The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 12 November 2013

Session 4

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HEALTH AND SPORT COMMITTEE
32nd Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab) (Committee Substitute)
Geoff Huggins (Scottish Government)
Alex Neil (Cabinet Secretary for Health and Wellbeing)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 12 November 2013

[The Convener *opened the meeting at 09:30*]

Interests

The Convener (Duncan McNeil): Good morning and welcome to the 32nd meeting in 2013 of the Health and Sport Committee. As usual, I remind those present to switch off mobile phones, BlackBerrys and other wireless devices, as they can interfere with the sound system. Members of the public may have noticed that some members and officials are using iPads and tablet devices instead of hard copies of their papers.

We have a continuing apology from Richard Simpson. Malcolm Chisholm is with us as the Labour Party's substitute.

I give a warm welcome to Colin Keir, who has joined the committee. He has replaced Mark McDonald. The first item on the agenda is to invite Colin to declare any relevant interests, as is usual.

Colin Keir (Edinburgh Western) (SNP): Thank you for your welcome, convener. I have no interests to declare.

The Convener: Thank you.

Ask the Health Secretary

09:31

The Convener: The second item on the agenda is our historic and groundbreaking ask the health secretary session. I warmly welcome the Cabinet Secretary for Health and Wellbeing and Geoff Huggins, who is accompanying him to participate in the session.

The committee asked members of the public what questions we should ask the cabinet secretary and used social media to promote the session. We received 126 questions. You will be relieved, cabinet secretary, that we have agreed that we cannot ask all 126 questions, although we may follow them up—we clearly do not have the time to go through them all.

I will invite members to ask the questions. I ask members to state the questioner's name, where they are from, the organisation, if relevant, and the subject area before they read out the question. Members will have the opportunity to ask their own supplementary questions after the cabinet secretary's initial answers.

In order to get through all 18 questions that have been chosen, I ask for brevity in members' supplementaries and ask the cabinet secretary to be brief in his answers.

I turn to Gil Paterson to ask the first question in this historic session. The honour is yours, Gil.

Smoking

Gil Paterson (Clydebank and Milngavie) (SNP): Thanks very much, convener. It certainly is an honour to ask the first question, and this is an innovation. I understand that the approach is, a bit like the Public Petitions Committee, new to Parliaments.

The convener said that 126 questions were received, and he made it plain that we cannot ask them all. I have been given the first 50 to do. [*Laughter*.] To be serious, the approach is innovative and I hope that it will be very successful. It is new to us and we hope that the public, the Government and the committee get some benefit from it.

The first question is from Dennis Williams in Edinburgh and is about plain packaging. I will split it, as there are actually two distinct questions. He asks whether, as someone whose business will be directly affected by plain packaging, he could be provided with any concrete evidence that the policy will have any impact on youth smoking rates and tobacco consumption as a whole.

The Cabinet Secretary for Health and Wellbeing (Alex Neil): I congratulate the committee on this historic innovation. This is absolutely the kind of thing that the Parliament should be doing from time to time. I am glad to be the first cabinet secretary to participate in such an event and I thank the committee for prior notice of the questions.

In answer to Gil Paterson's question on behalf of Dennis Williams, I can say that the public health research consortium undertook a systematic review of the evidence on plain, standardised tobacco packaging and found that there is strong evidence to support the propositions that standardised packaging

"would reduce the attractiveness and appeal of tobacco products ... increase the noticeability and effectiveness of health warnings and messages, and ... reduce the use of design techniques that may mislead consumers about the harmfulness of tobacco products."

The review also found that standardised packaging was most likely to be effective in preventing the uptake of smoking among young people. That is key to our efforts to reduce the prevalence of smoking across Scotland. Following our analysis of the consultation responses, our view is that the PHRC review provides the authoritative evidence base for the introduction of standardised packaging. A review of a further 17 recent research studies published by the University of Stirling in September this year reaffirmed the main findings of the earlier review.

Gil Paterson: Thank you for that answer. I know that the Government was, at one time, very keen on implementing the measure but there seems to have been some delay in getting to where we are. Can you explain to the committee why there has been a delay and when we are likely to see standardised packaging?

Alex Neil: We have been looking at all the evidence and, as I said, the most recent evidence—the very substantive evidence published by the University of Stirling—was only completed in September this year. We are very much an evidence-led Government so before we introduce any new legislation, we like to be absolutely sure that the evidence is there—as much as it can be—that the legislation will achieve its purpose.

Most attention has been paid to Australia, where the measure has already been introduced. We have been in touch with the Australians, but it is too early to say that the measure has been a success. The anecdotal evidence, however, suggests that it will be, and it appears to be upholding and reaffirming the evidence from the University of Stirling and the PHRC review.

Gil Paterson: Mr Williams asks for some details and, reading between the lines, I think that he is saying that the measure will have an effect on his business and that the effect will be passed on to individuals. What benefit do you anticipate? What impact will the measure have on people's health, particularly that of young people? What impact will it have on budgets? Will it free up any money by seeing fewer people presenting at hospital?

Alex Neil: In general, the evidence is that the fewer people who smoke and the more that we can reduce the incidence of smoking, the better the health outcomes. We have already seen the rapid impact of the legislation on smoking in public places that the Parliament pioneered. That legislation had a strong impact on the incidence of ill health, particularly childhood asthma, from the time when it was introduced. That legislation continues to mean a long-term benefit to the health of the nation.

Any measure that can reduce the incidence of smoking or prevent the uptake of smoking in young people will be beneficial, primarily to the health outcomes of the nation and, more generally, to the economy. Obviously, ill health, particularly preventable ill health, is costly for businesses and individuals because it increases taxes because we have to fund the effects of that ill health. When people are ill, they lose work, productivity goes down and profits are affected. Every aspect of business is adversely affected when people become ill. We also know, irrefutably, that when people smoke, their chances of becoming ill, of hospitalisation and of early death are substantially increased. It is therefore to everyone's benefit if we can reduce the incidence of smoking and prevent its uptake by younger members of our society.

Gil Paterson: Thank you for that. I will go on to the second part of the question.

The Convener: I thought that that was the second part of the question. I remind members and the cabinet secretary of my call for brevity in the questioning.

