that we should have one.

Shona Robison: Has your view on the principle changed since 2003?

Mr Kerr: Convener, I again seek your guidance. The manifesto commitment was to consult, which has been done via Bill Butler's bill.

Shona Robison: So you did not have a view about the issue in 2003?

Mr Kerr: My view was that we should support the manifesto, which said that we should consult on the idea.

The Convener: Perhaps that debate could be carried on in a different forum. There might be another way and a better place in which to raise the issue.

Bill Butler has the next question. I know that it is difficult for members who bring members' bills to the committee to have to sit and listen to all the

questions before they get an opportunity to speak. However, the minister is here until 3 o'clock, so you have a bit of time.

Bill Butler (Glasgow Anniesland) (Lab): Thank you, convener. I am grateful for the time that has been allotted and for the minister's appearance. He made a clear statement about the dangers, concerns and issues that he feels arise from the bill that I have put before the Parliament. I am pleased that I have been able, unbeknown to me, to fulfil an Executive pledge by carrying out the consultation on the bill—I take that as a plus.

I have a few questions about accountability. I guess that we will not agree, but I will ask my questions anyway, for the record. Minister, despite the apprehensions that you detailed in your written submission and in your evidence this afternoon, do you accept that, under the bill's stated provisions—those that are actually on paper—NHS boards would remain accountable to ministers and the Scottish Parliament?

Mr Kerr: I do not believe that that is the case. The present unambiguous relationship would change sizeably. As I said, if a board made a decision that was either outwith or against national policy, that would be a difficult issue for the minister. Where would the decisions lie if we had boards with a majority of members who were directly elected to them? That would leave the public confused. If an elected board thought that its allocation under the Arbuthnott formula was not appropriate and decided to run a deficit, it could tell me that and say that it wanted me to sort out the matter. How would I maintain my powers and my position as minister? The public would be confused about who controlled what. I believe genuinely that those issues would arise. Unless we had the New Zealand model, with controlling features in the process, ministers' powers and responsibilities would be undermined.

Bill Butler: I knew that you would not agree with me, but that is a slightly puzzling answer. Are you saying that amending one particular aspect of the National Health Service (Scotland) Act 1978 to make the simple majority of members on boards directly elected would undermine all your other powers? Quite frankly, it would not.

Mr Kerr: I said that the bill would undermine the clear and unambiguous nature of the current relationship.

Bill Butler: But not the powers.

Mr Kerr: I would need to speak to the lawyers and come back to you on the legal point. The powers under the 1978 act have rarely been tested, which is part of the problem that we have.

Dr Woods: I can comment on the powers. The key power is the power of direction, which is in section 2(5) of the 1978 act. It has never been used, so the legal boundaries to the exercise of the power are not entirely known. If the proposed changes took place, it might be necessary to consider carefully whether supplementary measures that were akin to those in the New Zealand legislation were required, if your objective is to ensure the primacy of ministerial accountability.

14:45

Bill Butler: It is not my objective—it is there in the bill. Do you accept that, under the terms of the bill, boards will still be required to deliver national targets, guarantees, strategies, initiatives and policies?

Mr Kerr: I almost feel like saying, "I refer to my previous answer". I accept that what you have stated is the statutory position, but I believe that the bill undermines lines of accountability, public understanding and the clear, unambiguous roles and responsibilities of ministers.

Bill Butler: We have a difference of opinion, which is not surprising.

In page 3 of the Executive's submission, there is talk of

"wilful refusal of a Board (or Boards) to implement nationally agreed policies/programmes",

which

"may permit the 'postcode delivery' of services."

Do you accept that "'postcode delivery' of services" is a very loaded phrase? Surely we are talking about boards responding to local needs—which they do at the moment—within the national guidelines and framework that are laid down by the Parliament and by the minister. If boards did not respond to local needs, they would merely be administrative units.

Mr Kerr: I believe that the bill shrinks ministers' opportunity to ensure that national policy is delivered. I refer, for example, to national policy on cancer, coronary heart disease and mental health. I expect those to be national priorities that are delivered at local bases. As I said earlier, this is a national health service that works on an integrated, partnership basis in Scotland. Anything that gets in the way of that could lead to postcode prescribing.