Gil Paterson: I am sorry about that. Those were my questions; this is the second part of Mr Williams's question. He asks whether the cabinet secretary can convince him that the Government is doing all that it can to combat the illicit trade in tobacco, which is directly harming his business and fuelling a wholly unregulated black economy.

Alex Neil: Along with the United Kingdom Government, we are doing everything that we possibly can to reduce the incidence of illicit trade. Indeed, a report published in March by the UK all-party parliamentary group on smoking and health contained evidence that showed that enforcement agencies do not rely on pack design to test

whether packs are illicit but use a number of other security features found in existing packaging, including coded numbers and anti-counterfeit marks, all of which would be present on standardised packs. Plain packaging would neither increase the illicit tobacco trade nor make things easier for those who engage in it.

Moreover, the National Audit Office's report on tackling tobacco smuggling, which was published in June 2013, showed that good progress is being made on that issue, with the market share for illicit tobacco products falling from 21 to 9 per cent for cigarettes and 61 to 38 per cent for hand-rolling tobacco between 2001 and 2010. We are winning the war against the illicit tobacco trade.

Gil Paterson: I had a supplementary to that, convener, but I will pass for the moment.

The Convener: Other members want to get in on the back of Mr Williams's question, Gil.

Richard Lyle (Central Scotland) (SNP): I confess that I am a smoker. I started when I was 12 and still smoke now. However, I totally agree with this measure and previous measures that have been taken—and, indeed, other smokers to whom I have spoken feel the same—but when will it be introduced? Furthermore, what will be on the pack? Will it just have the name of the cigarette at the top?

Alex Neil: It will also have the coding that I have already mentioned. We intend to introduce the necessary legislation within the next year to 18 months.

The Convener: A year to 18 months?

Alex Neil: Yes. The Cabinet still has to finalise the next set of bills that will come before the Parliament. This particular legislation will be included but the exact timing of its introduction will depend on a range of other matters.

The Convener: Let us press on.

Sport and Wellbeing

The Convener: The next question is from Stephen Morrison of Glasgow, who raises the age-old issue of inactivity continuing to blight the health of the nation. What more can we do or different measures can we take to ensure more participation in sporting activity?

Alex Neil: I totally agree with the question's premise that we need to do much more to get many more people in all age groups much more active. I will mention some of the things that we are doing. For a start, we are developing a new national walking strategy that will build on Government investment in the core path network, as well as specific interventions such as paths for all that support people in walking.

Secondly, a pilot study launched in primary care earlier this year will deliver accurate assessment of, advice on and intervention in physical activity and signpost people to appropriate resources, including community sports hubs.

Thirdly, we are taking forward a new national physical activity implementation plan. Fourthly, we are developing a youth sports strategy to ensure that we deliver the best and most appropriate opportunities for young people to participate in sport. We are also continuing to invest in a number of other initiatives to increase physical activity levels, including an investment of almost £3 million in physical activity projects such as the paths for all and active girls programmes, which are aimed at those furthest away from meeting the recommended physical activity guidelines. That is all over and above national programmes such as the active schools programme, which provides almost 5 million opportunities a year for young people to be active.

The Convener: You will be aware that in its community sport report the committee focused rightly on the tens of thousands of sterling volunteers who run our sports clubs and deliver sporting activity daily, nightly and weekly in our communities. Although we are very proud of those people, we also noted figures that show that volunteering in Scotland lags quite a bit behind that in our European competitors. For example, Finland has a 16.5 per cent participation rate in volunteering, Ireland has 15 per cent and the Netherlands has about 11 per cent—I could go on and on if I had the time. However, information from sportscotland suggests that Scotland lags behind England, Wales and Northern Ireland with regard to the participation of volunteers. What do we need to do to encourage greater participation in volunteering and support volunteers?

09:45

Alex Neil: In addition to all the initiatives—we are certainly not short of initiatives—my colleague Shona Robison has announced a £10 million legacy programme for the Commonwealth games, part of which will address the issue of increasing participation of volunteers, which you rightly highlight. We have to get across the message that physical activity is critical, and not just for its own sake, because the three big killers in Scotland are still cancer, stroke and heart attack and all the evidence shows that even half an hour of walking a day goes a long way towards preventing heart attacks, strokes and even cancers. We are doing everything that we possibly can, but I agree that we need to do more. That is the purpose of the additional £10 million in the legacy fund.

The Convener: That £10 million is very close to the figure for the lottery funding that was

announced in August. Are you talking about the same pocket of funding? That is a re-announcement, is it not?

Alex Neil: Which fund did you mention?

The Convener: The lottery fund—the legacy money.

Alex Neil: Yes. It is the same £10 million.

The Convener: I thought so.

In the sport inquiry, the committee was focused on the number of people available, their skill sets and so on. In 2010-11, 3,000 people took the UK coaching level 1 certificate; 2,654 took it in 2011-12; and 2,800 took it in 2012-13. We are not through the 2013-14 year yet, but the number seems to have dropped off to 554. Similar numbers of people are taking the level 2 certificate. I know that a lot of money is going in, but it is outcomes that matter. What are we doing to test those outcomes seriously to ensure that the money that we are putting in is building our capacity in volunteers in terms of numbers and skills?

Alex Neil: We use the participation rates that you mentioned in your earlier question to monitor progress. Although those rates are low compared to other European countries, I understand that they have been rising in recent years. However, they are nowhere near where they need to be, which is exactly why we are undertaking all these initiatives.

This is not to blame anybody, but it is fair to say that there was a squeeze on local lottery funding until the Olympics, because of the concentration and diversion of funds into that event, which I think possibly had a detrimental impact on local activity and funding. That has worked its way out of the system and the lottery funds have been freed up again because, obviously, the Olympics are well and truly over. I hope that we will see an improvement in the participation rates that you mentioned, in other key measures and in the physical health of the nation.

The Convener: We do not have time to pursue this, but I point out that the number of people taking certificates was higher in 2010, 2011 and 2012, but is dropping off now.

It would seem that the audit of volunteers that we did is beyond its sell-by date, because it was done in 2007 and 2010. We are anxious that when people—we hope—become more interested in the Commonwealth games, we will have the capacity to pick up that enthusiasm and ensure that people take up and continue with sport. That is the point that the committee was making.