For example, I strongly believe that if a board decides to buy a new MRI scanner because it wants to do something different and to do better than the target, but it takes the money for it from sexual health, children's health or mental health services, its actions undermine the national service. We set national standards for health because, as I have said, the taxpayer in Shetland

pays the same as the taxpayer in the Borders, Edinburgh or Glasgow. We make certain core commitments to every patient in Scotland on national waiting times, access to services and so on. I strongly believe that there is the potential for the bill to undermine that.

Bill Butler: Surely the core commitments can be met and flexibility left for NHS boards to consider the local needs of very different areas.

Mr Kerr: With due respect, that happens every day in primary care in our health service. Certain primary care targets have been set for health improvement and access to GPs and members of the local health care team, but local boards have a very wide playing field to respond differently to ill health and sexual health issues in different parts of Glasgow, let alone different parts of Scotland. That flexibility exists.

Bill Butler: Surely the bill does not change that.

Mr Kerr: It has the potential to change it. I return to the balance of risk. With due respect, I have not said that the bill will or will not change things; I have said that there is the potential for it to do so and I have asked whether that is a risk worth taking. In my view, it is not.

Bill Butler: That is clear.

I will move on to public involvement. Having followed the previous evidence-taking sessions, you will have been pleased to hear that all those who have given evidence have welcomed—as I do—the reforms of the past few years to encourage greater public participation. In its submission, Voluntary Health Scotland stated:

"While significant progress has been made by local NHS Boards towards integrating PFPI in the development and delivery of local health services, it is the experience of Voluntary Health Scotland that progress could be accelerated by introducing"

directly elected members. Why do you regard patient focus, public involvement and other forms of participation as incompatible with boards' having a directly elected element?

Mr Kerr: In recent times we have introduced a number of measures relating to the way in which we work with patients, patient groups and carers. Those measures should be given the opportunity to bed in and to develop further. The patient focus and involvement in CHPs, for example, is at a very formative stage. Anecdotal evidence and the evidence that I have received in annual reviews indicates that CHPs are settling in extremely well. The bill is not appropriate at this moment in time as it would run the risks that I have described. I would prefer the work that we are doing to play out more fully.

The coronary heart disease strategy and the diabetes strategy show that patients and carers have for years been working together at the heart of policy making to make a difference. The current system could achieve that locally and nationally. We disagree about whether the bill would make a difference to that.

My strong view is that we should focus on patients rather than on elections to boards. I would prefer the patient involvement processes that we have to bed in than to change the system to have directly elected boards, which would upset some of the progress that we are making.

Bill Butler: Is your view based merely on timing? Are you saying that a directly elected element would be complementary in the future or simply that you would not agree with it at any time?

Mr Kerr: I would never say that I would disagree with direct elections at any time in the future. I am saying that, as we crash down waiting times from 18 months to 18 weeks, as we improve survival rates from coronary heart disease, stroke and cancer and as we deliver on our mental health strategy, which is seen as an example throughout the world, and on our health improvement work, we are doing some really good stuff. I am not sure whether throwing the bill into the great balance that we have in our national health service would break that potential apart. I worry about that.

Bill Butler: I agree that we are doing some really good stuff. That is absolutely clear from the figures, some of which you referred to. Given that, are you disappointed that, according to a survey that the Executive commissioned in 2004, 73 per cent of the public feel that they have little or no influence over how the NHS is run? That is a rise in dissatisfaction of 16 percentage points over a survey in 2000.

Mr Kerr: When we make changes in the health service, it is sometimes really challenging for people like me and for communities. I do not know what the surveys say about how the Scottish Parliament, the Executive or local government works and I am not sure how we fit into the picture.

I return to the point that we are doing good stuff. We are trying to do more on patient focus and public involvement and we should allow that to bed in more before the balance of risk is accepted and we decide to have directly elected boards.

Bill Butler: How long should we wait?

Mr Kerr: I say with due respect that I do not know. We will examine how boards, the regular engagements board, the Scottish health council, which is at its formative stage, and the public focus and involvement in CHPs are working. I would prefer to focus on service delivery and engagement with the public than to drop in some

arguably risky legislation. Given that, I cannot suggest a timescale. In due course, we will all have a sense of whether the system is working.

Bill Butler: Are you saying that if an appropriate time arrives, you will not be against the principle behind the bill?

Mr Kerr: At this moment in time, I am against the principle that is behind the bill because it would not be right for our national health service. The case has not been proven and high risks are associated with the bill.

Bill Butler: That is clear. Thank you.

The Executive's submission says that the proposal's costs

"could be significantly higher than those set out in the Financial Memorandum"

and

"could be in the region of £5m."

The financial memorandum gives costs from £1.2 million for a turnout of 30 per cent to £2.4 million for a turnout of 60 per cent. They are based on experience in Stevenage. Mr William Pollock of the Association of Electoral Administrators said last week that

"the cost of an all-postal ballot would be anywhere between £1 and £2 per elector",

although, to be fair, he said that there are

"many other unknowables."—[*Official Report*, *Health Committee*, 31 October 2006; c 3175.]

What is the Executive's rationale for being so adamant that the financial memorandum significantly underplays the cost?

Mr Kerr: We looked at a number of evaluation studies on different locations: Stanley division of Durham County Council; two wards in Telford and Wrekin Borough Council; Walker ward in Newcastle City Council; Hunstanton in Kings Lynn and West Norfolk Borough Council; and East Downham in Kings Lynn and West Norfolk Borough Council. We considered the total number of electors, the turnout and the resulting cost per vote, which was £2.53. We applied the turnout for the Scottish Parliament election and local elections of 2003, which was 49.4 per cent. It resulted in a bill of £4.83 million. The turnout for the Scottish Parliament election in 1999, which was 58 per cent, gave us £5.67 million. We also considered the 72 per cent turnout at the United Kingdom general election in 1997. We sought to consider postal ballots over a wider sweep and the cost per elector. I am happy to share those data with Mr Butler.

Bill Butler: I am grateful for that.

The Convener: That would be useful to the committee.

Bill Butler: We could argue about figures all day, but I do not intend to. Even accepting the £5 million, is that too much to spend, out of a budget of £10-plus billion, to introduce an element of democracy?

Mr Kerr: If I thought that that £5 million would be well spent, it would not be a problem for me.

Bill Butler: Okay, that is clear. I have one last question. If you cannot answer it now I would be grateful if you would forward your response to the committee, and to me, if that is permissible. Will you give the cost of the greater public participation reforms that we have been talking about? Will you outline how much each of those reforms cost in total and per annum, or over the number of years that they have been in train?

Mr Kerr: I do not have that information to hand, but Kevin Woods will be working on it.

Dr Woods: We will try to get you an estimate of it.

Bill Butler: That would be handy.

The Convener: The minister has committed himself to corresponding further with us, so I thank him for his attendance. That was the penultimate evidence session on the bill.

Subordinate Legislation

Curd Cheese (Restriction on Placing on the Market) (Scotland) Regulations 2006 (SSI 2006/512)

Feeding Stuffs (Scotland) Amendment Regulations 2006 (SSI 2006/516)

Plastic Materials and Articles in Contact with Food (Scotland) (No 2) Regulations 2006 (SSI 2006/517)

14:57

The Convener: Item 2 on the agenda is consideration of three instruments that are subject to the negative procedure. The Subordinate Legislation Committee has raised no issues on the instruments, no comments have been received from members and no motions to annul have been lodged. Do members agree that we do not wish to make any recommendation on the instruments?

Euan Robson (Roxburgh and Berwickshire) (LD): Is it permissible at this stage to ask for more information on the Feeding Stuffs (Scotland) Amendment Regulations 2006 (SSI 2006/516)?

The Convener: It would have been useful if you had asked me that before I asked the question on the instruments. The clerks will advise me on the timescales that we have available to us.

We shall proceed with SSI 2006/512 and SSI 2006/517 today and hold off consideration of SSI 2006/516 until next week. According to the clerks, that fits in with the timescale. Does the committee agree that we do not wish to make any recommendation in relation to SSI 2006/512 and SSI 2006/517?

Members *indicated agreement*.

The Convener: In respect of SSI 2006/516, if Euan Robson asks for the information that he needs, we will see what we can do.

Euan Robson: In the light of paragraph 4.3 of the regulatory impact assessment, I would like an assessment of the cost to manufacturers of making the required changes. The RIA suggests that the Commission is undertaking a review of animal feed labelling, so replacement regulations may affect labelling as early as 2009 and a cost will therefore fall on some manufacturers for labelling equipment. The regulatory impact assessment does not quantify costs—it might not be possible to do so, but it would be helpful to know whether they will be a significant or minor burden. It may be that all the labelling machinery will have to be altered and new parts or machines bought, but in 2009 everything will have to be thrown out and started again. That might be an exaggeration, but it could be inferred from the papers.