Rhoda Grant (Highlands and Islands) (Lab): I welcome the walking strategy. Scottish Natural Heritage has published a map of some of the longer routes in Scotland, such as the west Highland way, but accessing those walks by public transport is an issue. Is it possible to tie that information together and make sure that it is available, so that people can get to the walks by public transport? They can break a walk down and do part of it; they do not have to do the whole route.

Alex Neil: I am certainly happy to take up that issue with Keith Brown, the Minister for Transport and Veterans, to ensure that there is a proper, joined-up approach. Long walks on routes such as the west Highland way are part and parcel of what we are encouraging people to do.

The Convener: Bob Doris has a question on cardiac rehabilitation services.

Bob Doris (Glasgow) (SNP): In fact, I have a supplementary on sport and wellbeing, but I knew that my question was next, so I waited patiently. I have a request to make.

I was fleetingly a substitute member on the Infrastructure and Capital Investment Committee when it took evidence on cycling in Scotland. I know that the Scottish Government, in partnership with local authorities, has put significant amounts of money into cycling. Just yesterday, Glasgow City Council won an award for its progress on cycling. At that meeting of the Infrastructure and Capital Investment Committee, I asked whether the money would be spent on getting people who cycle to cycle more or on getting people who do not cycle to get on a bike and get active. My point was that investment in cycling can lead to an unintentional exacerbation of health inequalities.

I do not expect the cabinet secretary to have the answer to that, but I ask him to work across portfolios to ensure that when that money is spent, part of it is used to get people who do not normally cycle and who are not normally active to get on a bike and do some active travel. Otherwise, beneficial though investment in cycling is, we will end up exacerbating health inequalities.

Alex Neil: The objective is both to get more people cycling and cyclists cycling more. The greater the number of people who cycle, the better that will be for the environment and for people's health, and the less crowded the roads will be. Similarly, cyclists cycling more will have the same benefits.

Cardiac Rehabilitation Services

Bob Doris: The question on cardiac rehabilitation services is from Jeff Holt. I do not know which part of the country Jeff comes from, but it might be quite useful to find out, because he has had a positive experience of cardiac

rehabilitation services after unfortunately suffering a heart attack. Although his experience has been positive, he is concerned that such services might not be widely available to people with heart failure across the country. The support that the national health service provided to Mr Holt in the form of cardiac rehabilitation services meant that he had a positive experience, but he would like more information on how we can ensure that that high-quality approach is rolled out consistently throughout the country.

Alex Neil: We have had quite a lot of success in tackling heart disease. Since 1995, there has been a 60 per cent reduction in premature deaths from coronary heart disease across Scotland. That is a substantial reduction, but we want to go further.

The clinical standards under which we operate govern the issue. That is why I am fairly confident that we have good coronary care services in every part of Scotland. The latest audits show substantial increases in the number of people with heart disease who are getting access to cardiac rehabilitation, which I think is at the core of the question. The figure rose from 45 per cent five years ago to 60 per cent last year. We will continue to push that improvement.

The key cardiac rehabilitation stakeholders met yesterday to explore all the issues around access to cardiac rehabilitation, including access in the community for people with heart failure. Future work will include revised Scottish intercollegiate guidelines network guidelines for cardiac rehabilitation, which are to be delivered next year; modernisation and a new focus on support for service redesign, in order to enhance the services' capacity and quality—NHS Lothian, NHS Tayside and NHS Ayrshire and Arran have already started that process; on-going monitoring of the provision of cardiac rehabilitation; and a new focus on access to exercise support in the community, which ties in with the previous question. We have asked the British Heart Foundation and Chest Heart & Stroke Scotland to develop a project that looks at how we can support an increase in the uptake of exercise classes in the community for people with long-term conditions, including heart failure.

We have had success, but there is still a long way to go. We are introducing further measures to get us into an even better position in future.

Bob Doris: You mentioned that access to cardiac rehabilitation services increased from 45 to 60 per cent, which is, of course, to be welcomed. Do you anticipate that when the new SIGN guidelines that you mentioned feed into the health boards, that figure will increase to 70 or 80 per cent? Do you have a specific target for increasing access to cardiac rehabilitation?

Alex Neil: We do not have a specific target of 70 or 80 per cent. The objective must be to reach 100 per cent eventually, because that will ensure that whoever is affected by heart disease will receive the appropriate rehabilitation. A further step change is how I would describe the way forward.

Bob Doris: You expect to see an increase without having a specific benchmark.

Alex Neil: Absolutely.

Bob Doris: I do not know whether you have the information with you or whether you will have to write to the committee with it, but is there any geographical variation in access to services? Clearly, there must be if the figure is 60 per cent—that does not cover the whole country. I know that in the north of Glasgow, which is the region that I represent, many of my constituents are for a variety of reasons far more at risk of cardiac arrest, for example, than people in other areas. How is NHS Greater Glasgow and Clyde, which might have the greater burden in that regard, performing in relation to access to cardiac rehabilitation services?

Alex Neil: There is wide variation in the Greater Glasgow and Clyde area as well as variation among the 14 territorial boards. Of course, some of that is to do with the incidence of chronic heart disease, which is much higher in areas of poverty and deprivation and areas where more people smoke or have other bad habits. We try to tailor services so they are where they are most needed but I will provide for the committee a detailed breakdown of how the 60 per cent that we have been talking about pans out between boards and, where I can, provide information about the Greater Glasgow and Clyde area.

Bob Doris: Recent research from the University of Edinburgh, which was part-funded by the British Heart Foundation, examined scanning techniques that can identify the build-up of significant fatty plaques and—we hope—predict those who are most likely to suffer a cardiac arrest. As a result of those techniques, preventative measures can be taken, such as the identification of the need for a stent much earlier in the patient journey or prescribing high-dose medication to lower the risk. That research needs to be peer-reviewed and a bit more work has to be done on it, but what pathway would the Scottish Government use to feed some of that positive research from an excellent Scottish university into making such services a reality for my constituents?

Alex Neil: The development that was announced yesterday is exciting but we need to be realistic: it will take five to 10 years to undertake the necessary work to ensure that those measures can become part of mainstream activity in

preventing heart disease. Given the amount of work that still has to be done on that project, I do not want to raise any expectations that those measures are going to be available next year or even the year after.

However, with regard to the introduction of a new treatment technique—this does not apply only to heart disease—there is a fairly well-laid path from proof of concept, which I think is the point that the project announced yesterday has reached, to the point where it can be prescribed for patients or form part of a preventative programme, and the length of that journey can vary according to the complexity of the technique. I have already mentioned the estimated five to 10-year horizon for the University of Edinburgh project that was announced yesterday. Obviously, we would be keen to speed that up if it can be speeded up but, as I have made clear, I do not want to set any unrealistic expectations. Depending on the complexity of the technique, the journey from proof of concept to general prescribing could be two or three years or 10 years. We read day and daily of new ways of tackling all kinds of diseases, particularly cancer, heart disease and dementia, but it can be a number of years before the developments that are reported in the *Daily Express* are available to patients.

Bob Doris: I do not have another question, convener, but simply note the important point that the cabinet secretary is making. When any new developments emerge, the Scottish Government will work in partnership with research institutions to see how they might be brought into mainstream provision in the NHS. If that takes 10 years, so be it, but the important point is that the planning starts now.

10:00

Alex Neil: Absolutely. We want to speed some of these processes along as much as we possibly can.

Actually, our chief scientist office funds some research in this area. It is spending a lot of time on and giving priority to data collection and data mining. Scotland has a huge advantage, given the amount of patient data that we collect, which allows us to take the initiative in a number of areas. For example, on diabetes, which is the area of expertise of Professor Andrew Morris, who is the chief scientist and therefore the Scottish Government's chief scientific health adviser, by using data and the science of informatics, over the past few years we have reduced amputations for diabetics by 40 per cent and the incidence of blindness resulting from diabetes by more than 80 per cent.

Some of the projects are initiated by the Scottish Government, so we have a very close working relationship with all the companies and universities involved.

The Convener: The committee is also dealing with the budget at the moment. Does the chief scientist have more or less money to spend on research this year?

Alex Neil: If you look at the budget—in fact, you have asked that question—

The Convener: I am asking it again.

Alex Neil: Aye. The research and development budget line is slightly down. However, I will make two points. First, we are leveraging in funding, particularly from European programmes, which means that the overall spend is greater. Secondly, a lot of R and D goes on that is not in the R and D line.

The Convener: I think that you have answered my question: less money is being spent on R and D.

Colin Keir has a question that is related to the subject under discussion.

Colin Keir: I have a question from Robin Lattimore MBE, who is from Banchory. Mr Lattimore says that in the past Grampian NHS Board has relied on funding from various external sources, including the Big Lottery Fund, the British Heart Foundation Scotland and the change fund, for its heart failure nursing service. Given that heart disease is a national clinical priority, will you address Mr Lattimore's concern that the board is likely to discontinue the service?

Alex Neil: I emphasise the importance of heart failure nurses in supporting the care of people with acute heart failure. We want to ensure that NHS boards have the full spectrum of heart failure services in place to meet the demands posed by the increasing incidence of heart failure. Ultimately, it is for the boards to ensure that services, including the provision of heart failure nurses, meet the needs of their local population.

NHS Grampian has advised that options to better support the local heart failure nurse service were considered recently as part of a resource allocation process. I understand that a business case for continuing and developing that service has been through NHS Grampian's decision-making and scrutiny process, and a recommendation for approval has been made, which is good news. As part of wider proposals, I am advised that the existing 3.24 whole-time equivalent specialist heart failure nurse posts will continue to be funded on a recurring basis by NHS Grampian; indeed, there will be an increase to 5.25 whole-time equivalent posts. That is good news for Mr Lattimore.

Colin Keir: You mentioned that it is for individual boards to ensure that appropriate services are in place. What about the national picture of provision of acute heart failure services? Is service provision patchy? Is the national picture similar to the position in Grampian?

Alex Neil: Provision of those services is not patchy but will depend on the scale of the problem locally, given variations in the incidence of heart disease. As I said, there is a very high correlation between the incidence of heart disease and the level of poverty and deprivation in an area. Compared with Glasgow, for example, Grampian—particularly the urban areas—does not have high levels of poverty and deprivation, so heart failure resulting from those factors tends to be much lower. Although the population profile differs, improvement in heart failure services is nevertheless required, which is why Grampian is investing in those services.

The territorial boards look at the population profile of their area. Decision making and resource allocation are delegated to them because they allocate resources in accordance with the priorities in their area.

NHS Grampian has Aberdeen city and a huge rural hinterland. The scale of that hinterland means that sometimes more of a particular type of resource—heart failure nurses, for example—might need to be employed simply because of travelling distances and the area's geography as well as its demographics. Glasgow, on the other hand, has a much more concentrated urban population, so it might be able to provide the same level of service as Grampian but with fewer people because it does not have the complexity of a rural hinterland on the scale of Grampian's.

Medical Devices

Rhoda Grant: Elaine Holmes from Newton Mearns asks why it is not mandatory for clinicians to report adverse incidents involving transvaginal mesh implants to the Medicines and Healthcare products Regulatory Agency. On the same issue, Ann Boni from Edinburgh would like to know why a national register has not been implemented in view of the numerous complications that are due to use of transvaginal mesh.

Alex Neil: Convener, I am going to give a reasonably detailed answer on this because it has been the subject of much discussion. As you will know, I have had quite a number of meetings with patients' representatives on the issue, so I want to put some of the important facts on the record.

First, there is currently no mandatory system of reporting adverse incidents for any implants, including transvaginal mesh, within the UK. Adverse incidents relating to medical devices that are reported through the NHS in Scotland are handled by the incident reporting and investigation centre at health facilities Scotland, which is part of NHS National Services Scotland. As the investigating authority for adverse incidents in Scotland, health facilities Scotland uses similar—but not identical—report, assessment and triage processes to the MHRA, which can result in a range of outcomes, from no action to specialist investigation.

HFS also co-ordinates investigation and liaises closely with the MHRA. It notifies the MHRA of every adverse incident that is reported, and of the results of any investigation. HFS is also responsible for passing on reports to each NHS board's equipment co-ordinator or risk manager. That system is voluntary, although clinicians are encouraged to report incidents—as is set out in the General Medical Council's "Good medical practice" guidance for doctors.

Agreement has been reached that the current voluntary registers, supported by the two UK national professional bodies for urogynaecologists and urological surgeons, will be merged into a single national register. Scotland will work with the clinical community to support reporting of all adverse events and clinical outcomes through the new register, when it is set up.