The Convener: We will try to get that information and we will put the regulations on next week's agenda.

Euan Robson: I apologise for not raising the matter sooner.

The Convener: You have to move fast around here.

Work Programme 2006-07

15:00

The Convener: Agenda item 3 is the committee's work programme for 2006-07. Members have a paper on the work programme, which includes a discussion about the Treatment of Drug Users (Scotland) Bill and a series of recommendations.

We have been joined by Rosemary Byrne, who is the member in charge of the bill. Rosemary has some concerns about the handling of the bill and has written to me and the Presiding Officer on that, so I will invite her to comment later. Before I do, Duncan McNeil will make a proposal, and then we will discuss our work programme in general.

Mr McNeil: The committee will know from our previous discussions that I am keen to have something on the subject of Rosemary Byrne's Treatment of Drug Users (Scotland) Bill in the work programme, but I am obviously committed to accepting the recommendations in the paper because we do not have the time that we would need. We should, however, at the very least have a single meeting on the subject, which would acknowledge some of the work that has been done for the bill and the interest in and around it.

The Convener: Okay. Are there any comments? I ask Rosemary Byrne to hold fire for the moment while I get comments from committee members.

Kate Maclean (Dundee West) (Lab): The third paragraph of the letter that Rosemary Byrne sent to the Presiding Officer says that it would be ultra vires and not lawful if the committee did not consider the bill. Can anyone here advise us on whether that is the case?

The Convener: We have discussed that: it is fair to say that the interpretation in Rosemary's letter is not shared by the current powers that be. As it happens—I say this just for the committee's benefit—Duncan McNeil made his proposal last week before the past 24 hours of lobbying. We did tell those in charge that the proposal had been made and that it was therefore possible that the committee would have a one-off meeting to discuss the subject. A fair interpretation of the advice that we have received is that Duncan McNeil's proposal would fulfil our obligations in relation to the standing orders.

Before we get too involved in this, I want to reiterate that it is those very standing orders that have created the difficulty for the committee in dealing with the bill in that they impose the timetable that makes it impossible for us to deal with the bill within the time that is allotted to us. I intend to bring that situation to the attention of the Procedures Committee—Rosemary Byrne has the right to feel aggrieved. Her bill is quite complex; it is by no means simple and straightforward and my view is that it was unfortunate that she was not given earlier advice that it should have been introduced earlier. I intend to raise with the Procedures Committee the matter of members introducing complicated bills late in a session during the run-up to an election.

The bill was not referred to us until the Thursday before the October recess; in other words, it came to us after we had met on the Tuesday and before a two-week recess. As a result, our first consideration of the bill was not until the final week of October. Various time limits in the standing orders make it almost impossible for the bill to progress even as far as stage 1. I hope that I have answered Kate Maclean's question.

Shona Robison: There are constraints that are not of our making, so Duncan McNeil's suggestion is helpful. I presume that there would be nothing to prevent Rosemary Byrne from taking part in that one-off meeting and that there could be follow-up work—questions to the Executive, for example—so that the meeting was not simply us talking about the bill.

The Convener: I intend to invite Rosemary Byrne to any such meeting, but that would by no means be a substitute for full consideration of the bill. We would have required at least four evidence sessions at stage 1, but we simply cannot manage that.

Helen Eadie: I agree with what colleagues have said. I read the papers for today's meeting and I noted a concern that we always note, which is to do with the period of public consultation. If we were to agree to go ahead, that period would be reduced to eight weeks, which is not acceptable for such an important issue.

I was caught up in a similar debacle with my bill on the abolition of tolls on the Forth and Tay bridges, so I chose to continue my consultation for much longer than is prescribed by Parliament. We should accept Duncan McNeil's proposal and invite Rosemary Byrne to the meeting. The issue in the bill is important for the people of Scotland.

The Convener: I make this point for Rosemary Byrne, because she is not a member of the committee. We allow 12 weeks for taking written evidence at stage 1 of a bill. We have considered a revised timetable that would reduce the consultation period to eight weeks. However, even had we managed to put out the call for evidence on 26 October—that is, on the very first day on which we considered the bill—the work on the bill could not have been completed until the middle of April, by which time Parliament will have been

dissolved. Also, that eight-week consultation period would have included two weeks over Christmas and new year. I would have been loth to agree to that, because we would have been consulting when members of the public would not really be focused on what was happening. Unfortunately, that is the position that we are in.