Rhoda Grant: Will that be used as a national register, so that everything will be on the register?

Alex Neil: Yes.

Rhoda Grant: Will that include those who have not had adverse incidents?

Alex Neil: The register will be for adverse incidents; we are investigating very closely the number of adverse incidents. One of the problems is that many of the procedures are done in the private sector, rather than the national health service, which means that there is a different dimension to tracking incidents. Regulation is a reserved matter, but that is not an excuse; it is why we need to work very closely with the MHRA. It is the MHRA, rather than the Scottish Government, that decides on regulations.

Rhoda Grant: Okay. What steps are you taking to ensure that other women are not fitted with the mesh and face similar complications? Are they being advised of the concerns that have been raised? Are they being fully informed before they have treatment?

Alex Neil: The chief medical officer for Scotland has written to all health boards, to all general practitioners and to a range of other people informing them of the scale and nature of the problem and to ensure that any woman who is referred for the procedure is made absolutely aware of the risks.

The Convener: If there are no supplementary questions, I will bring in Malcolm Chisholm.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): Mine are separate questions, but they are on the same subject. The first one is from Kathleen Parrish, although I do not think that it is in the cabinet secretary's power to do what she asks, although the MHRA might be able to do it. When is it expected that mesh devices will be removed from the market in order to avoid further damage? I presume that that is an issue for the MHRA, but what discussions have you had with MHRA about that?

Alex Neil: We have been discussing that with the MHRA for a number of months and have already set up a working group to address the issues that have been raised by women who have been affected by complications arising from mesh surgery. That will include a care pathway for surgeries for complications.

On the precise question, we are encouraging the MHRA to take a robust approach to the matter. There is a lot of disquiet around the issue because unsuccessful procedures have had long-term impacts on the women affected.

We are also working with the women involved—we are consulting them at every stage and are trying to fulfil their requests—for example, the request for a national register. We want to ensure that there is a more robust approach to inspection, regulation, dissemination of information and so on. This issue has clearly caused a lot of heartache, to say the least.

Malcolm Chisholm: I think that you have partly answered my second question, which is from Fiona Mowat in Wishaw. She wants to know how the Scottish Government plans to support mesh victims. Perhaps you could give a bit more detail around what you have said already, and perhaps more about what you mean by "a robust approach", which rather suggests that you are being critical of the MHRA and how it has acted until now. I am not objecting to that, but what might a more robust approach involve?

Alex Neil: Regulation of the procedures, the devices and sale of the devices, especially in the private sector, needs to be toughened up. We have made it clear to women who have been affected by the devices that if rectification is required and there is a clinical need for it, it can and will be supplied by the national health service. The chief medical officer has made it clear to all the health boards that that is what should happen.

Malcolm Chisholm: Okay.

Rare and Long-term Conditions

Aileen McLeod (South Scotland) (SNP): I have a number of questions about the important issue of support for people who have rare diseases and conditions. My question comes from Patricia Osborne from Dundee, on behalf of the Brittle Bone Society. You are probably aware that it is the only charity in the United Kingdom that supports people who have a genetic bone condition called osteogenesis imperfecta, which is characterised by fragile bones that break easily. Ms Osborne's first question is this: over the next 10 years, how will the Scottish Government monitor improvements in the care of children and adults who live every day with rare diseases and conditions?

Alex Neil: An estimated total of more than 6,000 rare diseases that at least one person has or has had in the UK have been identified. We are talking about a very large number of rare diseases. It is probably only in recent years that the need to do something more for people who have rare diseases has come over the horizon and moved nearer the top of the health agenda. That is quite right, because although we focus on diseases that affect many thousands of people—heart disease, stroke, and cancer—people who are affected by rare diseases might suffer as badly or worse than people who have more common ailments.

We are taking a UK-wide approach because there is advantage to working with our colleagues in London, Cardiff and Belfast to develop a UK rare diseases strategy that is aimed at improving services and support for people who live with rare diseases. The UK-wide work delivers on the European Union council recommendation of four years ago that member states should take action on rare diseases by the end of this year, which specifically asked that member states

"Establish and implement plans or strategies for rare diseases"

at the appropriate level

"or explore measures for rare diseases in other public health strategies"

in order to aim to ensure that patients who have rare diseases

"have access to high quality care, including diagnostics, treatments, habilitation for those living with the disease and, if possible, effective orphan drugs."

10:15

You may remember that we have set up a rare disease drugs fund, so the 51 children in Scotland with cystic fibrosis, and the Celtic gene make-up, have benefited by getting access to Kalydeco, which it is estimated will extend their lives by up to

16 and a half years. That is a practical example of what we are doing.

The UK strategy on rare diseases is due to be published this month, and the four countries are each developing an implementation plan. The aim is to publish those on Friday 28 February next year—world rare disease day. Incorporated in the plans will be issues associated with brittle bone disease, for example.

Aileen McLeod: Thank you for that response, and for drawing our attention to when the UK rare diseases strategy will be published. I was going to ask you about that in one of my follow-up questions.

Two other questions that Patricia Osborne has asked are whether there will be adequate transitional services, and how much improvement can be made to current access to complex wheelchairs. Will there be any opportunity to require that to be reviewed through the quality framework?

Alex Neil: As you probably know, the "Wheelchair and seating services modernisation: Action Plan" was launched four years ago. It contained 53 actions relating to service improvement, and formed the basis of our wheelchair and seating services modernisation project.

The wheelchair and seating services delivery group assessed the position in relation to all the actions that are set out in the action plan, and an additional £16 million was invested in wheelchair services in order to achieve improvements in areas including referral pathways, preventative maintenance, planned clinical reviews and improved access to powered wheelchairs. NHS boards and wheelchair service centres determined how to target that funding to achieve maximum improvement, and the wheelchair and seating services quality improvement framework was issued in spring 2012 with the expectation that boards and service centres would oversee continuing improvement based on the agreed set of standards. To support continuous improvement in wheelchair services beyond the life of the modernisation project, an additional £1.7 million of recurring expenditure has been invested via annual allocations to NHS boards.

There are no current plans to review the quality framework and it is for NHS boards to assess the needs of their resident populations and to provide appropriate services. However, it is clear that they are operating to a much better quality level than was the case before 2009.

Aileen McLeod: Thank you.

Finally, what measures are being taken to use patients' input on their experiences to assist in the training, practices and supervision across the full spectrum of NHS healthcare professionals, in relation to multidisciplinary care for those who have rare and long-term conditions?

Alex Neil: That work is done primarily through the person-centred care collaborative. The point of that—not just in relation to this question, but in relation to other ways in which we want to ensure patient involvement—is to ensure that patients and end users are involved in looking at how we will take things forward. I hope that the person who submitted the question, who is from Dundee, I think, is involved in the Tayside group.

The Convener: As members have no supplementary questions on that, we will move on to the next area, starting with a question from Nanette Milne. She has not asked a question yet, so I will allow her to do that, and I will then ask Richard Lyle and Colin Keir to put their questions to the cabinet secretary together, so that we can push on.

Mental Health

Nanette Milne (North East Scotland) (Con): Good morning, cabinet secretary. This question is from Fiona Sinclair from Ayrshire, on behalf of Autism Rights. Should people with learning disabilities or autism be included in the provisions of the mental health acts even when they do not have a mental illness? Do you agree that for them to be included is discriminatory, and do you support the Millan committee's and the McManus report's recommendation that the situation be reviewed?

Alex Neil: Nanette Milne is probably aware that there is a long-standing debate on the subject going way back to Bruce Millan's review of mental health services in Scotland. Malcolm Chisholm, I think, commissioned that excellent review.

Many people on the autistic spectrum have additional learning disabilities including dyslexia, and/or behavioural conditions such as attention deficit disorder, mental illnesses—most commonly depression or anxiety—and psychosis, in some cases. If, for example, learning disability were to be taken out of the Mental Health (Care and Treatment) (Scotland) Act 2003, a similar yet parallel system of protection would need to be set up under separate legislation, which would add another layer of complexity to the current legislation on mental health and adults with incapacity, and to the adult support and protection statutory framework. We think that that would not be helpful.

We do not believe that it is discriminatory for autism to be included in the 2003 act; indeed, I argue that its inclusion is beneficial in respect of provision of services. There is a difference

between coming within the scope of the mental health legislation and the secondary step of meeting the criteria for compulsory measures of care and treatment under the 2003 act. We should continue to make that very clear distinction, but we will keep the need for separate legislation under review, although we have no current plans for that.

More generally, I should mention that Scotland is doing very well on our spend on mental health. If members look at the global average percentage of the health budget that is spent on mental health, they will see that it is 3 per cent. Our figure is three to four times that. That is not just in Scotland as a whole; I think that we spend at least three times the global average percentage of the total health spend on that in almost every health board area. We are therefore doing very well on mental health. Obviously, that includes resources for dealing with autism.

Nanette Milne: As you said, the issue goes back quite a long way. I think that the initial report was produced in 2001 and was followed in 2003 by legislation. At that time, there was a recommendation for an early review. I think that Fiona Sinclair will be disappointed to hear that you do not have current plans for that review. Can you put a timescale on when a review might take place?

Alex Neil: We are not setting our face against a review; we are saying that we have no plans at the moment to change people's status. We are looking at and will look at the case for a review. As I said, I have not set my face against it, but I would need to see justification for it, because it is clear that changing the status would have fairly radical implications for delivery of services and the cost of that delivery, which may not be to the advantage of people with autism or, indeed, of people who suffer from mental health problems. We are not saying no to a review, but at the present time, we are not saying yes, either.

Nanette Milne: Thank you for those answers. I suspect that you might hear a bit more from Autism Rights in the near future.

Alex Neil: I am happy to meet anyone or to ask Michael Matheson, who takes the lead on the matter, to meet people. We are a listening Government, so if people feel strongly about the issue and can persuade us, we will approach matters with an open and fair mind.

The Convener: We have an additional couple of questions on that, from Richard Lyle and Colin Keir.

Richard Lyle: I actually have a question from Autism Rights, so you are getting a question from it earlier than you thought that you would, cabinet secretary. Do you agree that the issues need to be aired in public and that the Scottish Government should have published on its website the responses to its consultation on the mental health strategy?

Alex Neil: We made the information publicly available in the Scottish Government library, but I am happy to ensure that it goes on the website. I do not see why we should not put it on the website; indeed, I did not realise that it was not there until the question came in. Putting the information on the website is not a big issue; it is already in the Scottish Government library.

Richard Lyle: Autism and the other conditions that you mentioned are coming to the fore more and more. Do you agree that autism and those other conditions have been increasing in the past 20 years, or have we just recognised the conditions more in children?

Alex Neil: In the latest statistics, there is a bit of a plateau in the numbers of people who are being diagnosed with autism, but I think that parents, teachers and GPs are much more aware of the possibility of autism than they were 20 or 30 years ago, so the diagnosis rate has substantially increased.

The other key factor is that more and more adults are only now being diagnosed with autism, and I suspect that there are still quite a number of people of adult age who themselves, or whose family and friends, do not realise that they have autism. In my case load as a constituency MSP, I have been dealing with a number of adults who have been finding it difficult to get the services and support that they require because their autism was diagnosed only in adulthood rather than in childhood. I think that we still have a lot to do to provide the necessary level and quality of support and services, not only to young people with autism, but to adults with autism.

Richard Lyle: I know that you have a very open-door policy; indeed, diary pressures notwithstanding, you have been able to see people who have contacted me for help. Will you—as I think you already have done—give an undertaking to meet Autism Rights?

Alex Neil: Depending on diary dates, either I or Michael Matheson will have that meeting. If we want to have it earlier rather than later, it might be better if Mr Matheson were involved. However, we both have an open-door policy. In fact, Michael Matheson has been doing sterling work on autism and had a very successful meeting with the local group in my constituency, Hope for Autism, which covers North Lanarkshire, about improving the quality of services. As I have said, we both have an open-door policy because we want to hear at first hand about where services are not being delivered to the required quality, standard or quantity.

Colin Keir: You might have partly answered this question already, but Margaret McCool of South Lanarkshire has asked whether in the foreseeable future more of the health budget will be put towards mental health issues and whether there will be more publicity on where help can be obtained.

Alex Neil: As I have said, we are actually spending three to four times the average global spend of the total health budget on mental health. Many years ago, mental health services were the NHS's Cinderella service and, to be fair to my predecessors, including Malcolm Chisholm, we have all shared the agenda of ensuring that mental health is given the resources that it needs. Mental health problems, which cover a wide range of different conditions, require the same level of support to meet need as any other health problem.