Dr Turner: The crux of the matter is that a lot of hard work will be lost because it was not made clear to Rosemary Byrne by the powers that be that there might not be enough time, depending on the committee to which the bill was referred. An e-mail that was sent to me hinted that other bills had come in later than Rosemary's but have proceeded. However, I suppose that that will have depended on the committees to which those bills were referred.

It is very unfair that work has been done but the committee does not have time to see it through. It makes us feel bad, because the issue is important.

The Convener: I agree, which is why—assuming that the committee agrees to the recommendation—I intend to pursue the issue with the Procedures Committee.

Dr Turner: If we discuss the bill for just one day, will Rosemary Byrne—providing that she is returned to Parliament—or someone else be able to progress the bill towards stage 1?

The Convener: No. The bill would fall at dissolution and would need to be reintroduced.

Dr Turner: Would the bill fall in any circumstances?

The Convener: Even if we were to complete stage 1, the bill would fall, but we do not have capacity even to do that. It is now too late for the committee to consider the bill as we have dealt with previous members' bills, such as Colin Fox's Abolition of NHS Prescription Charges (Scotland) Bill, which we approved narrowly, and the Breastfeeding etc (Scotland) Bill, which we agreed should be passed. If we were to apply to Rosemary Byrne's bill the same standards that we applied to those bills, her bill simply could not achieve completion within the time that is available.

Although the paper on our work programme obviously contains other items for discussion, I appreciate that Rosemary Byrne's bill is the most important of those. Duncan McNeil has made a serious proposition that relates to paragraph 21, which suggests that the committee undertake a number of one-off hearings on specific subjects. Originally, we had thought of doing some follow-up hearings, in which we could sweep up some of the issues that we have worked on over the past few years that are still hanging around and on which we could still do further work. Basically, Duncan McNeil's proposal is that one of those one-off hearings be on Rosemary Byrne's bill. In that hearing, we might raise a number of specific issues for correspondence in which we could ask questions for further clarification. As I see it, Duncan McNeil's proposal is probably the only way in which the committee can address some of the issues in Rosemary Byrne's bill within the timescales that are available.

Paragraph 22 of the paper lists some issues that were originally in our heads as possible subjects for one-off hearings. All those issues follow on from work that the committee has already done. We need to choose which subjects to follow up.

I think that all committee members who wanted to do so have now spoken, so I offer Rosemary Byrne the opportunity to speak.

Ms Rosemary Byrne (South of Scotland) (Sol): I thank the committee for allowing me the opportunity to contribute to the debate. I appreciate the fact that committee members seem to have quite a bit of sympathy with the aims of the bill but, nevertheless, as Roseanna Cunningham said, I am extremely angry and annoyed that Parliament has not guided members—I know that I am not the only member who has been in this situation—correctly and properly on the timescales for members' bills.

The first point that I want to make is that, by putting in a great deal of work, we met the timescale that we were given, which put a lot of pressure on all the people who were involved. We also consulted within the timescale that we were given. We received a huge number of responses from all sorts of people and organisations, including families who have been affected by drugs, the Scottish Drugs Forum and Professor Neil McKeganey. All those people endorsed the bill and some of them added that the measures in it are very much needed. People in communities throughout Scotland welcomed the bill.

After receiving endorsement across the board in the consultation, the bill has raised many expectations that it would open up a debate at stage 1, during which witnesses would be able to give evidence to Parliament, and that we could move on from there.

I feel that the whole committee structure and democracy of Parliament have now been put in question. One of the jewels in the Parliament's crown is the committee system, which allows members to introduce members' bills. It is a disgrace if we are misled into doing all the consultation and research—which is time and resource intensive—at taxpayers' expense.

15:15

Although I appreciate that the committee is sympathetic to my position, I question its view of the legal situation. I would like the matter to be discussed and re-examined. As Roseanna Cunningham said, I have written to the Presiding Officer. A number of issues must be addressed.

I do not know whether all members have seen the letter that I sent, which shows that standing orders make a clear distinction. Rule 9.5.1 states that the procedure for a bill

"shall be … consideration of the Bill's general principles".

The rules go on to say that the lead committee

"shall consider and report on the general principles of the Bill".

In other words, the committee is directed not simply to report on, but to consider, the general principles of the bill.

I could read out the obligations of the Parliamentary Bureau, but I appreciate that such matters must be taken to the bureau. I question the way in which the committee wishes to proceed and I seek to enter a dialogue with the Presiding Officer, the bureau and the legal team. I realise that the committee has a demanding workload—I am a member of a committee that has a heavy workload, so I know what that is like. However, I ask the committee to re-examine its workload and to consider whether it could fit in a few extra meetings. I do not suggest that lightly; I appreciate that everyone is under pressure.

The Treatment of Drug Users (Scotland) Bill is a significant bill that has raised expectations. More important, consideration of it would open up the debate. Last week, Professor McKeganey's report said that only 4 per cent of people on methadone emerge successfully from the programme. The bill also deals with child protection and family support. Another report has come out today that tells us that substance misuse is a huge factor in abuse of children. I could talk at length on all those points.

It is time for us to consider legislation on the treatment of drug users. The bill seeks to open up the debate and to give us an avenue for such consideration.

I want a number of things to be done. I want to re-examine, with the legal team and the Presiding Officer, the legality of the present situation. I want to discuss the matter with the bureau and to re-examine its recommendation, which is not correct from a legal point of view. In addition, I ask the committee to think about making available more room for consideration of the bill, if that is possible. It is not for me to say whether that will mean extra meetings, but I suggest it as a possible solution. I appreciate Duncan McNeil's offer that the committee hold a one-off hearing on the bill, although at the moment I would obviously prefer the bill to go through stage 1.

The Convener: I reiterate that we are already dealing with two bills. The first is a major Executive bill on which we have yet to publish our stage 1 report and to deal with stage 2. On the second, we have only just come to the end of stage 1 evidence. That means that we are in quite a difficult position. I cannot speak for other committees because I do not know what their legislative workloads are. There may be issues about how the matter has been handled.

When I received Rosemary Byrne's letter, I asked for advice on some of the issues that she raised. I appreciate that there may be further discussions to be had, but my understanding is that the word "consider" is not defined in standing orders, that it has simply been the convention that consideration has been undertaken through the formal stage 1 process and report, and that that is not mandated. That is why we think that what Duncan McNeil has proposed would satisfy the consideration requirement in standing orders. That is the present position.

I appreciate Rosemary Byrne's desire for the bill to be considered fully but, as we have explained, that simply cannot happen before dissolution. In effect, we are being asked to begin work on a bill that we know cannot complete its parliamentary passage. In those circumstances, I must question how we deal with parliamentary time.

I ask Rosemary Byrne to consider that, in the short term, the one-off meeting is a compromise that is, although she would rather not have to make it, nevertheless better than nothing at all.

Kate Maclean: The issue is not just to do with members' time; I am sure that every member of the committee would be quite happy to have extra sessions, as we have done at times over the past three and a half years. Even if we were to complete stage 1, it would be the time for consultation that would be curtailed. As the convener said, our call for written evidence takes 12 weeks, and we would probably need four meetings for the oral evidence that we would want to hear; there just is not the time to conduct that level of consultation and to complete stage 1.

Rosemary Byrne is asking that stage 1 be completed, in the knowledge that all three stages cannot be completed, in order to raise awareness and start the debate. Those would be good things to do, but I would be interested to hear Rosemary outline what she thinks would be an appropriate timetable. I would not want to curtail public involvement and I would not want the people who have e-mailed us about the issue to think that it is because members of the Health Committee are not prepared to put in a few extra sessions that the

bill will not complete its passage. The evidence of the past three and a half years shows that that simply is not the case. We cannot embark on that process because we would not be able to do the bill justice, in terms of consulting the public, and because it would be impossible to get through the three stages of the bill. Nevertheless, if Rosemary can tell us how she feels the bill could be fitted into our timetable before the end of March, I would be interested to hear that.

Helen Eadie: I agree with everything that Kate Maclean said. The added complication is that everyone, including Rosemary Byrne, acknowledges that, even if we did complete stage 1, the bill would certainly fall. The communications that we have received also say that there would be a genuine risk that our consideration of the bill could be misunderstood by the public, and might even prejudice its later consideration. That serious issue needs to be borne in mind.

Every MSP has had a chance to introduce two bills during the past four years. When we introduce an important bill, even at the last gasp—we are in the final months of this session of Parliament—we need to reflect on what we could have done in the previous three years, rather than having left what is clearly an important issue to the last minute. You are right, convener, and Shona Robison is right to say that everyone around the table has gone the extra mile for the committee whenever that has been asked of us. However, even if we did go the extra mile again to complete stage 1, the bill would fall anyway, so I do not see that there would be any benefit in doing that.