As for increasing the budget, I will ask Geoff Huggins to provide more detail, as this is his area of expertise. He does a regular round of all the territorial health boards with regard to mental health services and the evidence that he is collecting suggests that services are improving across the whole of Scotland. Sometimes the reconfiguration of services is leading to better ways of doing things and better mental health outcomes; also, because we are not putting people through so many hoops, we are saving money that is being reinvested not only in front-line services overall but in front-line mental health services.

Geoff Huggins (Scottish Government): We visit health boards twice a year—just yesterday, I was in Ayrshire and Arran for our autumn visit—and, given some of the media reporting that we have seen, we have decided to ask boards whether there have been any reductions in mental health spend. The objective behind these meetings, which involve clinicians and managers, is to find out what is going on, and we have found not only in Ayrshire and Arran yesterday but last week in Tayside that people are continuing to work on making efficiencies and to ensure that services are working effectively. A lot of that is often about taking out of the system additional loops that patients have to go round and which they do not really welcome.

However, what has surprised me a wee bit is that boards are identifying additional spend in particular areas. Yesterday, we heard that NHS Ayrshire and Arran has created additional dementia adviser posts to support the post-diagnostic dementia commitment. It is also increasing its child and adolescent mental health services capability to ensure that it meets the 18-week target. It has also done some work with the police on custody suites.

10:30

Similarly, last week there was a discussion with NHS Tayside about the access to psychological therapies target. Tayside is a very good performer generally, but it is perhaps a bit weaker on two of its smaller services. It is identifying new spend for health psychology and neuropsychology, which are the areas where, at the moment, it is not meeting the 18-week target, to ensure that it does so.

In each of those cases we are hearing about another £100,000 here and another £200,000 there, but we are not seeing significant cuts in NHS services elsewhere to cover that; the money is coming out of other general allocations. It has been a heartening round of visits at a time when we might have expected to hear more about belt tightening and things like that.

Colin Keir: This is my first meeting as a member of the Health and Sport Committee—I have come from the Justice Committee.

Alex Neil: You have been promoted, Colin. This is a far better committee.

Colin Keir: One of the issues that came up was how we are dealing with people with mental health issues in the justice system, particularly those on short-term visits to prison, and how the finances are being allocated towards looking after such people who perhaps should not be in prison but would be better dealt with outside?

Alex Neil: I have had recent experience of this at a constituency level. There is an issue around the transition from prison to community when prisoners are discharged, irrespective of how long their sentence is, and the continuation of their psychiatric care. We need to tighten up on that area to make sure that, when a prisoner who is already under psychiatric supervision—I am not referring to secure supervision, just mental health supervision—leaves prison, there is a continuum of care and the transition between prison and the community is better managed. There is a general issue there, which we will address.

Care Visits

The Convener: Kevin Toshney in Dundee asks what the cabinet secretary's views are on 15-minute care calls for older people.

Alex Neil: Fifteen-minute sessions can be the building blocks for an agreed package of care and, in some cases, they may be what the client wants. Clearly, for more complex cases a 15-minute visit would not be sufficient time to provide appropriate support. Packages should be designed and delivered to reflect the client's needs and promote their rights.

By integrating health and social care, pooling resources and introducing a strategic commissioning approach, we are enabling partnerships to take a more holistic view based on the outcomes to be achieved both for individuals and for partnerships.

We currently do not routinely collect information that would allow us to understand the extent to which this type of service has a positive impact on the personal outcomes for service users. We have therefore asked the Association of Directors of Social Work to consider this issue further. If evidence shows that longer visits provide better outcomes, we must work together on what guidance might be needed.

There is also a national review of care standards. I would expect this issue to feature in the evidence to the review and suggestions for any improvement.

The Convener: Do you think that the 15-minute calls are acceptable? We heard evidence of 10-minute visits to prepare and provide someone with their lunch. Is that acceptable?

Alex Neil: It is not acceptable if the purpose of the visit requires substantially more time than that.

The Convener: You mentioned the national care standards, which were identified in the committee's inquiry. We look forward to the review. There is a bit of a delay. We had a commitment that it was coming along. Can procurement or commissioning play a part in addressing this issue?

Alex Neil: Inevitably, that must be the case, and the Association of Directors of Social Work will obviously be looking into that. I had a meeting with the directors two weeks ago, so I know that the allegations surrounding 15-minute care visits are a key area that will be considered in the work that the ADSW is undertaking. I hope that the ADSW will be able to give some facts about the situation, because there is a lot of anecdotal evidence for and against 15-minute visits. We need to get to the bottom of the issue, and the purpose of the ADSW review is to do exactly that.

The Convener: That is particularly interesting, because people might think that all visits must be for only 10 minutes, but we know that not all visits can be done in 10 or 15 minutes, as some will take longer. Has any work been done to require local authorities and providers to provide information so that we can establish to what extent 10-minute or 15-minute visits are being used? Regarding continuity of care, do we know whether people are receiving increasing numbers of different carers going in over a week or month or whatever? Have you commissioned any work to establish the extent of that problem?

Alex Neil: At the moment, that information is not collected centrally. The ADSW review will consider whether we need to monitor the issue more closely and collect information centrally.

The Convener: When do you expect the review to be published?

Alex Neil: Fairly early in 2014.

The Convener: Do members have any other supplementaries on that issue?

Richard Lyle: As you know, cabinet secretary, I was previously a councillor in North Lanarkshire. Do you agree with me that the whole system of care visits is run by councils, so the provision of extra care to people is dependent on each council's adaptation of the system? Even before I came to this place, issues were raised with me about people not getting enough time. We also had a situation in the tower blocks in Motherwell where carers were jumping in and out of—well, not jumping out of but going into—different tower blocks and crossing over, which was totally crazy. We tried to get the council to resolve that. Do you agree that the issue is entirely down to councils?

Alex Neil: Social care is a council-run function. Obviously, under the integration agenda—I am the cabinet secretary with responsibility for social care—I want to ensure that people are receiving the social care, as well as the healthcare, that they need. That is why I have asked the ADSW to undertake that piece of work. I think that we will need to pay more attention to the issue in future. Once we see the outcome of the review of the national care standards and once we have decided the national outcomes that are to be achieved by the integrated health and social care partnerships, we will need to be very clear that those standards must be met. The issue relates to people's needs and should not be dictated by other factors.