Ms Byrne: I repeat that I have worked within the programme and timescale that I was given by the Parliament. I cannot say any more than that I did, with good will, what we were advised to do. I worked with the non-Executive bills unit to ensure that we met the deadlines. I believe that there is therefore a responsibility, on the committee or on the bureau, to explain to me why my bill cannot complete its passage. It would be wrong of me to pre-empt the bill's falling at stage 1. I want the bill to go as far as the Parliament will allow it to go. I do not think that it is within the gift of the committee to say that it will not take the bill to stage 1 or that, if it does take it to stage 1, it will not go any further. I am still working within the timescales that I was given by the Parliament—

The Convener: I will have to cut you off, Rosemary. The fact is that the timescales that are now available to the committee make that impossible. I sympathise with the position in which you find yourself. One of the recommendations is that I should take the matter up with the Procedures Committee. It is a ridiculous position that we are all in; however, the fact is that, at this point, the committee is simply not in a position to take the bill forward. We are talking about a process that simply cannot be achieved. In the circumstances, we are in as difficult a position as you are in.

All that I can say is that you will have the support of some members of the Health Committee in respect of any representations that you might wish to make about the process that has brought us here. With the best will in the world, we cannot create the capacity to process the bill in the time that has been allotted to us. We would, effectively, have had to dump almost all our work from the past couple of weeks in order even to conclude stage 1 procedure. That shows how difficult the situation is for us.

Ms Byrne: The problem for me is that, having followed the rules and done everything correctly, I cannot concede that the bill should not go any further. You will understand my position. I must fight as hard as I can for the bill to be taken further. I acknowledge the difficulties that the committee has with its workload and given timescale, but I cannot sit here and concede that the bill should not go any further. I have worked to the instructions and advice that I was given. We are in a difficult position—I appreciate that—and I think that the matter must be referred to the Presiding Officer and the bureau before any decision is made. That is what I seek. I ask that the committee make no decision until we have taken further advice from the bureau, the Presiding Officer and the legal team. I ask you to bear with me on that.

The Convener: I will not allow the committee not to agree our forward work programme today. That would put us in an impossible position. If subsequent discussions change the work programme, we will put the bill back on the agenda for another discussion; however, I am not sure whether that will happen. In the meantime, we must start to make provision for our forward work programme.

Shona Robison: I do not think that those two things are mutually exclusive. We can agree our forward work programme and also agree that we would like those discussions to take place about the concerns that Rosemary Byrne has raised. I do not want the committee to be left with the blame for not proceeding with the bill, as that would be entirely unfair. It is important that, if blame is to be apportioned for the way in which the situation has arisen, it is directed to the right place. We can agree our forward work programme while also agreeing that discussions should take place with the Procedures Committee about how the situation arose and what the resolution to it is. I do not think that those two things are mutually exclusive.

The Convener: That is a recommendation.

Mr McNeil: We need to be careful that we are not creating a false expectation. The bureau can decide what it wants. The decision that the committee has made is that it cannot consider the bill.

The Convener: I am not agreeing to reserve the position of the committee on the matter; I want us to decide today. That includes deciding on Duncan McNeil's proposal and—because we have not reached recommendations—on my taking the issue up with the Procedures Committee as a matter of principle. The same principle will apply to other members' bills as well, at this stage, depending on the committee to which they are referred.

Shona Robison: To clarify, my suggestion is that, as part of the agreement today, the convener should be given the committee's backing to go to the Procedures Committee to raise our concerns about the way in which the process has been handled, so that we can make our dissatisfaction known. I am merely making the point that I do not want it to appear in any way that the situation is the committee's responsibility or fault, when it clearly is not. Part of the decision-making process should be for us to give the convener our backing to put our view on that to the Procedures Committee. That would not prevent us from agreeing to the other pieces of work that we have to do.

15:30

Helen Eadie: I disagree strongly with Shona Robison on the issue. We have had four years as elected members to introduce what we regard as important proposals. If we then introduce a proposal at the last possible moment—as Rosemary Byrne has done and as Bruce Crawford and I have done—that is our responsibility, not that of other committee members. The Parliament may want to change the general principle in the standing orders, but the fact is that the rules have been made clear to us. With my bill proposal, the advice that I received from the non-Executive bills unit was clear on the timescales. As an elected member, I accepted those timescales but, knowing that the issues that I am pursuing are still important to me and to the people I represent, I will continue to press forward with my proposal. If I am elected again—God and the electors willing—I will continue with that proposal in the next session of Parliament.