Bob Doris: On the issue of the amount of time provided for care visits, I was previously in correspondence with Glasgow City Council and Cordia (Services) LLP regarding how they report and quantify care visits. I cannot quite remember the specifics, but I remember that there was a lack of clarity in the reporting. I make no judgment about Glasgow City Council in relation to that, but it was not clear how much time was spent inside people's homes and how much time was spent travelling to and from people's homes, so there was possibly a double counting of the care provided if travel time was being included in the figures reported. I am not saying that Glasgow City Council did that, but there was a lack of clarity in how things were reported. Some consistency across the country on how such stats are reported would be helpful. I do not think that Glasgow City Council intended to obscure the data, but there

seems to be no consistency in how the time is reported.

Alex Neil: What matters to me as cabinet secretary is not so much how much time people spend with each end user but what the outcomes are and whether people are getting the service that they require. Some services can be delivered in 15 minutes, but some services obviously take a lot longer. If you are making someone's lunch, it will take a lot longer than 15 minutes. If you are getting some people out of bed in the morning, I suspect that it will take a lot longer than 15 minutes. Although it might be important for the purposes of performance monitoring and checking on things to keep a record of how much time is spent with end users, the key issue is the outcomes of the service that they receive. That is key, because you cannot achieve the outcomes if you are not spending enough time with the end user.

Bob Doris: I apologise; I think that there was a lack of clarity in my question. The point that I was trying to make was that if a local authority is reporting 10,000 hours of care in the community in people's homes, irrespective of how many service users there are and how long each visit is, it should ensure that travelling time is not included in the reporting. Also, reporting should be consistent throughout the country, to allow for national monitoring.

Alex Neil: Absolutely. If I was managing a council's resources, I would still want to know what the travelling time was, but that would be for management and resource efficiency reasons. I would want to know precisely how much time was spent with the end user. For other reasons, councils should also monitor how much time is being spent travelling.

Pharmacy Applications

Rhoda Grant: I have a question from Alan Kennedy: the cabinet secretary has agreed that pharmacy applications are adversely affecting patients in rural areas and is carrying out a review of such legislation; will the cabinet secretary direct that the review should include specific legislative change to encourage approval of applications where a community's patients support co-located GP and pharmacy practices, and that such applications must not be overturned by objections from pharmacists operating outwith the neighbourhood of the GP practices concerned?

Alex Neil: I am looking at two things as part of the review. One is the criteria for approving pharmacy applications. As you know, there are currently major concerns about an application in Uist; there are also concerns in rural Stirlingshire and other parts of Scotland. I do not think that the current legislative framework is fit for purpose, so we are reviewing it. I hope to be able to go out to consultation on the issue very soon.

In parallel and as part of the same review, I am looking at the process. I participated recently, in my role as an MSP, in a hearing for an application in my constituency for a local pharmacy. It became very clear to me that the community has no voice in the current application process. In the example from my community, in Airdrie, the application under consideration had active support from the community and had the support of the Labour MP, the Scottish National Party MSP—me—and every Labour and SNP councillor. We do not have Tory or Liberal Democrat councillors in Airdrie. When we went to the hearing, the large chemists were there and spoke throughout the hearing, but I was not allowed to say a word, although I was the only person there representing the community.

That is an absurd situation. I intend to bring it to an end and to put in place, sooner rather than later, a system that takes much more account of what the community needs and wants, instead of allowing large monopolies to dominate proceedings. That is exactly what we are looking at, and I will bring forward proposals to the Parliament on that.

Rhoda Grant: I welcome that. One of my concerns is that there appears to be a rush of applications, because people know that the review is coming and things will change—applications are certainly being discussed; whether they all come forward is another matter. Is there a way of putting through emergency legislation now, to call a moratorium on new applications, so that we can leave things as they are until the new regulations come through? We also need to allow the regulations to be properly consulted on, so that they are fit for purpose, because we do not want to rush through new legislation that might have unintended consequences, given that the area is quite complex.

10:45

Alex Neil: I absolutely agree. I have said this in the Parliament: if I had the legal power to call a moratorium on applications and consideration of applications—and we have explored every possible way for me to do that—I would have exercised that power and had a moratorium. I do not have the legal power to do that. Had I the legal power, I would definitely have imposed a moratorium until we have reviewed the rules.

We are going to do things quickly anyway. It would not make much sense to try to rush legislation through that would still require orders to be laid, for which there is a process that takes 40 days—or whatever it takes. We might as well

concentrate on the job in hand and get it right. I do not want to act in a way that opens me up to legal challenge. It is beneficial, particularly for communities who might be affected by such matters, that I do the job properly and according to process, and that I get it right. However, I intend to do it quickly.

Rhoda Grant: Can we not legislate on the small matter of giving you the power to call a moratorium, and then do the rest of it?

Alex Neil: The regulations will be secondary legislation, whereas giving me the power to call a moratorium would require primary legislation. Given that it would take much longer to get primary legislation than it would to change the existing position through secondary legislation, there is no great advantage in doing as you suggest.

The Convener: If there are no supplementary questions from members, I need to bring this part of the meeting to a close. The cabinet secretary has a Cabinet meeting to attend. Cabinet secretary, we will pass the remaining questions to your department and complete their consideration in that way. Thank you for your attendance. This was an interesting exercise and I hope that we can discuss how to take forward and improve the approach.

Alex Neil: I am happy to send you the answers to the questions that we did not get to. You can then circulate them to the committee and place them in the Scottish Parliament information centre, so that they are made available to the people who took the trouble to submit questions.

The Convener: Yes. We did not have any public participation in the meeting. However, I must apologise to the people who submitted questions and attended the meeting but did not hear their questions being asked. The cabinet secretary notified the committee that he would have to be away for half past 10 this morning. He stayed much longer than that. I apologise. I think that we have done well in getting through 12 questions and supplementaries, but we will review the meeting and discuss with the cabinet secretary's office and committee clerks how best we can improve the process and ensure that there is enough time. We will ensure that there is a response to everyone, through the cabinet secretary's co-operation.

Thank you all very much. As agreed previously, we move into private to discuss committee reports.

10:47

Meeting continued in private until 12:14.

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