I would accept the recommendations—

The Convener: I would like to move on. We have not put the recommendations yet—we will come to them. Rosemary Byrne may make one final point, after which we need to decide what to cover in the one-off sessions, separately from the issues of Rosemary Byrne's bill.

Ms Byrne: I reiterate for Helen Eadie that I followed the rules and the procedures. The reason why I waited to propose the bill was because of the Executive's multiple promises on drug treatment. I have considered the proposals throughout. As members know, I have spoken in debates on the issue over and over. I was compelled to introduce the bill at the stage that I did because the indications are that Executive policy is clearly not working, so we have to do something radical. I was patient and I waited, because promises were made. I followed the procedures and the timescales that were given.

The Convener: Duncan McNeil has proposed that we have a one-off session on the issues that are raised in the bill. Some other possible issues that we might consider in the one-off sessions are listed in paragraph 22 of the paper on the work programme. Is there any strong feeling about the primacy or otherwise of any of those issues? Obviously, we will add to the list Duncan McNeil's proposal on Rosemary Byrne's bill.

Shona Robison: That depends on whether we have three or four one-off sessions.

The Convener: There will be three.

Shona Robison: Is that including the session on the Treatment of Drug Users (Scotland) Bill?

The Convener: There will be three sessions, including the one on the bill. That leaves two spaces.

Shona Robison: Okay. I would like to revisit free personal care. I am also interested in considering prescription charges and the dental strategy, on which there are on-going questions and issues that were to be dealt with by the Executive and which we would like to know about. It is possible that some of the issues could be dealt with differently, perhaps by correspondence.

The Convener: So you suggest that we consider the Executive's review of free personal care when the outcome is published early in the new year.

Shona Robison: Yes.

The Convener: Do other members have specific comments?

Kate Maclean: I would like to consider the smoking ban.

Janis Hughes: I was going to suggest that we consider free personal care and the smoking ban.

Mrs Milne: I suggest that we tackle free personal care and prescription charges.

Dr Turner: I would like to do free personal care, the smoking ban and prescription charges.

The Convener: This is a kind of bidding process. Do we all agree with Duncan McNeil's proposal to have one of the sessions on Rosemary Byrne's bill?

Members: Yes.

Euan Robson: I do not agree.

The Convener: Okay. We will note that Euan Robson dissents.

I suggest that one of the other sessions should be on the Executive's review of free personal care? Is everybody happy with that?

Members *indicated agreement*.

The Convener: We now have to decide whether to consider the smoking ban or prescription charges. Will those in favour of considering the smoking ban please raise their hands? I see six members in favour of that. Will those in favour of considering prescription charges please raise their hands? There are two. Therefore, the third one-off session will be on the smoking ban.

We now move to the recommendations in paragraph 24 of the paper on the work programme, which will have to be amended slightly from what is printed. The first recommendation is that we note the committee's existing commitments. Do members agree to that?

Members *indicated agreement*.

The Convener: The second recommendation is that I write to the Procedures Committee outlining our concern about and dissatisfaction with the existing deadline for the introduction of members' bills, in the light of our experience with the Treatment of Drug Users (Scotland) Bill. Do members agree to that?

Members *indicated agreement*.

The Convener: The third recommendation is that we undertake a one-off hearing on the issues that are raised by the Treatment of Drug Users (Scotland) Bill, on the basis that it will not be possible for the bill to complete its progress in this session of Parliament. Do members agree to that?

Members: Yes.

Euan Robson: I dissent.

The Convener: One member dissents.

Do members agree to undertake two one-off hearings in 2007 on issues on which the committee has already done work, as well as the one that we have just agreed to carry out on the Treatment of Drug Users (Scotland) Bill, and to report to the Parliament thereafter?

Members *indicated agreement*.

The Convener: Do members agree that the other hearings will be on the Executive's review of free personal care and on the impact of the smoking ban?

Members *indicated agreement*.

The Convener: Do members agree to ask the clerks to produce a revised work programme on the basis of the agreements that have been reached and to publish that on the committee's web page?

Members *indicated agreement*.

The Convener: That ends our public business for today.

15:37

Meeting continued in private until 16:11.

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